NATIONAL QUALITY FORUM

+ + + + +

POPULATION HEALTH & PREVENTION ENDORSEMENT
MAINTENANCE STEERING COMMITTEE

+ + + + +

WEDNESDAY
SEPTEMBER 14, 2011

+ + + + +

The Steering Committee met at the Marriott Wardman Park Hotel, 2660 Woodley Park Road, N.W., Washington, D.C., at 8:00 a.m., Kurt Stange, Chair, presiding.

PRESENT:
KURT STANGE, MD, PhD, Chair
RON BIALEK, MPP, Public Health Foundation
LINDA KINSINGER, MD, MPH, National Center for Health Promotion and Disease Prevention
FRANK LEONE, MD, MS, Penn Lung Center, University of Pennsylvania

SARAH LINDE-FEUCHT, MD, Health Resources and Services Administration
KEITH MASON, MS, National Forum for Heart Disease and Stroke Prevention
JACQUELINE MERRILL, RN, MPH, DNSc
MADELINE NAEGLE, PhD, FAAN, APRN, BC, New York University College of Nursing

SUE PICKENS, MEd, Parkland Health and Hospital Systems
MARY PITTMAN, Dr.P.H., Public Health Institute
AMIR QASEEM, MD, PhD, MHA, FACP, American College of Physicians
SARAH SAMPSEL, MPH, WellPoint
JASON SPANGLER, MD, MPH, Partnership for Prevention
MATT STIEFEL, MPA, Kaiser Permanente

PRESENT(Cont'd):

MICHAEL STOTO, PhD, Georgetown University

ANDREW WEBBER, National Business Coalition on Health

NQF STAFF:

KAREN ADAMS, PhD

HEIDI BOSSLEY, MSN, MBA

HELEN BURSTIN, MD, MPH

KRISTIN CHANDLER, MPH

ANN HAMMERSMITH, JD

NICOLE McELVEEN, MPH

ELISA MUNTHALI, MPH

ROBYN Y. NISHIMI, PhD

KAREN PACE, PhD, RN

REVA WINKLER, MD, MPH

ALSO PRESENT:

MARK ANTMAN, PCPI

MARY BARTON, NCQA

KEVIN BOWMAN, Resolution Health/WellPoint

SEPHEEN BYRON, NCQA

LINDEE CHIN, Active Health Management

KEZIAH COOK, Acumen

DAVID HITTLE, University of Colorado

SARAH LACKNER, Active Health Management

ALLEN LEAVENS, Resolution Health/WellPoint

LISA McGONIGAL, Kidney Care Partners

BANI VIR, Active Health Management

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

Page
Welcome, Recap of Day 1, Goals 5
Consideration of Standards (Immunization) 24
0226 ESRD population (KCQA)
0041 Influenza immunization (PCPI)
0039 Flu shots, 50 and older (NCQA)
1659 Influenza immunization (hospital) (CMS/OFMQ)
NQF Member/Public Comment 106

Consideration of Candidate Standards (Screening) 109
0034 Colorectal cancer screening (NCQA)
0033 Chlamydia screening (NCQA)
0031 breast cancer screening (NCQA)
0032 Cervical cancer screening (NCQA)
0579 Annual cervical screening for high risk patients (RHI)

Consideration of Candidate Standards (Screening) 186
0037 Osteoporosis testing in older women
0629 Male smokers or family history of AAA screening (Active Health)

NQF Member/Public Comment 225
Consideration of Candidate Standards Immunization, cont.)
0043 Pneumonia vaccination, older adults
0617 Pneumococcal vaccination (Active Health)
1653 Pneumococcal Immunization (hospital) CMS/OFMQ)
1525 Pneumococcal vaccine ever received (home health) (CMS)

Discussion of Harmonization 299

C-O-N-T-E-N-T-S(Cont'd)

Page

Consideration of Candidate Standards 301

(Immunization, cont.)

0038 Childhood Immunization (NCQA)

Discussion of Process of Developing 319

Population Health Measures

Member/Public Comment 368

Next Steps 369

Adjournment 376

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

2 8:12 a.m.

3 DR. STANGE: Thank you, everybody
4 who is here. Thank you for people that are on
5 line. Thank you, particularly, to the
6 measures developers who got bumped from
7 yesterday, and we kind of messed up your day
8 today, I am sure.

9 I am Kurt Stange. I am co-
10 chairing this with Paul Jarris, who is not
11 here, and we have had diminished numbers here,
12 although one new member joining us, but we are
13 going to go forward.

14 What I would like to do today is
15 try to reflect on our process so far, and help
16 us with planning with the next steps. So if
17 you can indulge me for about five minutes, I
18 would like to go over some stuff, and then
19 open it up for us to discuss our charge a
20 little bit and what the next steps might be,
21 and then we will on to the more instrumental
22 work of doing the updates on the measures.

1 So I got awakened at 5:00 a.m. by
2 an ambulance this morning. I don't know if
3 anybody else did, and there is something
4 special about those early morning hours. You
5 are between the time when your subconscious
6 has been churning on stuff that we did, like
7 a full day like we had yesterday, and when you
8 are really fully with it.
9 In that moment, I just reflected
10 back on what we did yesterday, and I was
11 really impressed with how jazzed everybody
12 was, how we came here with a sense of great
13 opportunity in defining and measuring
14 population health, that frankly, this is part
15 of a larger movement. We sense this is an
16 important position in time.
17 The NQF is uniquely placed to do
18 something important here. I think we all had
19 a shared sense of that. The NQF's unique
20 position, I think we heard, is that what gets
21 measured gets paid attention to with sustained
22 effort, and that the NQF's position as a

1 framer and a convener could really advance
2 this larger opportunity and, conversely, that
3 doing this work, which is new for the NQF,
4 could actually help to advance the NQF's
5 relevance in an environment that is changing,
6 that is moving from individual to community
7 and populations.
8 So there really is something
9 larger going on here. Together yesterday, we
10 have been really learning about the NQF
11 process and working together to understand our
12 charge and to discover this opportunity of
13 working with the NQF.
14 As you heard yesterday, Paul and I
15 are very new, newly appointed as Chairs. As
16 you saw yesterday, we are working with you to
17 make sense of an agenda that really had two
18 very different goals. So what you saw going
19 on in real time was what we were experiencing
20 real time, too, which is figuring this out.
21 I think some of the reason it was
22 challenging is that we are trying to do very

1 different things. One, we are trying to frame
2 a potentially transformative new effort, a new
3 direction for the NQF that is based on this
4 Department of Health and Human Services task
5 order to develop measures of population
6 health. The NQF really is looking to us to
7 help develop that and to help frame that.
8 We are also doing some of the
9 regular work of the NQF in updating these
10 measures in their endorsement and maintenance
11 process. That is what we started to do, a
12 couple of measures up today. That is
13 instrumental work that we have to do later on
14 today, hopefully, in a streamlined way.
15 So before we get back to that
16 instrumental work, I would like to just take
17 a few minutes to first see if we have
18 consensus on what the transformative
19 opportunity is, then to make sure that we have
20 this larger opportunity matched to the unique
21 position of the NQF and what the Steering
22 Committee might do, and to develop a plan for

1 going forward.

2 So just to summarize -- and I want

3 to have some discussion of this -- what I

4 heard us saying, the opportunity yesterday is

5 to define a frame for developing and using

6 population measures, and then to help the NQF

7 in actually making the call for measures and

8 figuring out what that looks like and,

9 instrumentally, how do you actually measure

10 population health.

11 I heard three resources that have

12 available to support this. One is the NQF

13 staff. One is the LA Department of Health

14 with Don and Steve, who have been commissioned

15 to do a paper, to do the environmental scan

16 that will help us articulate principles and a

17 framework.

18 So they are going to help us not

19 reinvent the wheel by looking at what is out

20 there, giving us a framework for thinking

21 about that. Then we have the committee's

22 expertise, wisdom, and volunteers, frankly.

1 So when we talk in a minute about what we are
2 going to do going forward, we have to think
3 realistically about what we are going to be
4 able to commit to this with that support and
5 how we might get that done.
6 I thought we did a good start at
7 that yesterday with the three groups that
8 emerged from the discussion. We had the group
9 that Matt led on population health, a
10 framework for measuring population health; the
11 work that Ron did, thinking about what is the
12 scope of that work; and then the group that
13 Sarah led, which is kind of a how-to on
14 evaluating and measuring population health.
15 So if we combine those three --
16 combine the framework and scope groups, those
17 actually match pretty well into those
18 actionable opportunities of defining the
19 frame.
20 So if you put the group that Matt
21 and the group that Ron led yesterday, that is
22 really about defining the frame for developing

1 and using population measures, and then the
2 group that Sarah led is really about helping
3 NQF to make the call for measures, figuring
4 out what an actual call for measures looks
5 like and what the how-to of measurement looks
6 like.
7 So what I would like us to do is
8 reflect on both what we see as the actionable
9 opportunity and then develop a plan for
10 working forward. That working forward might
11 involve taking those -- maybe consolidating
12 those three groups into two. So we have got
13 that framework group and then the how-to
14 group. That would be one way to proceed.
15 So that is a lot of me talking,
16 but I think we need to revisit the big picture
17 today, but we have a lot of instrumental work
18 to do. So I wanted to give us some frame for
19 discussing that before we dive into the
20 instrumental work.
21 So first I would like us just to
22 see if we have some consensus on what our

1 actionable opportunity is. Here is my frame
2 for that. I would like to just open it up.
3 Does that reflect what you heard and what you
4 feel or are there other things we should be
5 thinking about? Ron, Matt?
6 MR. STIEFEL: I think it looks
7 good. One piece, I think, that is important
8 to fit in there somewhere is maybe the piece
9 that was from the other group of scope, is
10 what is a population? Actually, there are two
11 big questions: What is a population, and what
12 is health?
13 The "what is a population" one is
14 pretty significant, and maybe we can come to
15 a quick consensus about that, but I think it
16 is pretty fundamental.
17 DR. STANGE: So what is a
18 population, and what is health? Then the word
19 community came up. So I think within
20 population we will want to think of what is a
21 community, and how those relate to each other.
22 So that is going to be a really important part

1 of the work of that group then. Other
2 thoughts? Helen?
3 DR. BURSTIN: One additional
4 thought, Kurt -- I think this looks great --
5 is also just to not forget interweaving in the
6 work that LA is going to be doing. We want to
7 make sure that doesn't feel like it is kind of
8 floating off there. They could, in fact, try
9 to define some of this work and bring it back
10 to the group as one option.
11 DR. STANGE: Where would you see
12 that fitting in, Helen?
13 DR. BURSTIN: I think the
14 framework scope model group feels like the
15 right group to maybe also be the interface
16 with LA. Does that sound okay with folks?
17 DR. STANGE: And these tasks
18 really have to go in parallel. So these can't
19 be groups that go away and work in isolation,
20 and come back. They have got to -- There has
21 got to be some iteration and work together.
22 Anything else on the charge

1 opportunity we see here?
2 DR. KINSINGER: I am just curious
3 -- for Helen -- whether you have done any
4 preliminary looking around at what kinds of
5 measures might be out there, and what does the
6 field look like now, before we have really
7 tried to fine tune it? I was just curious.
8 What is your gestalt about that?
9 DR. BURSTIN: Yes. Actually, Reva
10 and Kristin and some of others did some really
11 nice work on an environmental scan, and there
12 are actually some very interesting measures,
13 most of which, not surprisingly, come from
14 things like State of the USA, BRFSS, the usual
15 suspects.
16 I think one of the questions we
17 need to kind of decide first is what are we
18 talking about? We will be happy to share that
19 list. It is part of what -- The LA group is
20 also going to do a broader environmental scan,
21 but it might just be a nice sort of thought
22 piece to get us going, if you would like to

1 see that work. I thought they did a really
2 nice job.
3 DR. STANGE: So we are iterating
4 here between getting the big picture and then
5 we need to not reinvent the wheel. So that
6 would be really helpful. Madeline?
7 DR. NAEGLE: Yes, good morning. I
8 was thinking about some of the comments
9 yesterday about looking beyond our own scope,
10 and I think a good bit of work has been done
11 with WHO and with Canada that combines some of
12 these behavioral health and general health
13 approaches.
14 It would be good to take a look at
15 that. Not all of it is so helpful, but
16 certainly, we are all talking about the social
17 determinants work, and that has already proved
18 very helpful, and there are some materials
19 that, I think, might enlighten us a little bit
20 by just getting out of the box and thinking
21 maybe how their approaches might articulate
22 with our system or not.

1 DR. STANGE: I think we are
2 transitioning in our conversation into the
3 how-to, and that is a really important point
4 that we want to start with, what is out there.
5 We want to -- We started yesterday with the
6 NQF existing measures and thinking about how
7 those might relate to population, and that is
8 one task that will keep going forward.
9 The other thing we are doing is
10 starting with what is the larger picture and
11 then coming back to the NQF's role. So what
12 Madeline is talking about is having a broad
13 enough scope for that, that we look
14 internationally as well as nationally, where
15 other countries have, frankly, been thinking
16 with a population perspective for a lot longer
17 than we have.
18 MR. STIEFEL: And would that fall
19 into Sarah's category of looking at how we
20 articulate and define the measures? I think
21 that is a really -- I mean, the European Union
22 has done some great work on population health

1 measurement sa well.
2 DR. BURSTIN: Is that okay, Sarah?
3 DR. STANGE: And then one thing we
4 have to do is make sure there is communication
5 with the NQF staff and with the people that
6 are charged -- LA Department of Health are
7 charged with doing this work, so that we can -
8 - so the volunteers here aren't spending all
9 their time doing the searches and the framing
10 and finding what is out there, but can take
11 advantage of that other work.
12 DR. STIEFEL:: That is just a
13 question I have, because obviously, that -- we
14 are kind of doing the same thing as LA. So
15 how does that relationship work?
16 DR. WINKLER: Well, I think what
17 we are envisioning going forward is the work
18 groups that you all have sort of being sort of
19 the thinkers, bringing the ideas. We can
20 schedule conference calls with your group,
21 staff and the folks from LA. You guys can
22 pose the ideas. We can do the work.

1 DR. BURSTIN: And some of the LA
2 work is actually quite distinctive. They will
3 do the broad environmental scan, for example,
4 of population health measures, nothing that
5 these work groups are doing.
6 I think what we clearly need to
7 figure out is some of the definitional work,
8 I think, is very overlapping, and some of the
9 model work is very overlapping, which is why
10 I think those two aspects we should -- and I
11 suspect they would welcome having a group to
12 sort of ping ideas off of.
13 DR. STANGE: So we don't have the
14 full group here. We don't have our co-chair
15 here. So we don't have to get this all locked
16 in for what we are going to do for the next
17 year, but we do need to think about some next
18 steps.
19 So one thing is that we are going
20 to give feedback on the draft paper. We have
21 already given feedback on the draft paper and
22 on the draft outline that Helen shared with us

1 yesterday about the how to measure this stuff
2 based on what the NQF is already doing.
3 If people have other things they
4 want to contribute, they can certainly email
5 that to Elisa. We will get other drafts of
6 that, and we will have a chance to do feedback
7 on that, but the other question is next steps.
8 Is the next step to have a
9 conference call among these two groups, and we
10 will have to then have an electronic process
11 for people to figure out which group they want
12 to be in initially, because there are people
13 that aren't here. Is that a reasonable next
14 step? Okay.
15 Other next steps that we should
16 capture while we are all here together?
17 MS. SAMPSEL: I just wanted to
18 make sure on the how-to group that we will g
19 et everybody's feedback from the criteria that
20 you shared, Helen, so everybody understands
21 that is part of the assignment, is to give the
22 criteria feedback, so we can filter that into

1 our work.
2 DR. STANGE: Right. These groups
3 really -- their charges dictate so much. We
4 can't have an isolated process. I think you
5 are exactly right. So anything that is shared
6 with one group should probably be at least
7 cc'ed to the others, because that is going to
8 be -- If we are working from different
9 background materials, we are going to have a
10 hard time getting the common language.
11 Other next steps? Personally,
12 that helps me to relax, because that seems
13 like it is the transformative opportunity that
14 got us all jazzed yesterday. I was very
15 impressed with how people immediately switched
16 gears and dove into the measures update
17 process. I was shocked at how people did
18 that.
19 If we keep going at that same rate
20 -- Obviously, we have got three days of work,
21 but what Reva told me in a holding my head in
22 my hand way on the one phone call we had

1 preparing for this beforehand, was don't
2 worry, the first measure takes a lot of time,
3 and we really worked through the process.
4 DR. BURSTIN: And hour and a half,
5 every time.
6 DR. STANGE: Oh, good, because
7 that is probably what Reva said. I heard
8 half-hour.
9 DR. BURSTIN: No, an hour and a
10 half.
11 DR. STANGE: Oh, that is good.
12 Okay. Oh, so we are in the norm. So I ask
13 one thing, is that don't have to vote on every
14 aspect of it. We did need to, I think, do
15 that, and I think we needed to vote on every
16 aspect of it so we know what we are doing,
17 because the global yes/no question is based on
18 having met those criteria, and particularly
19 the initial no go importance criteria, but
20 then all the instrumental criteria about how
21 things are measured and all those other
22 factors.

1 So we do need to think about that,
2 but we do have the opportunity to just vote
3 yes/no on each measure.
4 What I would suggest is that we
5 begin the framing comments by either the
6 person from the group who is assigned or the
7 measure developer. If we have those try to be
8 as succinct as possible, not so much working
9 through every criteria, but since we are
10 updating measures that are already pretty well
11 established -- all of them, I think -- what is
12 new? It was helpful yesterday to know that
13 these were preliminarily approved, the two
14 measures we discussed yesterday. That seemed
15 like a helpful frame.
16 The two people who discussed
17 yesterday, I thought, did a nice job of just
18 saying what is new, what is important; but if
19 we can just have that be the frame -- Tell us
20 from your careful look at it, what do we
21 really need to pay attention to, and we can
22 start the discussion with that, and just make

1 sure everybody has a chance to bring up
2 anything about the other criteria -- I think
3 we will be able to go through this pretty
4 quickly.
5 Reva, what do you want to say
6 about the process?
7 DR. BURSTIN: We also want to
8 invite our two new members -- welcome, say hi.
9 DR. STANGE: Yes.
10 DR. WINKLER: Amir and Mary.
11 DR. STANGE: Okay. Amir,
12 yesterday we introduced ourselves briefly and
13 did disclosures of any conflict of interest.
14 So if you want to start, and then, Mary, if
15 you could do the same thing, that would be
16 great. And welcome.
17 DR. QASEEM: Good morning,
18 everyone. Amir Qaseem. I am Director of
19 Clinical Policy at the American College of
20 Physicians. Sorry I couldn't be here
21 yesterday. I had to run another meeting.
22 In case of disclosures, I don't

1 have any financial conflicts of interest.
2 Non-financial, I am on various boards. I
3 don't know. Do you want me to disclose those?
4 Off the top of my head, I am on some CDC
5 committees, on IOM Guideline International
6 Network, but they are all non-financial
7 conflicts of interest.
8 DR. PITTMAN: Good morning,
9 everyone. Mary Pittman, President of the
10 Public Health Institute in California. I am
11 sorry I couldn't be with you yesterday. I
12 had my board meeting.
13 I have no financial conflicts of
14 interest and, same as Amir, serve on a number
15 of boards in areas where they do look at
16 indicators.
17 DR. STANGE: Reva, do you want to
18 pick us up with the next thing?
19 DR. WINKLER: All right. Just to
20 recap yesterday, we started on a group of
21 influenza immunization measures. We did do
22 two of them. Based on the availability of our

1 measure developers, we are going to start with
2 measure 226, influenza immunization in the
3 ESRD population.
4 This is from the Kidney Care
5 Quality Alliance, and this is the percentage
6 of end stage renal disease patients age six
7 months or older receiving hemodialysis or
8 peritoneal dialysis during the time frame from
9 October 1 or when the influenza vaccine became
10 available to March 31st who either received,
11 were offered and declined, or were determined
12 to have medical contraindications to the
13 influenza vaccine.
14 So Lisa McGonigal, I think, is on
15 the line from the developer. Any intro
16 comments, Lisa?
17 DR. McGONIGAL: Yes, I will just
18 take a couple of seconds. Can you hear me
19 okay?
20 DR. WINKLER: You are a little
21 soft. If you can bring it up.
22 DR. McGONIGAL: Is that better?

1 DR. WINKLER: Better.
2 DR. McGONIGAL: Great. Good
3 morning, I am Lisa McGonigal from Kidney Care
4 Quality Alliance, which is an alliance of
5 patient advocates, health care professionals,
6 care providers, and purchasers, all convened
7 by Kidney Care Partners to develop performance
8 measures for end stage renal disease care.
9 We are pleased to have submitted
10 information for our influenza immunization of
11 the ESRD population, which is a facility level
12 measure. Again, I would like to provide a
13 little background information on the measure.
14 The KCQA measure has been field
15 tested at 53 dialysis facilities across the
16 United States on a total of 1,115 ESRD
17 patients, and has been demonstrated as
18 reliable, valid, and feasible, and we have
19 included detailed testing results in the
20 measure submission form that you received from
21 NQF.
22 The measure was endorsed by NQF in

1 2008, and it is included among the Centers for
2 Medicare and Medicaid Service Phase 3 clinical
3 performance measures which are slated for use
4 by CMS in its Crown Web Dialysis Facility Data
5 Repository when it becomes functional.
6 The underlying rationale for the
7 measure is to ensure that all ESRD patients
8 aged six months and older who do not have an
9 underlying medical contraindication receive an
10 annual influenza vaccination, as is consistent
11 with the current clinical guidelines released
12 by the CDC's Advisory Committee on
13 Immunization Practices and the American
14 Academy of Pediatrics, and the major is also
15 consistent with the Healthy People 2020 goal
16 to immunize 90 percent or greater of high risk
17 individuals against the flu.
18 Unfortunately, however, evidence
19 indicates that the U.S. continues to fall far
20 short of these longstanding and well
21 established recommendations and goals.
22 According to the most recent data from the

1 United States Renal Data System, less than 63
2 percent of all ESRD patients received a flu
3 vaccine in 2008.
4 We would like additionally point
5 out that the measure is completely harmonized
6 with the NQF's Influenza Immunization Standard
7 Measure specifications that I heard you
8 discussing a bit yesterday.
9 Finally, we assert that a separate
10 measure addressing influenza immunization
11 status specifically in the ESRD patient
12 population is imperative, given the need for
13 the specifications to explicitly stress that
14 only inactivated virus should be used in this
15 population, and also to reflect the fact that
16 ESRD patients receive routine medical care in
17 a unique manner and setting -- that is, within
18 the dialysis facility.
19 The specifications from the other
20 flu measures being considered here today won't
21 and don't translate to this population,
22 because they are either intended for specific

1 populations, such as health care workers or
2 home health patients, or they are the wrong
3 level of analysis, the physician level, to
4 allow for an accurate and effective assessment
5 of the care provided to ESRD patients.
6 KCQA would like to thank the
7 Population Health and Prevention Steering
8 Committee and NQF for your consideration of
9 this measure, and we welcome any questions
10 either now or after your deliberations.
11 DR. WINKLER: Thank you, Lisa. I
12 just want to point out to the committee that
13 the four members of the Work Group have done
14 preliminary evaluations of this measure. They
15 are upon the screen. I think it is close
16 enough we can see them.
17 Amir, you were the primary
18 reviewer for this one, and what comments do
19 you have?
20 DR. STANGE: And, Amir, just
21 imagine that you were here yesterday, and we
22 did discuss the generic things that relate to

1 influenza immunization, both about the
2 importance of it and about some of the
3 challenges of measuring the evidence. So just
4 imagine that we have already done that. Is
5 there anything additionally unique about this?
6 DR. QASEEM: I am sure you
7 probably already discussed most of the issues
8 here. So a brief overview: These are pretty
9 established measures. We already know what
10 needs to be done, what doesn't need to be
11 done.
12 One thing I do want to voice, and
13 I am sure you already discussed this, is --
14 and that relates to the harmonization of
15 measures, and I am sure you had extensive
16 conversation, but I don't think we can all say
17 enough about it.
18 What I am struggling with is what
19 is this measure adding to the value? I think
20 the KCQA rep just mentioned the imperative
21 need to have an influenza vaccination measure
22 for ESRD population, but I am not really aware

1 of any evidence that shows that to have a
2 population specific measure for this
3 population is going to lead to increasing
4 vaccination rates in any way or it is going to
5 change physicians' behavior in terms of when
6 it comes to flu vaccination
7 So essentially, with influenza
8 ones, what I am struggling is why can't we
9 just have a measure -- and I know there is
10 some good measures out there. For example,
11 PCPI has a really good measure that you give
12 vaccination to everyone who is over six years
13 of age after March 31st.
14 If you have a measure something of
15 similar nature, that will cover the ESRD
16 population. That is sort of a feel for what
17 I had, was that what exactly is this measure
18 adding, and I know I am not really sure if it
19 is beyond the scope of this committee or not
20 or if we are supposed to even talk about that
21 or not.
22 Then in the meantime, if we can

1 move toward the direction of harmonization, at
2 least have the numerator and dominator
3 statement start feeling a little similar. You
4 can have it specifically for ESRD population,
5 but at least they should start reading what
6 the other statements are talking about.
7 Again, all of you are involved in
8 performance measurement. It feels like -- You
9 remember what the guidelines used to be, and
10 we have a little bit reined them in, in terms
11 of -- Of course, there is no harmonization
12 still there, but I am just not seeing what is
13 this measure adding.
14 DR. STANGE: That is a real
15 important measure. We discussed it yesterday,
16 but I don't think resolved it enough. Can we
17 park that until we have done all these
18 immunization measures or at least the
19 influenza ones, and address that question, is
20 there something more that could be done; and
21 then the other thing we will do at the end is
22 we will reflect on these. We will say, is

1 there anything that informs our larger
2 discussion.
3 So, Jackie, then Matt.
4 MS. MERRILL: I think that this is
5 the only special population that still remains
6 out of this general thing. So all the other
7 high risk populations have been folded into
8 the general. So the argument would really be
9 why is this the only one that is excluded.
10 DR. STANGE: So we should discuss
11 it now then.
12 DR. WINKLER: Just one comment to
13 Amir, something we discussed yesterday was
14 harmonization and NQF's previous efforts
15 around harmonization. If you can believe,
16 three years ago we had 16 measures for
17 influenza, and the way that harmonization was
18 approached was to create a sort of a standard
19 set of specifications that reflected the
20 guidelines.
21 Those specifications are generally
22 to have numerator categories of vaccinated,

1 declined, and contraindications computed and
2 reported separately in the numerator and in
3 the denominator as broad a population as
4 possible.
5 So the exclusions were not taken
6 out of the denominator, and this measure
7 actually does conform to that. Three years
8 ago, that was really established at NQF with
9 everyone being aware and advised and notified
10 that this was the direction we were moving.
11 So this is how we are trying to
12 pull everybody in alignment. So I just wanted
13 you to be aware, because we did talk about
14 that a bit yesterday.
15 DR. QASEEM: And I think that is
16 very helpful, but is it a fair question to ask
17 that what value is this measure adding?
18 MS. MERRILL: I actually agree
19 with that. It is a very small population. It
20 is in the thousands of people. So, really, I
21 mean, what does it hurt to have a special
22 measure by this special group? I don't know

1 if there is any downside to it, but it just
2 seems completely unnecessary.
3 If it is this particular group
4 trying to keep tabs on its membership and --
5 I don't really know what NQF's position is on
6 things like that.
7 DR. STANGE: So that is a question
8 for Reva and Helen. How do we take this
9 concern forward?
10 DR. WINKLER: A couple of things.
11 I think there are a couple of things to
12 consider. When you look at other measures,
13 the question is who could pick up this
14 population as an alternative, and this is a
15 facility level measure. As opposed to some of
16 the others, the level of analysis may not
17 apply.
18 So it can get into the devil is in
19 the details. I think, keeping that as an
20 overlying question is definitely something for
21 the group to consider. You may need us to do
22 a little bit more looking into the details for

1 you before you can make a final consideration.
2 DR. QASEEM: And I think that will
3 be very helpful, because to get the data on
4 this specific population, I think you can
5 extract that from -- even at the facility
6 level, if you are just looking at the ESRD
7 population. You can extract the data and get
8 that information. Am I wrong? I just don't
9 see. Why can't you get that information from
10 -- even if you have the population broader
11 statement, you can still extract the
12 information. I get information about my
13 diabetic patients or any of the population.
14 DR. WINKLER: Can we at least just
15 -- From the criteria we have for the measure
16 as it is, putting that question aside, do you
17 feel that the measure meets the criteria for
18 importance? Is there an opportunity for
19 improvement in this population, and is the
20 evidence solid?
21 DR. QASEEM: Sure. I think,
22 definitely, and I think it is -- That is the

1 one question I struggle. I agree with
2 Jacqueline about that in terms of impact. I
3 think it is a small population, but if you
4 just look at that specific population, the
5 impact will be there, but in the broad scheme
6 of things, you are talking about a very small
7 population over there.
8 In looking at the opportunity for
9 improvement, what the measure developer
10 actually presented , if I understood the
11 numbers correctly, it seemed like there was
12 already reasonably good rate that was there,
13 to begin with, and maybe I didn't really
14 interpret the numbers correctly.
15 In terms of evidence, again as I
16 was talking to Kurt this morning, influenza is
17 a well established measure. I mean, I am not
18 going to contest anything when it comes
19 through. That reliability was good over
20 there. Validity, I wasn't really too
21 convinced, and I gave it, I believe, a
22 moderate, the next to high. I think it was

1 moderate, but generally -- Am I supposed to go
2 over like this, or not?
3 DR. STANGE: So just as a model
4 for how we might get through these, it sounds
5 like we have -- Does anyone have any
6 disagreement about importance, and it sounds
7 like we have strong -- good evidence, enough,
8 certainly, to approve, with the concern about
9 maybe combining down the road. Any
10 disagreement with that? Madeline?
11 DR. NAEGLE: I don't have a
12 disagreement with that. I heard something
13 that you mentioned I want to just follow up
14 on, and that was that you felt that physician
15 behavior might not change.
16 I think that fits under usability
17 and feasibility, but it also raises the
18 question about why do this, if it is going to
19 impact a small number of people, and it might
20 not be implemented anyway.
21 DR. McGONIGAL: May I speak to
22 that? We know that-- There is a strong

1 indication that the measure will be widely
2 implemented. As far as why it is separating
3 off the ESRD population, it is to do with the
4 fact that they receive their service in
5 facilities. So we would like to look at a
6 facility level measure, and that is how the
7 measure is being used by CROWNWeb and CMS as
8 well.
9 DR. QASEEM: The final question I
10 was going to ask Rita and Helen is: Of
11 course, looking at all these different,
12 separate criteria, you can give it high,
13 moderate, and it seems to be a good, well
14 developed measure. But then the struggle
15 comes in, and I don't know how we are
16 supposed to talk about it when it comes to
17 final endorsement for the issues I that raised
18 What the criteria was does not
19 address the things that I am talking about.
20 DR. WINKLER: typically, what we
21 want to do is look at the criteria for the
22 measure independently, and if it meets all the

1 criteria and then, looking at the group of
2 measures, ask the question you are asking.
3 So we kind of need to do this
4 first, to be sure that -- because, for
5 instance, if it failed one of the criteria, it
6 would be off the table, and there is no need
7 for any further discussion. So we need to
8 establish, and everybody is comfortable, that
9 it meets the criteria.
10 Then the subsequent question is,
11 is it a necessary addition or not. It is a
12 perfectly appropriate discussion to have, but
13 we do want to establish that it meets all the
14 criteria up front.
15 DR. STANGE: Is anyone not ready
16 to vote on whether it meets the criteria?
17 MR. STIEFEL: It is hard to
18 separate out the two issues. If there is a
19 family of measures with exactly the same
20 numerator and just different specifications,
21 different cuts for the denominator, on what
22 basis would we vote differently about all of

1 these criteria? The other thing is why
2 wouldn't there be 1,000 of these? I mean you
3 could do it for every imaginable subset of the
4 population. You could say influenza
5 immunization is important.
6 DR. BURSTIN: Simply to respond to
7 it -- and I think you are right. What we have
8 seen already is, for example, many of the
9 physician level measures have been
10 consolidated. There was one for COPD. There
11 was one for many, many different conditions.
12 That has now gone away, to the credit of the
13 developers.
14 I think the only difference in
15 some ways about the ESRD measure is actually
16 the data source, that it is built into
17 CROWNWeb. It is done at dialysis facilities.
18 So that, I think, is more of a harmonization,
19 and they harmonize to standard specifications.
20 So the question is, is it really a
21 competing measure or is it harmonized, and
22 that is acceptable? I think that is one of

1 the questions that is still not completely
2 clear.
3 DR. STANGE: But it sounds like
4 the mechanism we have for going forward with
5 this would be to approve the measure if we
6 feel it meets the criteria, and then ask you
7 to do additional work on looking at both the
8 logistics and the politics of getting it
9 combined or harmonized.
10 DR. WINKLER: Kristin, can you go
11 forward to the voting slide that asks about
12 the summary: Does it meet the criteria for
13 endorsement? There it is.
14 So as you can see, the question
15 is: Does it meet the criteria for
16 endorsement. That is sort of the first step,
17 and then we can continue having this other
18 conversation about, in the big picture, how
19 does it relate to all the other measures?
20 So this is our first one. Amir,
21 there should be a little vote -- You got it.
22 Okay. Thank you. All right. You have to

1 point it at Kristin's computer over here, but
2 if everybody is ready to vote, go ahead.
3 Does it meet the criteria for
4 endorsement? It is not -- Okay, do you want
5 to take a hand vote, which is the old way?
6 DR. STANGE: Shall we try it
7 again, Kristin?
8 DR. WINKLER: Want to try it
9 again, Kristin.
10 DR. STANGE: Let's give Kristin a
11 minute to look at that. Should we do a hand
12 vote. All those in favor that it meets the
13 criteria, raise your hand. Okay. Anyone
14 opposed? Jackie, were you opposing?
15 MS. MERRILL: Yes, I am opposing.
16 DR. STANGE: So Reva and Helen,
17 help us with what is the next step to get this
18 --
19 DR. McGONIGAL: I'm sorry. May I
20 ask what the outcome of the vote was?
21 DR. WINKLER: Oh, okay. Yes, 11;
22 No, one.

1 DR. McGONIGAL: I'm sorry, again?
2 DR. WINKLER: Yes, 11; No, one.
3 So the next measure we want to
4 look at --
5 MR. MASON: I think, to Amir's
6 point, and to Matt's point, how many resources
7 does it take to continually go back and ask
8 people for more information or get more
9 information or put it somewhere else? If you
10 had, to Matt's point, 1,000 of these, and that
11 is an hour each, that is a thousand person-
12 hours work. So if we continue to approve very
13 small subsets of measures, you are going to
14 have thousands of hours of work to do, in
15 general, setting a precedent.
16 DR. BURSTIN: And to be clear,
17 since three years ago, as Reva pointed out, we
18 have worked with the developers and eliminated
19 almost all of the condition specific ones.
20 Again, this is somewhat unique because of the
21 facility level measurement and building it
22 into CROWNWeb is the database that dialysis

1 facilities use.

2 So I think it is more of a data
3 source issue, I think, than necessarily a data
4 slide, but I think it is certainly something
5 we can come back to when you finish the other
6 immunization measures, to see if we think
7 there is still a competing measure issue.

8 DR. STANGE: So I think the
9 committee is -- At least I am not clear on how
10 we act on this concern. So there is this
11 concern.

12 DR. BURSTIN: The way you act on
13 it is we will finish the review of all the
14 related measures, and at the end, our fifth
15 criteria is you then take the measures that
16 you think met the criteria for endorsement,
17 and we then do a competing or a best in class
18 assessment, and it is at that point -- We just
19 don't want you go through an exercise with
20 measures until they have passed.

21 Once they have passed, we will
22 have you do that assessment, and at that point

1 we can have a discussion of whether or not you
2 think this measure is really best in class,
3 does it add value, or is time to somehow bring
4 it into the other measures.
5 DR. STANGE: And that will be at
6 the end of the immunizations. So we are still
7 doing yesterday's work. So let's try to get
8 through yesterday's work here, so we can get
9 to today's agenda.
10 DR. WINKLER: The next measure we
11 will look at is 1659, which is the from CMS.
12 It is inpatient hospital based measure:
13 Inpatients aged six months and older
14 discharged during October, November, December,
15 January, February or March who are screened
16 for influenza vaccine status and vaccinated
17 prior to discharge, if indicated.
18 In this measure, I don't believe
19 we have a representative from the measure
20 developer. This is a hospital level measure.
21 This measure essentially is a new measure that
22 was created on the recommendations from the

1 work NQF has done previously.
2 Previously, CMS had a measure for
3 the patients with pneumonia in the hospital,
4 and the question was why just pneumonia
5 patients; why not everybody? So the
6 recommendation was to expand this to all
7 hospitalized patients, and essentially that is
8 what they did.
9 So it is new only in that the
10 denominator is much more expanded, but
11 essentially measuring immunization status on
12 all hospitalized patients rather than just the
13 narrow subset.
14 So who was the -- Jason, I think
15 you were the reviewer for this one. Where did
16 he go? Oh, okay. So perhaps -- I didn't
17 realize he wasn't here. I think perhaps we
18 will then switch to another one.
19 Do we have the folks from NCQA on
20 the line? Oh, they here? Great. You are in
21 my blind spot. Then great.
22 Let's look at the measure 39 from

1 NCQA. We have the measure developers in the
2 room. This is flu shots for adults aged 50
3 and older. This measure represents the
4 percentage of adults aged 50 and older who
5 received an influenza vaccine within the
6 measurement period within the respected age
7 stratified CAHPS surveys.
8 This measure is only reported by
9 age group stratification. The terms -- and it
10 uses the terms FSA and FSO. FSA is the
11 rolling average of percentage of members 50
12 through 64 years of age. FSO is 65 years and
13 older.
14 So as we do have the measure
15 developers --
16 DR. SPANGLER: I am back, too.
17 DR. WINKLER: Okay. Well, we will
18 get back to you. Why don't we go ahead with
19 this measure. Did anybody from NCQA want --
20 MS. BYRON: Good morning,
21 everyone. I am Sepheen Byron, the Director of
22 Performance Measurement at NCQA, to give a

1 little intro about this measure.
2 This is actually two measures.
3 The FSA and FSO are abbreviations for the
4 measure names. So it is Flu Shot for Adults,
5 and it is Flu Shot for Older Adults, and they
6 are both collected via CAHPS survey. One is
7 the CAHPS for Plan OH, and then the other one
8 is the Medicare CAHPS for the 65 and older
9 groups.
10 So these measures focus on the age
11 groups that originally were the targets for
12 flu shots, according to a Advisory Committee
13 for Immunization Practices, part of the CDC,
14 the ACIP recommendations, and they are
15 longstanding HEDIS measures, and we actually
16 just presented this yesterday to our committee
17 on Performance Measurement -- sounds like
18 September is a really busy time for people --
19 and the measures were approved for
20 continuation in HEDIS with no changes.
21 Happy to answer any specific
22 questions you have about the measures.

1 DR. WINKLER: Linda?

2 DR. KINSINGER: Thanks. As was

3 said, this is a longstanding measure. It is

4 pretty straightforward. I don't think there

5 are really any issues with it. I think it

6 meets all the criteria.

7 You know, it gets into the

8 discussion of whether it is overlapping with

9 other measures, but I think -- Does it meet

10 the criteria? I would say, absolutely, yes,

11 it certainly does.

12 DR. WINKLER: Just to point out

13 that the summary from the Work Group is up

14 there. I guess the one question that makes

15 this measure different is that it is a survey

16 measure.

17 DR. KINSINGER: It is.

18 DR. WINKLER: And so I guess that,

19 I think, different from other measures that

20 tend to use medical record sources -- I think

21 that is a discussion point that the committee

22 would want to consider, the pros and cons of

1 that.

2 DR. KINSINGER: And maybe I could

3 just say, since the recommendation has changed

4 now to a universal recommendation over age six

5 months, I guess that would be a question as to

6 whether the age range is appropriate any

7 longer. So I would look to you for a question

8 for that.

9 MS. BYRON: So on the survey

10 measure, the reason it is a survey measure is

11 because we understand that these are health

12 plan level measures, and relying solely on

13 administrative data and codes would not be

14 helpful, because people are getting flu shots

15 from all sorts of places that don't record it.

16 You know, they get it at Costco and CVS and

17 Wal-Mart. So that is why it is a survey

18 measure.

19 In regard to the age group, we are

20 aware that the recommendation has been

21 expanded. Our typical policy for HEDIS is to

22 give the industry a little bit of time before

1 we implement changes to vaccines. So
2 typically, we wait about three years before we
3 put them into HEDIS to give the industry some
4 time to adjust to new vaccinations.
5 This is something that is on our
6 plate to look at expanding the age ranges.
7 For now, it is as is, but will be in the queue
8 for -- It would be considered almost like
9 development of a new measure, but we are
10 aware, and we don't think it would be a
11 problem.
12 DR. STANGE: Sarah?
13 MS. SAMPSEL: I promise to behave.
14 I think it is important to note, though, that
15 immunization is already captured in HEDIS,
16 flue immunization for children, and is it in
17 the adolescent one as well, or not yet?
18 MS. BYRON: It is. We actually
19 just added -- We have an immunization for
20 adolescents measure and, in fact, we just
21 added an HPV immunization measure that is
22 brand new for this year in HEDIS.

1 MS. SAMPSEL: Okay. So I just
2 thought I saw it, because we have been talking
3 about the full age band.
4 MS. BYRON: It is just captured
5 differently in those different populations for
6 HEDIS is important to note. So we are really
7 just almost talking about 18 to 50 that would
8 be reevaluated.
9 MS. SAMPSEL: Okay.
10 DR. STANGE: So it sounds like we
11 have the same concern about maybe combining or
12 harmonizing on this, but given that, any
13 additional concerns about this before we vote?
14 DR. WINKLER: One thing I brought
15 up. You said that the level of analysis for
16 this could be the clinician or group practice
17 or the individual clinician, and I guess, how
18 do you see this being implemented in an
19 individual physician practice, given that it
20 is a survey measure?
21 MS. BYRON: Well, I think that we
22 marked any level of measurement that could be

1 applicable, and it would really rely on them
2 administering a CAHPS survey.
3 The specifications -- they are
4 available, and I know that there is some work
5 with PCMH to implement different surveys. So
6 we thought it was applicable in that sense.
7 DR. BURSTIN: So this is part of
8 which CAHPS survey?
9 MS. BYRON: It is the CAHPS 4.0H
10 and also Medicare CAHPS for the 65 and older.
11 DR. BURSTIN: And it will also be
12 brought into the Patient Centered Medical
13 Home, you think, as well?
14 MS. BYRON: We -- I have to say, I
15 don't know a ton about the Patient Centered
16 Medical Home, but I know that there is some
17 work to consider different measures that would
18 be applicable for that.
19 DR. QASEEM: So your numerator
20 statement is to number of patients in the
21 denominator who responded yes to the question?
22 MS. BYRON: Yes.

1 DR. QASEEM: And then your
2 denominator is the number of members who
3 responded yes or no to the question?
4 MS. BYRON: Right. So it is
5 actually the denominator that you turned the
6 correct age and that you actually answered the
7 question. So it is just the way the CAHPS
8 survey is set up. You answer yes or no, and
9 then you take the people answered yes as
10 numerator compliant. I know it is a little
11 confusing.
12 DR. WINKLER: So just to clarify,
13 so people who did not answer the question are-
14 -
15 MS. BYRON: Put in according to
16 the way the CAHPS --
17 DR. WINKLER: Do you have any idea
18 how often that happens?
19 MS. BYRON: I could get that
20 information but, no, I don't.
21 DR. QASEEM: That is definitely --
22 It is an important point you raise, Reva.

1 MS. BYRON: I could look into that
2 and see if we can pull that information, but
3 this is -- as we know, it is a longstanding
4 CAHPS measure, and it is the way that the
5 CAHPS survey is set up. It is not an NCQA --
6 The CAHPS survey is not made by NCQA, but we
7 made the measure for the CAHPS survey.
8 DR. WINKLER: Any other
9 discussion?
10 MR. STIEFEL: So when we get to
11 harmonization -- Well, I don't know if it is
12 an issue now or when we get to harmonization,
13 but it is -- That is different from that rule
14 you just described about making sure that we
15 are handling the measures in the same way.
16 DR. WINKLER: Again, I think the
17 first question is does it meet the individual
18 criteria? Is there an opportunity for
19 improvement, given the data that was
20 presented? Is it consistent with the
21 evidence? Does the measure have sufficient
22 reliability, validity in the way that it is

1 specified?

2 This one is different, and it is a

3 survey measure. So I think there are

4 different questions you may ask in terms of

5 reliability/validity. Similarly, for

6 usability and feasibility.

7 So I think, you know, you do want

8 to look at the various criteria in terms of

9 the characteristics and specification of this

10 particular measure initially, and then we will

11 look to the harmonization issue.

12 MR. STIEFEL: So if this

13 particular measure leaves out that piece of

14 the denominator that we feel is important in

15 the other measures, is that -- are we

16 assessing that as part of the criteria or are

17 we assessing that later?

18 DR. WINKLER: I think that is --

19 Since you are talking about the specifications

20 of the particular measure, that is part of

21 scientific acceptability, and I think it is

22 part of the criteria.

1 DR. STANGE: So Matt and Amir, do
2 you want to -- one step further before we
3 vote. Do you want to talk about that? Linda?
4 DR. KINSINGER: I think you could
5 make a judgment as to whether that makes it
6 moderate versus high in terms of its validity,
7 which is, I think, where that would come in.
8 I guess I wouldn't see that as bumping it down
9 to a low, but it is a judgment call.
10 DR. QASEEM: Can you give us just
11 a feel for in terms of how many people you are
12 talking about, because that will affect the --
13 I mean, that can have a major impact or a
14 small impact. The range is so broad. I don't
15 have a call in terms of the population, if it
16 is really going to do what it is supposed to
17 be doing. Not everyone is being included, and
18 we may need more information, I think. Is it
19 possible to get a feel for it at least?
20 MS. BYRON: I can look into
21 getting that information maybe by the end of
22 the meeting. I can see if we can get that

1 information, but I am not sure how quickly we
2 can get it, to be honest.
3 DR. BURSTIN: I think it would be
4 helpful to actually state the specific concern
5 about the denominator, just so we are all on
6 the same page. I am not sure we are all --
7 DR. KINSINGER: My understanding
8 is the question has to do with the percent of
9 people who respond to the question. So if
10 there is a large number of people who don't
11 answer the question at all, they drop out of
12 both the numerator and the denominator, and
13 does that skew it in some way.
14 You would have to assume that
15 people non-randomly drop that question, and
16 maybe that is true, but I don't know.
17 DR. BURSTIN: I guess that is the
18 question. I mean, it is part of a larger
19 CAHPS survey. I am not sure I have any priors
20 to think that you would answer that question
21 differentially in CAHPS sampling, and
22 assessments have been shown to be valid and

1 reliable.

2 So I guess, for me, it is more of
3 the vehicle of CAHPS, which we know about. I
4 am not sure I can differentially up front
5 think of a reason why you would answer that
6 question differently.

7 MS. SAMPSEL: So in my history,
8 the way that those CAHPS measures are
9 developed on behalf of NCQA when they insert
10 is, first of all, they go through the validity
11 testing of is this a valid measure to begin
12 with.

13 That is more of a face validity
14 which, we have already talked about, is
15 important in influenza immunization. But then
16 the actual testing goes through a number of
17 focus groups, and then actual administration
18 for a number of years to ensure that the
19 question isn't answered any differently than
20 any other CAHPS question.

21 So if we believe in the overall
22 reliability and validity of CAHPS which, I

1 think, AHRQ does -- Mary, I don't know if you
2 have any insight on CAHPS at all, but there is
3 no reason to believe that this question is any
4 different or that we are losing a lot of
5 people in the denominator.
6 MS. MERRILL: But do they mention
7 how they deal with the missing observations?
8 How do you deal with the missing observations
9 in the analysis?
10 MS. BYRON: And again -- and I am
11 sorry, I am not as well versed on the CAHPS
12 survey, but I would have to get some
13 information on that. But to me, that is a
14 CAHPS vehicle issue versus a measure specific
15 issue.
16 DR. STANGE: So my sense is we
17 should vote on the information that we have
18 and your judgment about -- really, this is for
19 -- really, this is for any information by
20 self-report is the issue that has been raised.
21 So just using your judgment about the
22 tradeoffs between that and between other

1 measures that would have the missing data from
2 people getting the immunization and other
3 sources, just using your best judgment about
4 that, let's go ahead and vote on this.
5 I think we can vote on the whole
6 thing. I think we have consensus on the
7 importance. I think we have enough consensus
8 on the rest, and the vote really will be about
9 that. So let's do the overall vote.
10 DR. WINKLER: Is everybody ready
11 to vote? Yes, 11; No, one.
12 DR. STANGE: Thank you.
13 DR. WINKLER: Thank you, Sepheen.
14 Mark, are you guys ready? Okay.
15 The next measure is measure 041 from PCPI.
16 This is the percentage of patients aged six
17 months and older seen for a visit between
18 October 1 and the end of February who receive
19 an influenza immunization or patient reported
20 previous receipt of an influenza immunization.
21 Linda, I think this is yours also,
22 and we have Mark Antman from PCPI here to talk

1 about the measure, and the summary of the Work
2 Group evaluations is up. Mark, did you want
3 to make a couple of introductory comments?
4 DR. ANTMAN: Yes, thanks, Reva.
5 Good morning, everyone, and thanks for the
6 opportunity to present this measure.
7 Again, this is the influenza
8 immunization measure from PCPI. This measure
9 has been endorsed by NQF since 2009, and it is
10 a clinician level measure, as I think you
11 probably already noted.
12 The measure, again as I think you
13 have probably already noted, does include all
14 patients six months and older, and so it is,
15 therefore, consistent with the ACIP -- the
16 updated ACIP recommendation from 2010, which
17 I know you have already discussed.
18 We documented, we believe, ample
19 data related to the importance of the measure,
20 the importance of the topic in the measure.
21 I think importance has been discussed by this
22 committee quite a bit already. So I won't go

1 into those details.

2 The measure has been tested, and I

3 can refer you to the measure evaluation form

4 and the data that you have available to you,

5 which we believe documents reliability,

6 validity, and feasibility of the measure. We

7 also had a low exception rate, exclusion or

8 exception rate, which I believe you will have

9 noted in our results.

10 If I may, I will take a minute to

11 talk about what I think may be somewhat unique

12 features of the measure, anticipating some of

13 the discussion of the committee; or, Reva,

14 would you prefer to go with the reviewers'

15 analysis first?

16 DR. WINKLER: Go ahead.

17 DR. ANTMAN: Okay, thank you. I

18 already said that the measure has a low

19 exception or exclusion rate. This measure

20 does allow for exceptions. It allows for

21 patient level medical reason or system level

22 exceptions, as you have probably noted in the

1 information in our submission.

2 The reason for the system level

3 exceptions is related in part to the time

4 frame provided for the measure. You have no

5 doubt already noted that the time frame for

6 immunization or for physician documentation

7 that an influenza immunization was received is

8 October 1 to the end of February.

9 I know this committee has already

10 discussed a good bit the standard time frame

11 for your immunization measures, and I

12 recognize that this is not in full agreement

13 with the time frame that has been discussed or

14 the standardized time frame.

15 The reason for that -- One reason

16 for that is that the Work Group felt that the

17 intent of the measure is to capture the bulk

18 of activity in medical practice. Given that

19 vaccine is, as I think you have already

20 discussed, frequently available now early in

21 the season or before the season, but it is

22 sometimes not available, depending on the

1 year, until sometime in September.
2 Our Work Group was concerned that
3 it would be necessary to exclude a lot of
4 patients from the measure if they went with
5 the time frame of September through February
6 or September through March.
7 So the feeling was, let's capture
8 the bulk of activity from October 1 to the end
9 of February, and there is a system level or a
10 system reason exception provided so that, if
11 a vaccine is not available, then the clinician
12 can exclude a patient from the measure.
13 Additionally, our clinical leaders
14 for the Work Group also referred me to the
15 details of the ACIP recommendation, which note
16 that when vaccine is in limited supply,
17 vaccination efforts are intended to focus on
18 delivering vaccination to the high priority
19 populations or the populations at greatest
20 risk of influenza, and that is another intent
21 of the use of the system level exclusion.
22 I think I will stop there, and see

1 if there are any questions after the review.

2 DR. KINSINGER: So my question

3 gets to the end time of your time frame, which

4 is end of February. Why not extend it to the

5 end of March like the other measures are?

6 DR. ANTMAN: Right. This was also

7 discussed by our group, and I think the

8 feeling was that, by the end of February, the

9 bulk of the flu season will have passed. Most

10 immunizations will have already been given.

11 Vaccine at that point may be running low, and

12 physicians will still use the remainder of

13 their vaccine supply, but again the feeling

14 was that it would be burdensome to ask

15 physicians to use that exception for a lot of

16 patients either before the season or nearing

17 the end of the season, if for one reason or

18 another they needed to exclude the patient

19 from the measure.

20 So again, the Work Group

21 recognized that, by choosing October 1 through

22 the end of February, they were somewhat in

1 conflict with the time frame chosen by NQF and
2 by other developers, but the intent was,
3 because this is a clinician level measure and
4 because the intent was to capture the bulk of
5 activity in the ambulatory setting, they chose
6 to focus on, again, October 1 through the end
7 of February and allow for clinicians to except
8 or exclude patients as needed either before
9 the very beginning of the season or near the
10 end of the season.
11 DR. KINSINGER: Maybe I don't
12 understand how this measure works. Who
13 responds? Who provides the data? Are you
14 saying that physicians actually have to go
15 through their charts to --
16 MS. MERRILL: Yes. They are just
17 saying that, if they run out of vaccine, then
18 they have to exclude all their patients. That
19 is more work for them, but I don't see how you
20 can go against what recommendations are coming
21 from another body.
22 DR. ANTMAN: So let me see if I

1 can respond to that, and I do have -- I
2 believe I have a couple of colleagues on the
3 line who are welcome to chime in, if they
4 wish. I am sorry. Can you --
5 DR. KINSINGER: Explain very, very
6 briefly how this whole process works in terms
7 of responding. It sounds like you are talking
8 about the burden on physicians to exclude
9 their patients. If they are making -- How
10 does this measure work, just so I understand
11 that?
12 DR. ANTMAN: Okay. It is a
13 clinician level measure, and the intent is for
14 physicians to document either that they
15 provided the influenza immunization to the
16 patient or document that the patient, in the
17 language of the measure we said who received
18 an influenza immunization or a patient
19 reported previous receipt of an immunization.
20 DR. KINSINGER: How were patients
21 chosen to be reported on?
22 DR. ANTMAN: The denominator to

1 the measure is basically all patients with an
2 ambulatory visit within the time frame of the
3 measure, between October 1st and the end of
4 February.
5 MS. SAMPSEL: But, Mark, isn't
6 this deployed at this point through PQRI?
7 DR. ANTMAN: I'm sorry?
8 MS. SAMPSEL: Isn't it deployed
9 through PQRI? Isn't that where you data is
10 from?
11 DR. ANTMAN: Hopefully, not
12 uniquely through PQRI, but yes, Sarah, it has
13 been in PQRI since 2008, I believe.
14 MS. SAMPSEL: So there is not an
15 understanding of what that means, and I think
16 that is what Linda would like an explanation
17 of, is how that works for PQRI and they
18 actually do that.
19 DR. ANTMAN: That is fine. I can
20 do that. I choose not to focus exclusively on
21 PQRI or PQRS, because we hope the measure is
22 being used elsewhere, but PQRI, or PQRS as it

1 is called now, is the Physician Quality
2 Reporting System of CMS where physicians
3 report on measures for which patients, more or
4 less automatically, appear in their
5 denominator based on the denominator
6 specifications.
7 In this case, in the case of this
8 measure, again the denominator of the measure
9 is all patients aged six months and older seen
10 for a visit between October 1 and the end of
11 February. Consequently, all patients with an
12 ambulatory visit code automatically wind up in
13 physician's denominator, and they are,
14 therefore, asked to report to the PQRS program
15 on all of those patients.
16 To do so, they either have to
17 indicate that they provided the flu shot or
18 that the patient indicates that they have
19 already received the immunization, and the
20 patient can -- and that can include either
21 having received it, as we have indicated in a
22 definition of the measure, that they either

1 received it from another provider or that same
2 provider in a visit prior to October 1st. So
3 that also accommodates the possibility that
4 the patient was vaccinated before October 1st.
5 DR. STANGE: Can I raise a larger
6 issue? My understanding is that this concern
7 was brought up three years ago, and so what --
8 We are saying, okay, things like this, they
9 are about harmonizing about the population.
10 Here it is harmonizing the dates.
11 If that has been brought up
12 before, and nothing has happened, do we need
13 to disapprove this now or what do we -- or do
14 we say please go back, please see if you can
15 harmonize this with the others again, and give
16 another three years to do that?
17 DR. BURSTIN: This is a somewhat
18 unique situation, because the last time NQF
19 did this there was a standard set of
20 standardized specifications that were put
21 forward that the developers did it to meet.
22 I think it is difficult to agree to a

1 different set of specifications, and I guess
2 I will curious, Linda, with your role in ACIP,
3 if the ACIP says it is through March, I am not
4 sure that simply cutting it off in February is
5 logical unless there is evidence to give us
6 how much of additional burden it would be for
7 a measured based on CPT-2 code. I just think
8 it is a question.
9 So I think it is very appropriate
10 for now, given the fact this is three years
11 later from the last time we did this.
12 MS. MERRILL: Is there value
13 having that data when vaccine is in short
14 supply than if it is a lot of exclusions in
15 that month of March? Is that valuable data to
16 have?
17 DR. WINKLER: Does the data exist?
18 MS. MERRILL: Well, if that is
19 included in the statement, then they must
20 exclude their patients for cause, which is not
21 having vaccine, if it is in the denominator
22 statement. Is that not correct?

1 DR. ANTMAN: So all of those
2 patients are counted in the denominator, and
3 the intent in all PCPI measures with
4 exceptions or exclusions is that those
5 excepted or excluded patients be counted
6 separately. So that data is available. It is
7 recorded.
8 DR. WINKLER: Mark, just to
9 clarify, your exclusions are in the
10 denominator. Correct? So they are subtracted
11 from your denominator population, which is
12 another difference from what we are seeing in
13 the other measures.
14 DR. QASEEM: I was going to bring
15 the same issue. I think that -- Wouldn't it
16 be better to have the numerator that talks
17 about that who received the vaccination
18 assessed and offered vaccination but declined
19 or assessed and couldn't get a vaccine then
20 because of contraindications? Shouldn't that
21 go into the numerator statement rather than
22 denominator? That may help, and the

1 denominator should be everyone who should be
2 getting the vaccination, because you have done
3 it the other way around. It is a process
4 measure, and in a process measure these things
5 should go in the numerator rather than
6 denominator.
7 DR. ANTMAN: I think we are saying
8 the same thing in different ways, Amir. So
9 the patients are -- Yes, all patients are in
10 the denominator. The only patients for whom
11 the exceptions are counted are those patients
12 who did not receive -- for whom there wasn't
13 a numerator hit. In other words, those
14 patients for whom the vaccine was not
15 received.
16 So the intent is that the patients
17 are counted in the denominator, but the intent
18 is to not capture any false exclusions. In
19 other words, if a patient did receive the
20 vaccine but an exclusion was also recorded,
21 that, we think, would be a false exclusion.
22 So they are within the

1 denominator, but the intent is to only count
2 them as exceptions if they indeed were not
3 counted in the numerator.
4 DR. QASEEM: Correct, but the
5 intent is to assess that, right?
6 DR. ANTMAN: Absolutely.
7 DR. QASEEM; So that is what I am
8 saying. Don't you think that belongs in the
9 numerator, though, because you need to assess
10 them. Denominator is always going to be
11 whoever needs to get the vaccine. Numerator
12 is what you are supposed to be doing.
13 Again, as I said, going back to
14 the process measure, and if you are already
15 putting them in the denominator, to the
16 exclusions -- What you are asking physicians
17 to do is they should be assessing the patients
18 to get the vaccine. I mean, the end result
19 might be the same, but the point is a process
20 measure should have the assessment in the
21 numerator.
22 DR. ANTMAN: Yes, I agree, and so

1 -- Well, let's go back to the PQRS
2 methodology, since as was pointed out, that is
3 the bulk of the use of the measure currently.
4 In the PQRS methodology, patients
5 who are counted in the numerator and the
6 patients who are excluded are all counted
7 within the -- as patients for whom the measure
8 was met, essentially. So they are counted,
9 but I am trying to emphasize that we ask that
10 they be counted separately as exceptions so
11 that it truly represents who received vaccine
12 and who didn't receive vaccine. But, yes,
13 they are counted along with the numerator to
14 give a true picture of to what extent the
15 intent of the measure was met.
16 DR. STANGE: I think we have
17 raised a concern here. My understanding is
18 this concern was raised three years ago. I
19 don't think it is the job of this committee to
20 actually fix it now, and I really am concerned
21 about us -- We are not even coming close to
22 getting through our agenda.

1 So when we consider our vote on
2 this one, one option that I would like us to
3 consider that a No vote might mean would be
4 asking for more information about how this
5 might be harmonized with other existing
6 measures, and that is both about the time
7 frame issue, about the end of the time frame,
8 and about the exclusion criteria, and then
9 whether that is done in the denominator or the
10 numerator.
11 So I don't think we are going to
12 solve that here, but at least I think we have
13 raised that as a concern. So when we are
14 doing the vote, one thing that a No vote -- or
15 I guess we could vote on that explicitly --
16 would be yes, no and return with more
17 information before a vote is actually done.
18 Is that a reasonable thing to vote on?
19 Okay. So could I have a shown of
20 hands if you would like to have more
21 information about how this could be harmonized
22 on those two issues before a vote is taken?

1 Raise your hands, and keep them
2 up, please. Eight.
3 DR. BURSTIN: Eight yeses. Noes?
4 And the No is that you think it is good to go
5 or you have concerns beyond that?
6 DR. KINSINGER: I am just not
7 sure. I mean, I think we have heard the
8 explanation. I am not sure that going back
9 and asking them to explain it to us again is
10 going to get us anywhere. It seems like we've
11 got what we got, and I would say we should
12 vote up or down on that, but that is just my
13 thought.
14 DR. QASEEM: Just to add to that,
15 because just following what we have been doing
16 all morning, the question on the table is does
17 it meet NQF criteria. I am having -- That is
18 what I am evaluating this for, I think, to
19 answer that question. Otherwise, I may have
20 to go back and revote on all the rest of the
21 measures from this morning.
22 DR. STANGE: Let's just vote Yes

1 or No on endorsement and go from there.
2 DR. QASEEM: I think we vote for
3 it.
4 DR. ANTMAN: May I ask, before you
5 take that vote, I do believe I have colleagues
6 on the phone. Can we ask if they have
7 anything else that they can add to this
8 discussion?
9 DR. STANGE: yes, but we really
10 need to respect the need for us to move on
11 with the agenda.
12 DR. ANTMAN: That is fine.
13 Unfortunately, our clinical expert was
14 available yesterday afternoon, but neither of
15 them were available this morning.
16 DR. STANGE: I am not sure if
17 there is more information that would fix this
18 at this point. It is a concern that was
19 raised three years ago. So I am not sure it
20 is an information issue at this point. We
21 trust your expertise.
22 DR. WINKLER: Everybody ready to

1 vote? Okay. Four Yes; 8 No.

2 All right. Our last immunization

3 measure -- we go back to Jason -- is measure

4 1659, immunization for hospitalized patients,

5 and we don't have a measure developer

6 representative.

7 This is a measure for inpatients

8 aged six months and older discharged during

9 October, November, December, January, February

10 or March who were screened for influenza

11 vaccine status and vaccinated prior to

12 discharge, if indicated.

13 Let me find the -- I do have the

14 summary of the Work Group up on the screen.

15 Did we lose Jason again? Is anybody from CMS

16 or FMQ on the line, just to double-check?

17 Where did Jason go? This is the last flu

18 immunization.

19 I was going to say, we have the

20 results from the Work Group. This is a

21 measure that essentially is a revision of a

22 previous measure that CMS had used with

1 immunization of pneumonia patients as part of
2 their whole hospital quality reporting system,
3 and again three years ago when we were going
4 through this whole exercise, it was why just
5 pneumonia patients; why not everybody in the
6 hospital.
7 So they have come back to us with
8 the broadened measure. I think that, if we
9 look at the Work Group summary, it was felt to
10 have high impact. The performance gap was
11 there. I don't have the data right in front
12 of me, although what they report on in the
13 submission is just the subset of the pneumonia
14 population. Oh, here it is. The gap is
15 small. Currently, it is at 92 percent.
16 This is, again, this subset they
17 tested on, which was only the pneumonia
18 population, not the entire general hospital
19 population, which quite possibly might be
20 different. Again, it is an opportunity for
21 intervention.
22 The quality -- The evidence is the

1 same evidence. It is all about flu
2 immunization. So is there anybody --
3 Comments, particularly from the other Work
4 Group members who looked at the measure?
5 Thoughts? You need to use your microphone,
6 Jackie.
7 MS. MERRILL: When we had our
8 subgroup immunization group phone call, this
9 was the measure we used as our example. So we
10 all have looked at this measure. Few of us
11 bothered to actually review on paper, but we
12 all looked at it.
13 DR. WINKLER: And these are the
14 issues. Anything else that you recall, Amir?
15 DR. BURSTIN: Did the measure meet
16 the full set of standard specifications here?
17 DR. WINKLER: Yes. That was one
18 thing that I had hoped to be able to clarify,
19 because it is interesting the way the specs
20 are presented. The numerator is stratified,
21 and so rather than write it in the numerator
22 specs as the three different categories, they

1 give us the combined, but then write it as
2 stratified for those subsets.
3 So it is just an interesting way
4 of presenting it. I think we ultimately end
5 up in the same place. I would have liked to
6 have confirmed that with CMS, but that has
7 been difficult to accomplish, and Jason has
8 returned. Not a problem.
9 I was trying to substitute for you
10 for the hospital measure. You will do a much
11 better job.
12 DR. STANGE: Actually, Jason, we
13 have heard that this is actually the measure
14 that your group discussed and that there
15 weren't any particular concerns about meeting
16 criteria. Anything you want to add to that?
17 DR. SPANGLER: I will just add a
18 few things. Reva, did you mention about the
19 previous measure? This is an extension from
20 a previous measure. Oh, okay.
21 There are only two concerns I had,
22 actually, about this measure. One is that in

1 the validity testing, when they talk about
2 face validity, I am not sure that the face
3 validity was systematically assessed. They
4 just say that there is a group of national
5 experts, but there is no other information
6 about who they are, what their expertise is,
7 where a lot of the other measures have those
8 details. So that was one concern that I had.
9 Then I had one other. This is one
10 that actually listed the other measures that
11 are related. That was mentioned yesterday, or
12 competing. So they actually listed all the
13 other measures that related to that.
14 I thought there was one other
15 thing, but I can't find it right now. But
16 otherwise, those are the main -- I guess the
17 one main issue that I had.
18 DR. STANGE: Madeline?
19 DR. BURSTIN: Does it match the --
20 I see it matches the timeline, Jason, of the
21 standard specifications. How do they address
22 -- just because we had those previous

1 discussions about the numerator exclusions.
2 Can you clearly see that in the measure? Reva
3 was mentioning while you were out that you had
4 done some stratification, but I just want to
5 confirm it actually meets the standard specs.
6 DR. SPANGLER: Yes, I thought it
7 did. They actually had a pretty -- I thought,
8 a pretty well detailed description of
9 inclusion and exclusion.
10 DR. WINKLER: I think the only
11 thing, Helen, that is -- It isn't totally
12 clear. When you look at the stratification,
13 if you look under 2(a)1.10, the stratification
14 details, you do see those categories, and they
15 convert them to a pass, pass, pass, pass, and
16 the issue would really be whether they are
17 computed or reported separately. That is a
18 clarification that would be useful to try and
19 get from CMS. I mean that the measure is
20 constructed that they certainly could do it.
21 The question is will they do it that way.
22 DR. BURSTIN: I am just confused.

1 So it is stratification, meaning we should be
2 able to see the proportion who offered and
3 declined the vaccine. That is the key issue
4 from the standard specifications that Reva and
5 Karen went over yesterday. We want to be able
6 to see how often they were offered and
7 declined, because we know that is pretty
8 mutable, depending on the way the clinical
9 team can be -- We just want to confirm that it
10 is, in fact, something you can see as a
11 numerator strata.
12 MS. SAMPSEL: Right. If they
13 converting it all to Pass, we wouldn't be able
14 to see the differences.
15 DR. BURSTIN: That is my question.
16 MS. SAMPSEL: Okay, yes, that is
17 what I thought.
18 DR. SPANGLER: Sorry. I did find
19 it. The one other concern I had was about
20 usability. In looking at the public reporting
21 aspect of it as well as the quality
22 improvement, they used PN7, which is -- and we

1 had this discussion, I think, on the phone.
2 It is a very small subset of actually the --
3 of the entire population that they would be
4 looking at, and I am not sure that is the best
5 reporting to be used.
6 So there was a question about
7 additional explanation. Is that the only kind
8 of program they would use or population set
9 that they would use when it comes to public
10 reporting, because there seems to be -- The
11 much larger population would not be reported
12 on and would not be used for quality
13 improvement.
14 DR. WINKLER: Jason, I think this
15 represents the transformation from what they
16 did previously with just the pneumonia
17 patients, and now that this measure is
18 available more broadly, they would change the
19 implementation to the broader population.
20 DR. SPANGLER: Okay.
21 DR. WINKLER: It is just that is
22 what their experience is.

1 DR. BURSTIN: This is an example
2 where they stop the slicing and dicing by
3 condition. They actually included children.
4 I think that was extraordinary.
5 DR. STANGE: Ready to vote?
6 DR. WINKLER: Yes, 12; No, one.
7 DR. BURSTIN: Reva, I just did
8 confirm, it is actually in the numerator,
9 those strata. So that should take care of it.
10 DR. STANGE: Good. So thank you
11 for your careful attention and persistence on
12 the immunization measures for influenza.
13 DR. WINKLER: The question is: At
14 this point, out of the six measures that were
15 put before you, one is about health care
16 personnel, which may be looked at differently,
17 and the other five you voted to approve four
18 of the five.
19 The question is now would be the
20 appropriate time to have that discussion about
21 the global measure or the further
22 harmonization or further consolidation about

1 the measures.

2 So of this group, you feel that

3 meeting the criteria, you feel for the one for

4 hospitals, the one for home health, the one

5 for dialysis facilities, and the survey

6 measure that becomes part of the CAHPS survey.

7 So those are the four recommended so far.

8 Do you want to talk about possibly

9 further consolidating those measures. Are

10 they different enough?

11 DR. STANGE: So, really, you

12 should give us some frame for this. How do

13 you act on this? What can we do to help you

14 to act in a way that is helpful? We will talk

15 about what should be done, but give us what

16 the end game is, so we know how to frame our

17 discussion.

18 DR. WINKLER: I think that -- In a

19 perfect world, I think everybody has voiced

20 the idea that one measure that could be

21 applied all over the place would be ideal.

22 However, we are not there yet, and there are

1 logistical issues, real world issues about
2 data sources, collection methodologies,
3 programs that they are implemented in, and the
4 way the measures are implemented that may not
5 be surmountable to force us into a global
6 measure at this time.
7 The question is: Is that where we
8 are? Is there somewhere else we can push
9 this?
10 DR. STANGE: What do you do then?
11 You go and talk to the measure developers, and
12 you cajole them to try to come up with a
13 consolidated measure, and you have the threat
14 of not approving next time? Is that what
15 happens, or what happens? So we can go back
16 and undo the approvals based on this issue.
17 Is that it?
18 DR. BURSTIN: So, basically, you
19 have -- For the ones you have approved, they
20 now need to go through the head to head
21 comparison, and I guess the question would be
22 -- sounds like the ones you want are the ones

1 that are outstanding as potentially being one
2 that people thought might be -- could be
3 consumed under others. So I guess we should
4 finish that discussion. We would go back to
5 the developer and see if there are any options
6 to pull it in.
7 I think the only issue that we
8 will be challenging is the data source issue,
9 because currently the data are collected in
10 dialysis facilities in a different way. So I
11 guess one question would be: Is harmonization
12 enough? They have harmonized to the standard
13 specifications.
14 I don't know that they can
15 harmonize further in terms of moving into the
16 same data source.
17 DR. STANGE: So I guess the renal
18 disease -- whether they should be a separate
19 category, but there is also having different
20 measures for different age groups. Is that
21 also something that we are talking about
22 harmonizing?

1 DR. SPANGLER: Reva, can you
2 repeat the ones that we --
3 DR. WINKLER: The measure for
4 inpatient hospital, the measure for home
5 health, the measure for ESRD, and then the
6 NCQA survey measure for patients over 50 that
7 is stratified into 50-64 and over 65; and then
8 realize that in the background also we have
9 two measures appropriate for nursing homes.
10 DR. SPANGLER: So except for the
11 last one, it is all based on location.
12 DR. WINKLER: Correct, and each of
13 those locations has a different data source.
14 DR. NAEGLE: I guess I am thinking
15 about this in a real world way. So I am
16 wondering if harmonization is possible at this
17 time, given the difficulties with the
18 disparate data sources. That is one.
19 Then also thinking about level of
20 both consumer and provider awareness,
21 compliance. Maybe I am wondering if sort of
22 this state of the science of utilization of

1 these immunizations is where we can harmonize
2 this and have -- begin to approach as good an
3 outcome as we would if we leave them
4 separately. Is that clear? Do you
5 understand?
6 DR. BURSTIN: The measures are
7 harmonized. The issue we are really talking
8 about today is: Is a separate measure going
9 to exist or should it be subsumed under
10 another measure? They are harmonized.
11 DR. NAEGLE: Consolidating. So if
12 we consolidate, does that mean that there is
13 the possibility that some of these discrete
14 groups which these are written to target might
15 not be included for real world issues?
16 DR. STANGE: Matt, and then
17 Jackie.
18 DR. McGONIGAL: I think that the
19 dialysis care patients would likely be
20 excluded, and they are a particularly
21 vulnerable population. Their data will be
22 collected through CROWNWeb by CMS, and if you

1 try to incorporate them into a broader
2 measure, it is likely that they will get
3 missed.
4 MR. STIEFEL: This is just another
5 potential assignment for Sarah. So this is
6 the population health group, and almost all of
7 these are patient health measures, and I think
8 -- So when we look at the criteria for this
9 group, I think we ought to be looking at how
10 would a population health measure for flu
11 vaccine be different than these patient
12 focused measures. I think we might come up
13 with different criteria from the population
14 perspective.
15 MS. MERRILL: what about the
16 double counting issue? In other words, if we
17 have all these different measures and someone
18 says, okay, I ant to get a picture of how this
19 immunization is in the population, and I have
20 six different measures; and if I more or less
21 look at those six different measures, am I
22 going to get some true sense of what is going

1 on or is the ambulatory care setting going to
2 count some of the dialysis people? Is it
3 going to give a false picture of what actually
4 is the state of the population in terms of
5 this immunization?
6 DR. BURSTIN: I don't think so,
7 because it is a fairly unique group who are
8 picked up in dialysis facilities. They could
9 be admitted. They could have home health.
10 They could --
11 MS. MERRILL: So they excluded
12 from the ambulatory care measure, because the
13 ambulatory physician may see their dialysis
14 patient for a visit and then count them, and
15 they are already counted in the ESRD data.
16 DR. BURSTIN: It is not a
17 prevalence sample.
18 MS. MERRILL: No, it is not.
19 MR. STIEFEL: You can't add these
20 up to get a population.
21 MS. MERRILL: Yes, you can't add
22 them up, but when you are looking at the four

1 of them -- the six of them as a composite, is
2 it going to give you something realistic, a
3 realistic environment scan, so to speak, or
4 they are just totally not comparable?
5 DR. STANGE: No. So that is
6 Matt's charge to Sarah's group.
7 DR. BURSTIN: And as I mentioned,
8 there is an item on BRFSS that asks flue
9 vaccine immunization. It is a regular thing,
10 but again you then can't -- The problem with
11 our current Federal data systems as well is
12 you then can't take that data and stratify it
13 down to look at hospital, provider or dialysis
14 level performance.
15 So it is really the conflict of
16 the performance of the individual entities
17 within the health care system. But, no, you
18 cannot take these and get a global assessment.
19 DR. QASEEM: So just back to the
20 harmonization issue, in terms of why folks --
21 everyone needs to develop their own
22 performance measures, would it be possible for

1 NQF at least to somehow harmonize what goes
2 into numerator and denominator statement,
3 because even of those four measures, you are
4 seeing the differences.
5 I know you said that they are
6 harmonized, and I am not entirely convinced,
7 Helen, that their measures are really
8 harmonized. In consolidation, we may be a
9 little bit far away from consolidating these
10 measures. I think that is not going to
11 happen, but at least if we can agree on even
12 for the subset of population, ESRD or whatever
13 it is there, at least we have what goes into
14 the numerator and what is excluded and what is
15 not excluded, and right now there is so much
16 variation just seeing across all these.
17 I am going to bring it up when we
18 talk about pneumococcal vaccination. I mean,
19 there are patients in hospitals that, if you
20 are not really sure someone has been
21 vaccinated, you vaccinate. People are getting
22 double vaccinated, and there are a lot of

1 patients that are going to come down the road.
2 At least, I have to say that if we
3 can just have harmonized what goes into what
4 we are measuring, and I think that is what I
5 am struggling with, that might be a good
6 start.
7 DR. WINKLER: Amir, that was the
8 purpose of the standard specifications, was
9 the agreement on what should go in the
10 numerator and the denominator. So that is
11 really a fundamental part of what we are
12 doing, is looking at the measures to see how
13 well they meet that, because that is what
14 everybody is standardizing to.
15 Certainly, there are logistical
16 and philosophical issues in getting at
17 alignment. I think you are seeing the result
18 of it. These measures -- that was one of the
19 assessments you all were making, was how well
20 did it line up.
21 DR. QASEEM; But in looking at
22 these four measures that we have approved

1 today, am I the only one or are you all seeing
2 the differences across these? Then in that
3 case, is it possible for us to send them back
4 to these folks and say that they may not --
5 Either they are not meeting your criteria or
6 maybe your criteria is not clear enough.
7 There is something missing.
8 DR. WINKLER: I think the thing we
9 would need to do is really take a look in
10 detail, and this is something staff can do, to
11 really tease out what those are, those
12 differences are; because it looks like they
13 are -- The big things seem to be there, but
14 perhaps it is the small things that we are now
15 able to -- which is a huge step forward,
16 frankly, in this whole process, if we are
17 looking at the little things and not the big
18 things.
19 So we could certainly do that and
20 see exactly the degree of issues you guys are
21 identifying, and see what we can do by just
22 pointing those out, and bring it back to you.

1 DR. STANGE: Before we do that,
2 can I just ask if Amir's summarization is the
3 feeling of the group, that because of the
4 differences in the populations and the data
5 sources, that we are not quite ready to
6 recommend a consolidated measure across all
7 immunization measures, but that after you have
8 done the big chunk work on the numerator and
9 denomination issue that there is some further
10 work done for harmonization, and that we are
11 going to ask you to do more work on that and
12 report back, and then probably work with the
13 developers. Is that a consensus?
14 So is there anything else to
15 discuss then? Jackie?
16 MS. MERRILL: Well, part of it is
17 -- and I am sure these forms are very onerous
18 for the developers to put out, and I
19 understand that the forms have changed during
20 this period. So some of them have submitted
21 one form and then it has been put into another
22 form. So fields are not filled out.

1 That makes our work much, much
2 harder, and sometimes it is not actually
3 harmonization of the criteria. It is the
4 language they use to describe it. So they
5 need to use the same language all the time.
6 If that is what they mean, that is what they
7 need to write.
8 So if it is like anybody who was
9 seen, it means they were seen, and they were
10 screened, and they received it, if they needed
11 it. That needs to be explicitly stated. So
12 it is like sloppy language is being put in the
13 thing; and, I'm sorry, I would hate to have to
14 fill out these forms, but they really should
15 meet a standard for a sort of language that is
16 the same across categories.
17 MR. STIEFEL: Just to strongly
18 endorse the recommendation, Reva, I wasn't
19 clear if when you said it is the
20 responsibility of this group to look at that.
21 If it is the responsibility of this group to
22 look at consistency of numerator

1 specifications as we are going through each
2 measure or if that is after we looked at them
3 all. I thought it was after we looked at them
4 all.
5 DR. WINKLER: You were doing it --
6 You were kind of doing two things, but during
7 the course of your evaluation of each measure
8 you were also considering within the
9 specifications how well they met that
10 standard, because that had been an up-front
11 expectation for the measures. But now Amir
12 and Jackie are pointing out that, even if
13 we've got the big things, there are still a
14 lot of little things.
15 So that is a next step that we can
16 see if we can get further harmonization on.
17 MR. STIEFEL: Which criterion
18 applies to how well it meets the standard?
19 DR. WINKLER: It is probably a
20 combination of scientific acceptability,
21 because you are looking at the specifications
22 as well as the competing related measures

1 issue.

2 DR. BURSTIN: Sometimes settings

3 of care have different language. I think the

4 key thing is that the spirit is there. We

5 cannot mandate that the exact language be used

6 on every single one. Hospitals are inherently

7 very different than ambulatory facilities, but

8 I understand the spirit of it.

9 DR. STANGE: Keith?

10 MR. MASON: My question is: Once

11 endorsed, what is incentive for any of these

12 developers to change it within the next three

13 years or just wait until three years? If you

14 go back to them and say, hey, we want you to

15 standardize this, they will say, well, it is

16 going to come up in three years. Is there any

17 incentive for them to actually change, once we

18 have endorsed?

19 DR. BURSTIN: You won't endorse

20 it.

21 MR. MASON: Well, we have endorsed

22 them already. Right?

1 DR. BURSTIN: No, you have not.
2 You have only said they have met the
3 conditions for consideration -- that they have
4 met the criteria. They have the fifth
5 criteria as the key one, which is about
6 harmonization and competing measures. So, no,
7 you have actually not approved them for
8 endorsement yet.
9 DR. WINKLER: And also remember
10 that you only recommend them to the rest of
11 the process anyway. So we are still in the
12 early stages.
13 DR. STANGE: So we have not
14 approved one, and we have apparently not
15 endorsed the others, and we are not going to
16 endorse them then until more information --
17 DR. BURSTIN: Just in terms of the
18 wording of this, since many of you are new:
19 So your role as a Steering Committee is to
20 approve -- or to recommend the measures to
21 move forward. They go out for comment. They
22 go through all the various channels to follow.

1 At this point you have not recommended one
2 move forward, although I suspect we will
3 probably hear from the developer on that one
4 as well, and then you have now -- The others
5 you think have met criteria will come back to
6 you with additional analyses to see if it
7 satisfies your concerns about harmonization
8 and competing measures that fit the criteria.
9 CHAIRMAN STANGE: Then you will make a final
10 recommendation on those measures, whether they
11 should move forward.
12 DR. STANGE: Is there any other
13 discussion about the influenza measures before
14 we take a break -- or before, actually, I
15 guess, open it up to public comment? We need
16 to do that and then take a break. Amir?
17 DR. QASEEM: So just on the
18 process, Helen, so essentially it is going to
19 go back to the developers and then now they
20 are going to come back, all the discussions we
21 had over here about harmonization in terms of
22 numerator and denominator. At that point, we

1 are going to deal with it again.

2 DR. BURSTIN: Again, the question

3 is -- I think we may actually be able to just

4 do a staff analysis of a side by side, shoot

5 that back to you, see if you think there are

6 additional issues, if we need to back to them.

7 You know, I don't want to keep pinging them,

8 if we don't need to.

9 DR. STANGE: Rufus, can you open

10 up the lines, please, for anyone who has been

11 listening in and wishes to comment.

12 OPERATOR: And if anyone on the

13 phone line would like to ask a question,

14 please formally press the star key followed by

15 the digit 1 on your Touchtone telephone.

16 If you are on a speakerphone,

17 please make sure that your Mute button is

18 disengaged so that your signal can reach our

19 equipment. Again, that is *1 to as a

20 question.

21 We have no questions on our roster

22 at this time.

1 DR. STANGE: Rufus, would you
2 record my voice mail, a message for me,
3 please?
4 Anybody in the room wish to
5 comment?
6 So we have now caught up with our
7 agenda for the end of yesterday. Why don't we
8 take a 10-minute break, and then come back,
9 and we will start talking about some of the
10 screening measures.
11 (Whereupon, the above-entitled
12 matter went off the record at 9:52 a.m. and
13 resumed at 10:04 a.m.)
14 DR. STANGE: We are going to start
15 up again here, and we are going to try to do
16 a process where we take what we have learned
17 about the process of doing this and use that
18 to not do a gloss but to not spend time
19 discussing things that we already have
20 consensus on.
21 So when the measure developers are
22 presenting things, if you could really focus

1 on just the important context we need for the
2 discussion. People that are doing the primary
3 introduction of a measure, if you could focus,
4 please, on what are the areas that we need to
5 particularly focus our energy on. We don't
6 have to go through all the different criteria,
7 but where do you think we should focus our
8 efforts, if you can prime the pump of our
9 discussion, that would be very helpful.
10 We are going to begin with
11 colorectal cancer, and if people can take
12 their seats, I really would appreciate it. We
13 will begin with colorectal cancer, and Sarah
14 is going to introduce it. Reva, do you have
15 any framing comments?
16 DR. WINKLER: Dr. Medows is not
17 able to be with us today, and she was the lead
18 discussant on the first two measures for
19 cervical cancer. So what we are going to do
20 is just juggle the agenda just a little bit to
21 get folks oriented to these types of clinical
22 screening measures.

1 So we are going to start off with
2 the first measure, 34, which is colorectal
3 cancer screening, the percentage of members 50
4 to 75 years of age who had appropriate
5 screening for colorectal cancer.
6 This again is a measure from NCQA
7 and, Sepheen, I don't know if you wanted to
8 have one or two sentences just to intro just
9 briefly, please.
10 MS. BYRON: All right. This is an
11 NCQA HEDIS measure. It is another
12 longstanding measure. It was actually
13 reevaluated about three years ago or maybe it
14 was two years ago, and we made sure to align
15 with the U.S. Preventive Services Task Force.
16 So it looks to see that members
17 received a colorectal cancer screening, and
18 what counts as screening is a colonoscopy,
19 flexible sigmoidoscopy -- sorry, that was
20 FOBT, thank you -- and the age groups are also
21 aligned, 50-75, with the U.S. Preventive
22 Services Task Force recommendation.

1 MS. SAMPSEL: Okay. So it looks
2 like I was the only one who rated it which,
3 obviously, means brilliance. I did want to
4 say that, even though I was formerly employed
5 by NCQA, I never worked on this measure. So
6 I will just divulge that. So I don't have any
7 bias for it or against it.
8 I wanted to mention, though, that
9 we do run this measure at WellPoint on a
10 WellPoint population with slightly different
11 specifications, but still stand by what the
12 NCQA HEDIS measure is.
13 A couple of things, and I guess,
14 Sepheen, it might actually help if you are
15 back. In my review of the measure, I
16 definitely feel it meets all of the
17 importance, impact evidence, etcetera. But
18 there was something in the form that indicated
19 that NCQA is considering adding the virtual CT
20 or the CT contrast, and that was kind of a
21 concern, one, because it is not recommended by
22 USPSTF, and in WellPoint's internal review of

1 this measure we had strong concerns with
2 adding that, just because it raises patient
3 safety issues vis a vis radiation.
4 MS. BYRON: Yes. I would have to
5 find where that is in the form and why it was
6 written in that way, but when we formally
7 reevaluated the measure, we considered the
8 virtual colonoscopy and decided against it,
9 because it did receive an I rating from the
10 USPSTF. So I apologize if this may have been
11 older language when we were reevaluating the
12 measure and considering adding it, but we made
13 a definitive decision not to add it.
14 MS. SAMPSEL: Okay. So then the
15 other just comments that I would make is this
16 measure continues to have fairly good
17 variation in that you have a lower minimum, in
18 the 20s to 30s, and your max is still around
19 81. Some of that does have to do with data
20 fluctuation and the fact that you have a
21 significant look-back period, but since this
22 is a plan reported measure, all plans have the

1 same kind of issues on doing those look-backs.
2 Then regarding reliability of
3 specifications, validity of specifications,
4 the only threats to those, again, have to do
5 with lengthy look-back periods and the period
6 of time that a plan could actually have a data
7 piece using this measure.
8 We do use this measure, and I
9 would say most plans use and focus on this
10 measure, not only on the plan side but in a
11 community side and a population health side.
12 So this might be a really good measure as well
13 to determine in the future how it would
14 translate to a population health measure,
15 because we are working with a lot of public
16 health agencies across the country on also
17 trying to improve screening on this type of
18 measure in our communities.
19 DR. WINKLER: Just in terms of
20 this measure, we received a question about the
21 implementation of this measure, that given the
22 look-back period, is there any accommodation

1 for patient history: I had my colonoscopy
2 five years ago, I am now a new patient, or
3 something -- so that they have already been
4 screened. Is there some accommodation for
5 capturing that in the measure?
6 MS. BYRON: Yes, there is. As
7 long as they have documentation of the
8 screening, then it counts.
9 DR. WINKLER: This is also a
10 measure that is listed for clinician --
11 individual clinician or group, as well as
12 health plan. Is it currently being
13 implemented at the clinician level, and are
14 there any issues with doing so?
15 I believe this is another measure
16 that has been retooled for EHR and for
17 meaningful use.
18 MS. BYRON: Right. So this
19 measure -- Many of the HEDIS health plan
20 measures actually are also specified for
21 physicians. We have a physician volume, and
22 so we made sure to enable physicians to be

1 able to report it, if they so chose. So that
2 is how it is, but it is part of the HEDIS
3 health plan set primarily, and it is -- Also,
4 I believe, it was respecified for meaningful
5 use.
6 DR. KINSINGER: Just to clarify
7 again, so the language still talks about
8 double contrast barium enema. Is that still
9 included?
10 MS. BYRON: that is not included.
11 I will have to check to make sure that we --
12 make sure that this form is updated. I
13 apologize.
14 DR. STANGE: Any concerns that
15 people want to bring up?
16 DR. BURSTIN; I do think it would
17 be helpful to try to get that clarification.
18 It is very confusing in the form as to what is
19 actually in and out and the Task Force
20 recommendations. That would be important to
21 clarify that actually now before people vote,
22 I think, to make sure the evidence actually

1 matches the measure.

2 MS. BYRON: Mary, do you want to

3 add anything in your new role -- Mary Barton?

4 I will just state that -- and I

5 apologize, because I know in some cases we are

6 updating existing forms. So sometimes it

7 might be hard to catch those subtle changes,

8 but we did reevaluate the measure and align it

9 with the U.S. Preventive Service Task Force

10 exactly.

11 DR. STANGE: So that should,

12 hopefully, take care of the issue then. So it

13 sounds like we have consensus on importance

14 evidence. Any feasibility/usability concerns?

15 Oh, my goodness, are we ready to vote?

16 OPERATOR: Ladies and gentlemen,

17 we have lost audio from our feed line. One

18 moment, please.

19 DR. BURSTIN: We are still here.

20 Sorry.

21 MR. MASON: Yesterday we got a

22 great slide back with all the measures and

1 stuff. Do we have one for today?
2 DR. WINKLER: Not printed. They
3 are up there. Do you feel that it would be
4 helpful to have one? We will get one done for
5 you.
6 MR. MASON: No, that's okay.
7 DR. WINKLER: The next measure is
8 measure 33, Chlamydia screening, again from
9 NCQA. This assesses the percentage of women
10 16 to 24 years of age who are identified as
11 sexually active and who had at least one test
12 for chlamydia during the measurement year.
13 Dr. Stange, I think this is yours.
14 Maybe Sepheen had something to say.
15 MS. BYRON: I will just sit here,
16 if you have any questions. Again, it is a
17 longstanding HEDIS health plan measure,
18 chlamydia screening, and it is aligned with
19 the USPSTF.
20 DR. BURSTIN: And is it also
21 aligned with the new adolescent measure that
22 recently went through the Child Health

1 Project?

2 MS. BYRON: What Helen is

3 referring to is for the Child Health Quality

4 Measures Project, we also submitted a

5 chlamydia screening measure that was specified

6 at the physician level, and they are all

7 aligned. That one actually requires follow-

8 up. So that is one piece that goes a little

9 further because of the medical record, but

10 this is a health plan measure, and it does not

11 track follow-up.

12 DR. STANGE: So this is a high

13 importance, high impact topic for the target

14 population; good evidence of efficacy of

15 intervention and of the screening. It is an

16 administratively -- It is done with

17 administrative data, and so the only issue,

18 really, I identified is how do you identify

19 someone who is sexually active from

20 administrative data.

21 If you look at the codes they have

22 for their -- Anything that has an inkling of

1 that, they add up. So it looks to me like it
2 is done as well as can be done from
3 administrative data. Because it is
4 administrative data, the burden then is,
5 hopefully, minimal. So I don't have anything
6 other than that, which I think they have done
7 the best they can on.
8 MS. SAMPSEL: And I can just add
9 on that piece. We have been trying to play
10 with this at WellPoint as well, and I know
11 when NCQA tested this measure. Basically, you
12 do a medical record review to validate the
13 administrative claims, and it really was done
14 the best that it could to identify though
15 claims and to keep the burden down for health
16 plans, which is a huge issue on the plan side
17 that we don't have to go into the medical
18 records, because unfortunately, you can't
19 identify a sexually active patient population
20 just through a medical record either.
21 So I really feel that this is an
22 example of it's the best we can get to for

1 such a high impact issue for this population.
2 DR. WINKLER: Sarah, I just missed
3 that. I just want to clarify. You say at
4 WellPoint you have also looked at the
5 comparison of the two?
6 MS. SAMPSEL: We haven't done the
7 medical record validation of it, but we have
8 been kind of aligning through our own 34
9 million members on making sure that we are
10 identifying those current folks in our
11 databases.
12 DR. STANGE: Any concerns or
13 questions before we vote? Okay.
14 DR. WINKLER: Thirteen Yes; zero
15 Noes.
16 DR. STANGE: Looks like we are
17 getting the payoff for the careful work
18 through the process we did on the earlier
19 ones.
20 DR. WINKLER: Just to talk about
21 this a little bit, because it is important
22 that we are able to convey to audiences the

1 overall grading of the different elements of
2 the measure evaluation criteria.
3 We use as a starting point the
4 Work Group, but we are going to draft this
5 summary, and we are going to send it back to
6 you all, and we want you, really, to pay
7 attention and look and be sure it does truly
8 reflect what you believe the ratings are of
9 the evaluation criteria; and we really are
10 going to ask you as part of your role as
11 members of the Steering Committee to really
12 take on that responsibility for being sure
13 that what we are laying down, what we reflect
14 is accurate.
15 DR. WINKLER: The next measure is
16 measure 31. This is breast cancer screening,
17 again from NCQA. It is the percentage of
18 eligible women 40 to 69 who received a
19 mammogram in a two-year period.
20 Dr. Stange, I think this is yours.
21 Did NCQA want to make any comments?
22 MS. BYRON: This is an existing

1 HEDIS measure, longstanding, and it is
2 straightforward, and I can answer any
3 questions about it.
4 DR. STANGE: So the main issue I
5 would raise is what to do with the controversy
6 about women 42 and -- 40 through 50, because
7 the U.S. Preventive Service Task Force
8 recommendation is to have an informed
9 individual discussion. So that makes it
10 difficult to develop a kind of -- a global
11 assessment of this.
12 One way to handle that, actually,
13 would be to keep the 40 to 50 year old women
14 in the denominator, but to report the results,
15 which you certainly gather the data. The data
16 already are together on age in a way that
17 would allow stratification of the reporting,
18 and you could report an overall rate for the
19 women in the target age group of 40 to 69, but
20 then you could also stratify the under-50 and
21 then the over 50 among that, which would at
22 least allow interpretation.

1 There is going to have to be just
2 individual interpretation of what that means,
3 and different people will do different things
4 with that. So that would be my only
5 suggestion, is just to emphasize collecting
6 the data and then the opportunity to report it
7 in a stratified way.
8 MS. BYRON: Right. And this was
9 actually a discussion yesterday at the
10 Committee on Performance Measurement. So you
11 are all aware that we had some issues with the
12 guidelines not aligning, and we were caught in
13 the middle a little bit there when the new
14 USPSTF guideline came out.
15 We made the decision at the time
16 to leave the measure as is, because there was
17 no consensus among the guidelines. Given that
18 we did discuss, actually, that that potential
19 solution of stratifying the measure so that
20 people could look at the younger age groups
21 and the older age group separate and,
22 basically, you would be able to present the

1 results showing years.
2 If you wanted to look at the
3 USPSTF guideline, you could look at this age
4 group. If you were concerned about younger
5 age groups for whatever reason, considering
6 other guidelines do point to that, you could
7 look at it separately, and it is something
8 that we plan to do, actually, hopefully,
9 taking to our January meeting of the committee
10 on Performance Measurement, which is the
11 governing body over the HEDIS measures.
12 So it would just be an issue of
13 stratifying, exactly as you had noted. I
14 should see if Mary had anything to add. I am
15 sorry.
16 DR. STANGE: So Mary, and then
17 Linda, and then Amir.
18 MS. BARTON: I think, you know,
19 HEDIS measures are always routinely updated.
20 So I think this is going to be part of the
21 conversation in updating this measure. With
22 an eye toward, as Sepheen was implying,

1 navigating a somewhat tightrope-like shoal
2 between what the Senate has told the
3 Department of Health and Human Services they
4 must follow and what the Task Force's approach
5 to looking at the evidence was, and then
6 alongside that ACOG and the American Cancer
7 Society and a lot of other august bodies
8 having their own opinions as well. So watch
9 this space.
10 DR. BURSTIN: I do think we need
11 to be clear about the fact that this measure
12 did not get very high ratings on consistency,
13 not surprising, given the evidence; and since
14 it is one of the requirements of consistency -
15 - and I think this one makes it just because
16 it is three out of four, at least moderate or
17 high, it is something that, I think, if this
18 group wanted to make that as a formal
19 recommendation about the stratification, I
20 think it might be something. Then NCQA could
21 bring back as an ad hoc review the additional
22 strata.

1 I just think it is -- This is such
2 a high profile area. There has been so much
3 attention. The morning our old USPSTF made
4 that recommendation, our phones were ringing
5 off the hook of when we were going to update
6 the measure, and I know NCQA's was as well.
7 So this is a real issue. I want
8 to at least have it appear that we are being
9 responsive to the inconsistency there.
10 DR. KINSINGER: The other change
11 to the 2009 Task Force statement, as you
12 probably know,is that it actually increases
13 the upper age. So it is not 69. It is 74,
14 and why wasn't that reflected here?
15 MS. BYRON: At the time we made
16 the decision to leave the measure as is -- and
17 it was originally aligned with the 2002 USPSTF
18 recommendation statement, and so part of the
19 leaving as is was to even leave the upper age
20 range the way it was, but that would be part
21 of the considerations that we would take when
22 we look at the measure now.

1 At the time, I think, because of
2 the swirling differences and controversies, we
3 felt that you wouldn't want to look at it and
4 change one part of it and not the other;
5 whereas, as Mary brought up, the HHS rule
6 which pointed back to the 2002 recommendation
7 statement, which is what the measure was
8 originally aligned with, gave us more reason
9 to leave it the way it was at the time, until
10 we could look at it again.
11 DR. QASEEM: So -- and I promise
12 you guys that I am not going to talk anymore,
13 but this is -- I think this is one of those
14 measures that I am a little concerned looking
15 at the numerator statement where it says that
16 one or more mammograms during the measurement
17 years, and the denominator is 42 to 69.
18 I understand all the controversy.
19 We also have a guideline on 40 to 49. I think
20 the issue is, especially between 40 to 49, the
21 shared decision making is very important. I
22 don't think that anyone is saying you don't

1 screen during that age group, and the measure
2 is not capturing the shared decision making,
3 which is a process part, in any way.
4 If you look at that measure, if a
5 patient comes to you, and you do shared
6 decision making and all that, what it is
7 saying is whether a mammogram was done or not.
8 Right? If someone has said that, okay, I have
9 talked to you; I understand the problems are
10 more than the benefits, and let's -- I don't
11 want to get the mammogram done -- does that
12 mean that I will be dinged in that case?
13 MS. BYRON: Yes, and I think that
14 that probably highlights one of the
15 difficulties of quality measurement. You
16 know, this is -- You would have to look into
17 the medical record, and you would have to
18 define exactly what would count as the
19 physician discussing and was it shared
20 decision making; did he just bring it up? Did
21 he just write "discussed"?
22 Unfortunately, when it comes down

1 to some of those details that we would love to
2 be able to get from the different data sources
3 we have, because there isn't just a checkbox
4 that says "shared decision making occurred,"
5 we are faced with that difficulty, and so the
6 measure can do what it can do.
7 DR. QASEEM: So just repeating the
8 concerns and not getting into too much detail,
9 we really did sit down with some of the
10 societies who do recommend that you screen
11 between 40 to 49, but I don't think there is
12 any controversy in terms of that you do sit
13 down with a woman and do the shared decision
14 making.
15 So I am actually very concerned,
16 including 40 to 50 in this age, and I know it
17 has been going on. I don't know if it is our
18 role. Again, I am not very clear on the role
19 of the Steering Committee, but the measure,
20 the way what it is measuring, you are running
21 in to make sure physicians, who are maybe
22 doing a very good job, but you are telling

1 them you are not doing a good job, and that is
2 against what most of the folks are
3 recommending.
4 MS. BYRON: And I wonder if a
5 measure such as that would be better served as
6 a survey measure where you do actually ask the
7 patient from their perspective was shared
8 decision making -- or did you have a
9 conversation with your physician? Did you
10 feel like you were part of that conversation.
11 The limitations of an
12 administrative medical record measure, I think
13 -- you have to think about the different data
14 sources.
15 DR. QASEEM: And I completely
16 agree, and I think the way around that is
17 that, since we all agree that it is an issue
18 between 40 and 49, that maybe the measure
19 needs to change from 50 to 69, because that
20 measure is supposed to be based on evidence.
21 If the evidence is already
22 controversial, we cannot make a performance

1 measure that says that you screen everybody
2 between 40 to 69 when you don't have any clear
3 evidence.
4 MS. BYRON: We do think that
5 stratifying the measure might be a way to be
6 able to address some of that, because there
7 are guidelines that do recommend that for the
8 younger age groups. So by stratifying the
9 measure, you would be able to say this part of
10 our population conforms with the USPSTF; this
11 other part -- you know, the measure rates
12 maybe lower, and it may be okay.
13 I understand what you are getting
14 at. It is more implied than explicit, but I
15 would just say that certain measures might be
16 better for service as these measures, and you
17 have to think about data sources that are
18 available with the kind of measure we have.
19 DR. QASEEM: I am not going to hog
20 the mic. This last thing is the way the
21 measure currently exists, what goes into the
22 numerator and what is in the denominator and

1 what is the denominator exclusions -- none of
2 it is being reflected in terms of what is
3 excluded. The only thing excluded is the
4 bilateral mastectomy and the evidence for a
5 mastectomy.
6 I think that in the 40 to 49 I am
7 concerned the measure the way it currently
8 exists, for the reasons -- As I say, I am not
9 going to hog the mic.
10 DR. STANGE: So Kurt and then Reva
11 and then Sarah -- the only time in my life I
12 have ever done that.
13 I agree that the stratification is
14 probably the best way to handle that, given
15 just the political frenzy around this and how
16 not reporting that could be interpreted, and
17 at least reporting it can contribute to the
18 ongoing discussion of it.
19 The measurement between 40 and 49
20 -- there is the administrative burden and just
21 how you would actually do it to decide whether
22 there was informed discussion going on. The

1 other thing is that there is the competing
2 demands of reporting that discussion and, if
3 we are taking 10 minutes out of a 12 minute
4 visit to have that discussion, all the
5 evidence based services we are not doing. All
6 the patient agendas we are not attending to.
7 If it is reported, there could be
8 some text that would go around that, that
9 would at least raise these issues and help
10 foster the discussion, but where we are at
11 this point in time, it doesn't seem to me that
12 it is an option to not do the reporting. But
13 we can actually at least frame that
14 discussion.
15 If it is all lumped together and
16 the rates of doing it between 40 and 49 are
17 the same as your rates of doing it at the
18 higher ages, that is just really problematic.
19 So I think we need to stratify for
20 that reason, but we don't have easy ways to
21 contextualize what the data mean for 40 to 49,
22 and at least we can report it and let other

1 people contextualize it in their context and
2 at least help the discussion. So Sarah, Matt,
3 Linda.
4 MS. SAMPSEL: So internally at
5 WellPoint, we have had a lot of discussions
6 about this as well. In fact, we are switching
7 our internal metric to 50 to 69. However, we
8 still have that tightrope that NCQA has, in
9 that you have the ACOG and other
10 recommendations that start at 40.
11 So realistically, our preventive
12 services guidelines within WellPoint are
13 starting at 40, but our measurement will start
14 at 50, but it has more to do about our ability
15 to impact and the ability on who we will be
16 able to directly identify as you haven't had
17 it, these are the strongest recommendations.
18 So it is a balance, unfortunately,
19 and we still show significant variation on
20 this measure. We still feel it is extremely
21 important, and I believe it was our
22 representative who talked about stratification

1 yesterday on the CPM, because we feel so
2 strongly about that. We want to know that 40
3 to 49, but it is hard to translate how do you
4 do the "consider" part of it.
5 MR. STIEFEL: I would say the same
6 for KP. We are on that same type of
7 tightrope, but did I miss? Did you summarize
8 what was discussed at CPM yesterday about this
9 particular issue of 40 to 49?
10 MS. BYRON: Right. It was about
11 suggesting to stratify the measure, continuing
12 having people report on the younger age group,
13 but to move it out of the older age group so
14 that you could look at them separately.
15 MR. STIEFEL: But it was approved
16 as is?
17 MS. BYRON: It was brought up as a
18 potential solution for this measure, and it is
19 something that NCQA staff are going to do, and
20 it probably wouldn't -- We would probably
21 present it in January. So we would have to do
22 a little leg work first, and it would go to

1 public comment in February; because all of
2 HEDIS measures are in public comment. So we
3 would go to public comment in the spring,
4 final decision in May.
5 MR. STIEFEL: In the meanwhile,
6 was it approved as is?
7 MS. BYRON: It was not an approval
8 item. It was a point of discussion.
9 DR. BURSTIN: I was actually going
10 to ask a question to NCQA staff. This is,
11 obviously, a tough situation for all of us,
12 for the health plans, for all of us. What is
13 the timing of when you are going to
14 potentially make this change around
15 stratification, because I think it is going to
16 be really important. I think it would be
17 difficult for the committee to act when you
18 are in play.
19 MS. BYRON: We would -- If all
20 goes well, we would present it in January and
21 put it out for public comment February/March,
22 and then a final decision would be made in May

1 2012.

2 DR. BURSTIN: So if this group

3 chose to make the recommendation that it be

4 stratified, it is probably going to be in sort

5 of a parallel path anyway. So just a

6 consideration for the committee.

7 DR. STANGE: Consideration,

8 meaning we can vote to approve it with

9 stratification?

10 DR. BURSTIN: I think you would

11 potentially put it forward with a modification

12 that it would be approved if NCQA's process --

13 again, not putting words in your mouth. Just

14 sounds like, if the discussion is the

15 committee wants to move in that direction, it

16 could be approved only if that modification is

17 subsequently made. And again, keep in mind,

18 it is pretty early in the NQF endorsement

19 process. So we would put it out for comment

20 as well.

21 So we would, I think, just enhance

22 your comment period anyway, but it may just be

1 one approach to not have us get stuck in this
2 box, and I guess I am still -- would also
3 question whether, as part of this additional
4 process, will you consider bumping it up to
5 meet the USPSTF upper limit of 74.
6 The other thing for the committee
7 is do you want to also consider?
8 DR. STANGE: Reva and then Jackie.
9 MS. MERRILL: So approved yes with
10 modifications. So we just vote yes, and you
11 take care of the implied part.
12 DR. BURSTIN: Just two things I
13 wanted to bring to the committee's attention.
14 Number one, the specifications are for
15 optional exclusions, and I wonder what your
16 thoughts are in terms of things that are
17 optional when perhaps some choose to take the
18 option and others choose not to. How
19 significant is that for ongoing comparability?
20 The other thing is this measure
21 has been retooled for EHRs for meaningful use,
22 and given that is a data source that

1 potentially could start bringing in the
2 ability to capture data on shared decision
3 making, what are NCQA's thoughts and plans
4 along that direction?
5 MS. BYRON: Optional exclusions
6 are actually a part of the HEDIS measure set.
7 What we want to do is give people an
8 opportunity to show that they are meeting the
9 measure. It is really sort of giving health
10 plans the benefit of the doubt here.
11 So if they were to meet the
12 measure, even if they could have applied
13 exclusions, they can count those people,
14 because they have fulfilled the numerator
15 requirement, and it is applied across many
16 measures, and it is applied to all health
17 plans equally.
18 So our sense is that it is
19 something that all health plans -- It should
20 affect all health plans equally.
21 In terms of meaningful use, yes,
22 it is respecified for meaningful use. It is

1 respecified as it is, and if we were to -- you
2 know, I am not sure what the process would be
3 to be making changes with meaningful use.
4 DR. BURSTIN: Updated process
5 happens in the summer here.
6 DR. STANGE: Actually, just a
7 quick question about that, and then Linda and
8 then Sarah.
9 Is the exclusion because some
10 groups won't have the data for the exclusion?
11 MS. BYRON: The reasons for the
12 exclusions are that there are some people who,
13 like Amir had brought up people with
14 mastectomies, where it makes sense for them to
15 be excluded from the measure, but it could be
16 that some people have had a mastectomy in the
17 right time period and then maybe had the
18 mastectomy afterward. So they could be
19 included as numerator compliant.
20 We want to give health plans the
21 opportunity to include those people, because
22 they did do the right thing.

1 DR. STANGE: So Linda and Sarah.
2 DR. KINSINGER: My question has to
3 do with a very small number of people, but in
4 thinking about the question yesterday about
5 disparities, how are transgender people
6 handled in this and the cervical cancer one
7 that will come up?
8 So if you are a male to female
9 transgender -- I mean, the guidelines don't
10 address that issue. I don't know. Are those
11 folks excluded from the denominator?
12 MS. BYRON: We do not have
13 explicit exclusions for transgendered
14 populations, because it is such a small -- I
15 mean, we would anticipate no impact on the
16 measure. It is such a small population.
17 There are no explicit exclusions.
18 DR. KINSINGER: So those folks,
19 they are going to get counted as not meeting
20 the measure, but it is such a small number
21 that it won't affect them.
22 MS. BARTON: I would ask WellPoint

1 how they measure such a thing because, you
2 know, if you have a cervix or you don't or --
3 MS. SAMPSEL: Oddly, I have asked
4 this question internally. This is a curiosity
5 thing. Once somebody gives me access to data,
6 it is really quite scary. Our database
7 captures male, female or indeterminant, and
8 you only -- for the way that the measure logic
9 works, you would only be looking for females.
10 So if that member when they filled
11 out their enrollment form had indicated male
12 or female, is how they would be included.
13 Indeterminant, if it is not in a specification
14 as in include indeterminant genders, it
15 wouldn't show up. And I'm sorry, it would
16 really pass that term. Here, she would not
17 show up.
18 DR. KINSINGER: A transgender
19 person who has transitioned from male to
20 female would, I would think, report themselves
21 as female.
22 MS. SAMPSEL: Yes. I mean, I

1 think it really just all depends how they fill
2 out that form, and we have no way -- you know,
3 we don't go out and verify what they have done
4 or how they have done that. But I also agree
5 with Sepheen that the impact would be very
6 small.
7 I just wanted to comment, Reva, on
8 your comment about optional -- or a question
9 about optional exclusions. We exclude anybody
10 we can, not as a matter of not wanting to
11 provide the care, but as of a denominator size
12 and truly being able to measure who needs that
13 service.
14 So if we have the information in
15 our clinical claims system of having a
16 mastectomy, then we would exclude those
17 members, and I think all plans -- I don't
18 know, Matt, if you know any different on that.
19 DR. WINKLER: Then perhaps is
20 optional really the right word to use here,
21 simply because it gives the sense of you get
22 to choose, and that sort of makes me feel that

1 standardization isn't optimal, but if it is
2 more a matter of we can if we can, I am not
3 sure that is the same thing as optional, I can
4 if I want to.
5 MS. SAMPSEL: That may be
6 something to talk to HEDIS policy about
7 general guidelines, because we will follow, we
8 will interpret the general guidelines.
9 Then EHRs -- you know, we have
10 really been trying to transfer data and pull
11 as much data as we can out of EHRs to simplify
12 the medical record abstraction, because for a
13 health plan, that is the most expensive part
14 of HEDIS abstraction.
15 Unfortunately, the percent of
16 physicians -- and I don't know, Amir, if you
17 know what that percent is, but over the years,
18 while it has been getting bigger, there is
19 still not enough physicians on EHR talking the
20 same language that we are able to convert to
21 that. So I think it is great we have the
22 specs, but --

1 DR. STANGE: Amir, in follow to
2 Jackie, that is not a remnant. That is a
3 current discussion. So you are next then.
4 MS. MERRILL: What are the
5 implications if we were to vote no on this,
6 because it seems like it is not ready for us
7 to vote yes because of all this change that is
8 going on.
9 DR. STANGE: After Amir, if there
10 aren't other discussion, I will set up what
11 the vote would be, and then we can discuss
12 that.
13 MS. MERRILL: Okay.
14 DR. QASEEM: I just want to follow
15 up on that, and I don't know. Maybe this is
16 the measure where we may want to go through
17 each separate rating. That might take too
18 much time. I don't know, but just reading
19 what you yourself are presenting in terms of
20 evidence of high impact, it reads that
21 mammography screening trials indicate breast
22 cancer mortality is sufficient benefit, blah,

1 blah, blah. False positive rates are common
2 in all age groups, leading to additional
3 imaging and biopsies, and highest rate between
4 40 to 49.
5 I think we really need to keep
6 that in mind when we vote on this measure in
7 terms of where it currently stands and what it
8 reads. The evidence that has been presented
9 in there -- it is acknowledging that you
10 should. But the measure is not really reading
11 the way what it has been presenting.
12 If you look at the reliability and
13 validity section as well, validity is
14 completely missing, and again, as I said, I
15 wasn't the reviewer for this measure, and
16 maybe it needs to go back to the subgroup.
17 But if you just read what is being presented
18 versus what is being recommended there, they
19 are not jiving right now, I think.
20 DR. STANGE: I guess this is such
21 well plowed ground that I wonder if many
22 people have really looked at this evidence

1 recently. So I am not sure that we are
2 constrained by what is written down on the
3 form as much as we are to make a broader
4 decision within the larger context of how this
5 will be interpreted.
6 If we were going to vote, one vote
7 would be yes to approve as is or no. The
8 intermediate vote would be to approve
9 contingent upon a year period in which NCQA
10 will really look at the two issues of
11 reporting in a stratified way, and then
12 looking at the upper age range to make it more
13 congruent with the recent Task Force
14 recommendations.
15 So that would be -- If we were
16 going to vote now, that is what we could vote
17 on. I wonder if, considering the political
18 context, if that isn't the best we can do
19 right now for all the totally true issues that
20 Amir is raising about the risk-benefit ratio
21 is lower in that age group. I don't think
22 there is any doubt about that.

1 DR. QASEEM: Is it possible to do
2 like what Sarah pointed out, something that
3 WellPoint has done. There are folks who have
4 done it in the 50 to 74 group. At 49 to 49
5 you want to know it, but it is not part of the
6 measure. Is it something that can be -- Is it
7 on the table or not, that we just leave 40 to
8 49 out of it?
9 DR. STANGE: In the current
10 political climate, I think we need to think
11 about unintended consequences of what if NQF
12 said, no, we are taking the 40 to 49 off the
13 table for reporting. What are the
14 consequences of that in creating more noise,
15 instead of staying at the table to really be
16 in discussion about how do you handle this
17 issue?
18 DR. QASEEM: No, we are not taking
19 it off the table. What we are saying is we
20 are acknowledging there is an issue with the
21 evidence right now. That is what they are
22 saying. It is not ready yet. I don't think

1 NQF is in the position to take a side on one
2 way or the other.
3 If NQF goes with the 40 to 49, I
4 think we are more likely to run into the
5 problem that the Task Force and everyone --
6 some societies are saying not to do it.
7 Others are saying you do it, and NQF is taking
8 sides when there is controversial evidence,
9 which we all acknowledge.
10 DR. WINKLER: Just in response to
11 your question about what is or is not on the
12 table, we aren't the measure developer. We
13 have to accept what NCQA is doing. We have
14 certainly heard what their plans are.
15 So it is vote on what we have got
16 in front of us as is right now or, if you want
17 to, the good faith contingent on all things
18 they sound like they are planning to do within
19 the next year. That would be your option, but
20 in terms of breaking the measure apart and
21 remaking the measure, no. That really is not
22 something you can do.

1 DR. BURSTIN: I think the only
2 other option, and Reva won't like this one,
3 but I do this a lot, is if the measure is
4 truly not ready, the other question is do we
5 just defer and come back to it at a later date
6 when it is ready.
7 This committee is going to be
8 staying together through the next phase of
9 work anyway, and just hold this measure in
10 abeyance for a while. I just don't know that
11 you can actually act on a whole lot of
12 potential considerations and contingencies
13 that we don't know are going to happen.
14 I almost rather would have us just
15 say this measure is withdrawn until a later
16 date when NCQA can provide more detail on the
17 actual plan, and the committee can vote on the
18 actual plan. Otherwise, I am just not sure --
19 If it is so uncertain, I don't know what to
20 do.
21 MS. MERRILL: That seems like the
22 most politically prudent approach.

1 DR. BURSTIN: And your timeline is
2 you think January or early winter you would
3 probably return to us?
4 MS. BYRON: We would say we would
5 have a final result in May, because as we have
6 noted, it is based on public comment. It is
7 based on a multi-stakeholder expert panel
8 review. So we can't even guaranty what would
9 happen after we get all the feedback and go
10 through the evidence and do our entire process
11 for HEDIS measures.
12 DR. BURSTIN: Check with Elisa on
13 timing. Does that work?
14 MS. MUNTHALI: That works. We
15 could put it into the second phase in the
16 fall.
17 DR. STANGE: Keith and then,
18 Frank, I don't know how long your card was up
19 that you just put down. If I am not seeing
20 you, wave or something.
21 DE. LEONE: Oh, no, no. That is
22 okay. I am satisfied with -- I had a

1 question, but it was satisfied.

2 DR. STANGE: Okay, thanks, Keith.

3 MR. MASON: I was just going to

4 say, it sounds like they are going to put

5 something to your members, though, in January,

6 right? For comment. So what is that, and how

7 would that be different than what you have in

8 May?

9 MS. BYRON: I will just give a

10 really quick rundown on our process. Out

11 Committee on Performance Measurement is an

12 external, multi-stakeholder panel with

13 representatives from users, research,

14 academia, all of that. They make the

15 decisions about or recommendations to our

16 Board of Directors about the HEDIS measures.

17 They meet three times a year.

18 So as part of the HEDIS process,

19 because it does go into our HEDIS publication

20 for health plans, all the measures are -- They

21 are presented by January in order to go to

22 public comment in February and March.

1 So the process is that you would
2 to this committee in January, recommend
3 whatever we are going to recommend based on
4 our review, based on our Measurement Advisory
5 Panel input, based on input from numerous NCQA
6 panels of experts, technical advisors, and
7 then they would approve or not approve the
8 measures in a certain fashion to go to public
9 comment.
10 After public comment, we would
11 have to process all the comments that we get
12 from that and make a final recommendation
13 based on input from numerous organizations,
14 and take that to our committee in May. That
15 is when the final decision gets made, and then
16 it gets implemented into the HEDIS volume that
17 is released in July that summer.
18 So that is how it works, and then
19 health plans can start to implement it. So it
20 is aligned with our HEDIS publication process,
21 which is what health plans are using in order
22 to change their measures.

1 DR. STANGE: So the most expedient
2 thing to do, really, would be to table this,
3 it sounds like. Any objection to doing that?
4 You don't need a push from us. The things we
5 have talked about doing, you are going to be
6 doing anyway. That seems fine.
7 DR. BURSTIN: Really, you have
8 heard the committee who is going to be
9 reviewing this the next time. So it shouldn't
10 be a surprise that the exact same issues will
11 come up. So, hopefully, we will get
12 resolution on the stratification of the upper
13 age limit. I just think it is going to be --
14 It is a hard one either way, but I think in
15 its current form it is, obviously, not going
16 to pass today. So I don't want to have an
17 artificial vote of no confidence.
18 DR. WINKLER: The next measure we
19 are going to look at is -- We are going to go
20 to measure 32, cervical cancer screening
21 again. Sepheen, stick around.
22 This is again another NCQA HEDIS

1 measure, the percentage of women 21 to 64
2 years of age who received one or more PAP
3 smears to screen for cervical cancer.
4 This measure was assigned to Dr.
5 Medows. She is not able to be with us today.
6 So I will try and kind of go through the
7 measure. Let me find it.
8 Again, this was evaluated by Work
9 Group members for cervical cancer screening.
10 Again, this is a measure for health plans, but
11 also it is specified for clinician use.
12 Again, it has the optional exclusions for
13 patients who have had a hysterectomy.
14 It is lined up with the U.S.
15 Preventive Services Task Force. Sepheen, did
16 you want to say anything? I'm sorry, I jumped
17 in.
18 MS. BYRON: No.
19 DR. WINKLER: Okay. The current
20 performance in commercial health plans is
21 about 77 percent, and for Medicaid plans
22 about 63 percent. Dr. Medows particularly was

1 interested in bringing up issues around
2 potential disparities. This is the only way
3 that the measure is stratified, is by the
4 commercial versus Medicaid plans, but there is
5 definitely a difference there.
6 The testing was done similarly to
7 the other HEDIS measures for reliability and
8 the similar face validity. So the methodology
9 is really the same. Measures are audited for
10 consistency and accuracy.
11 The feasibility is, again,
12 administrative specs. This is another
13 retooled measure for EHRs for meaningful use,
14 and one question Dr. Medows has was: Okay,
15 these are process measures. Is there any plan
16 to tie them to outcome measures?
17 Any other comments from other Work
18 Group members? I know, Sarah, Kurt, you both
19 looked at this measure perhaps, Sarah, you
20 have used it.
21 MS. SAMPSEL: It seems like
22 looking at these over the weekend was so long

1 ago now. We do use this measure, and it is
2 one of the measures that, actually, Angela
3 Braly, the CEO of WellPoint, is very
4 interested in, just because she is very
5 interested in women's health, and so continue
6 to track it.
7 Our measure results kind of track
8 the same as the HEDIS results, and we really
9 have no problem implementing this measure or
10 have ever had, really, any strong concerns
11 about the measure at all.
12 DR. STANGE: For me, it is a mom
13 and apple pie thing. HPV vaccines are not
14 going to change this during the rest of my
15 professional career anyway, I think, and the
16 optional exclusion of having a cervix seems
17 like it is optional, because you might not
18 always have data on that, I would guess.
19 DR. BURSTIN: A somewhat related
20 question, but I agree with this measure as is.
21 We have had discussions over the years with
22 NCQA potentially about to kind of create some

1 overuse measures of the converse, of when it
2 is not needed, to get at the issues of older
3 women or increased frequency. Has that been
4 considered at all or is it on the plate?
5 MS. BYRON: Right. NCQA has
6 thought about doing overuse measures that are
7 based on things like that or maybe C and D
8 recommendations from the USPSTF, that sort of
9 thing. That is something for the future. I
10 am not sure what our immediate plans are for
11 that, but right now this measure is --
12 DR. STANGE: Not formally, but
13 just informally, that could really be helpful
14 in a conversation around mammography and have
15 something that is less controversial, the
16 interaction for women's health, and you can
17 say do less. You can be for women's health
18 and be for doing less. That could really have
19 a good unintended consequence or at least an
20 indirect consequence.
21 MS. BYRON: Right, and we agree.
22 I think those could be important measures, but

1 we do look at this measure and see that the
2 rates could still significantly be improved,
3 especially for the Medicaid population. So we
4 think it is important to keep it.
5 DR. STANGE: Just to have the
6 other as part of the conversation would be --
7 Just to have a way to have it into the
8 conversation would be so helpful.
9 DR. WINKLER: Is there any plans
10 to further explore the disparities issue? You
11 break it down by Medicaid plans, but that is
12 a fairly gross division, and I think that the
13 interest and focus and priority on disparities
14 really is pushing us to want to do more than
15 that.
16 MS. BYRON: We do know a lot of
17 health plans that take HEDIS measures and
18 stratify them according to race, ethnicity
19 information or other sorts of sociodemographic
20 variables, if they have them.
21 The measure itself is simply you
22 got the cervical cancer screening or you

1 didn't, and the same with colorectal cancer
2 screening or any of our other measures. We
3 think it doesn't preclude plans from going
4 further and using race, ethnicity information
5 if they have it, and applying it and doing
6 quality improvement analyses.
7 NCQA does have in its descriptive
8 domain measures that look at race, ethnicity,
9 diversity of membership, language diversity of
10 membership, and it is our hope that they could
11 apply those measures in conjunction with some
12 of our effectiveness of care measures and look
13 at disparities.
14 We also have -- This is outside of
15 the measure's context, but just to give you
16 some context, we have a multi-cultural health
17 care distinction program that does just that.
18 It talks about collecting race, ethnicity
19 data. We know that this is difficult for
20 plans. Even plans that have been doing it for
21 a really long time probably only have about 25
22 percent data on race, ethnicity.

1 So we do see these as part of the
2 greater context of work that they would do for
3 quality improvement, and we do have different
4 tools trying to push the field forward on
5 this.
6 DR. WINKLER: Sarah, do you have
7 any experience with WellPoint with that? Do
8 you guys try and do that?
9 MS. SAMPSEL: Yes. I mean, not
10 only -- You know, Sepheen's estimate was
11 fairly accurate. We probably only have on our
12 34 million people where someone has filled out
13 face and ethnicity information, so what is
14 coming in from the actual member. But then
15 our team is one of the groups that has won an
16 NCQA award in that we are doing some
17 predictive profiling, and this is one of the
18 measures that we do that in order to know what
19 kind of materials, resources, etcetera, that
20 do we need to go out and do those member
21 interventions.
22 So it is imperfect, and the way

1 our system works is based on a ZIP Code and
2 surname and trying to predict if there is a --
3 and putting it through an algorithm to
4 identify those folks.
5 We do have some bad hits out
6 there, and people aren't always pleased with
7 it, but the team has really done an incredible
8 amount of work, and we are at least moving,
9 and I know Kaiser has as well.
10 MR. STIEFEL: Yes. Our rates are
11 much higher, but we also use, for those for
12 which we don't have self-report data, the same
13 geocoding algorithm, and it actually is quite
14 effective to do the geocoding.
15 DR. STANGE: So this is an issue
16 that transcends these measures. I have been
17 trying to just push things forward, but can we
18 take just a minute or two more on this now and
19 just tell us a little bit more, Sepheen, on
20 what you are doing to push the field forward.
21 We have reporting fields that
22 people can have, but is there a way that you

1 have for people that they can aggregate
2 measures and say we are looking at disparities
3 in this way.
4 Is there another way you can
5 report and get credit for actually having gone
6 the extra mile, rather than just you can do it
7 for any of the individual measures. Tell us
8 more about what you are doing to try to push
9 the field forward.
10 MS. BYRON: NCQA launched, I
11 believe last year, a multi-cultural health
12 care distinction program. What this is, is a
13 set of standards that encourage plans to --
14 and really kind of shows a pathway toward
15 achieving quatro and linguistically
16 appropriate services.
17 The first standard within that
18 looks at collection of race, ethnicity and
19 language information. The measures that we
20 have go hand in hand with this program, and
21 they are aligned with the Institute of
22 Medicine report on collecting date for race,

1 ethnicity and language.

2 So what we are trying to do is

3 outline a standardized way that plans or

4 anyone could collect this sort of information.

5 It recommends the Office of Management and

6 Budget categories for the race, ethnicity

7 data, things like that, that were recommended

8 in the IOM report.

9 So in a field where

10 standardization was an issue, you will have

11 people asking about ethnicity as a race

12 category, for example, whereas the OMB

13 recommends doing it two ways or asking it in

14 two different ways, asking about race and then

15 asking about ethnicity.

16 The HEDIS measure provides a

17 cross-wall for, if you have done it as a two-

18 question format versus a one-question format,

19 you could combine the data, and you would

20 report out the measure.

21 So those are some of the ways that

22 we are trying to promote some consistency with

1 the way disparities -- with getting the data
2 to be able to run these analyses that could
3 tell you about disparities.
4 Then from there, there are health
5 plans, such as WellPoint and Kaiser, that have
6 been doing just that, using that information,
7 running it against the effectiveness of care
8 measures; and the multi-cultural health care
9 standards really blaze a path toward doing
10 that as well.
11 So it starts with data collection,
12 and then the lat standard says did you then
13 use these variables to run quality improvement
14 projects and, if so, you get some credit for
15 that.
16 So we really think that the best
17 way to look at this issue is probably not
18 through one individual measure, but really
19 through a program where measures are used
20 within the context of standards and procedures
21 that are recommended for doing quality
22 improvement analyses, doing it in a

1 standardized way, collecting the information
2 in a standardized way, and getting all the
3 tools that you need to be able to do
4 disparities analyses.
5 DR. STANGE: So there is no
6 reporting, though, about that. It is just the
7 next level, up to level 1, which is
8 collection. It is just that you use it to do
9 something internally.
10 MS. BYRON: For that particular
11 program, it is actually -- There is a
12 complicated -- or not complicated. There is
13 a series of standards that you get pointed to
14 based on, depending on how far you have gone
15 doing a whole myriad of things.
16 So it is actually not just the
17 data, but it is also things like did you look
18 at your provider network to see that you have
19 providers that might be able to deal -- speak
20 different languages or that sort of thing.
21 That is included.
22 It is did you do quality

1 improvement? So it goes beyond just data
2 collection and really puts it into the context
3 of all the different things that we think an
4 organization could do to promote culturally
5 and linguistically appropriate services.
6 DR. STANGE: So I apologize to the
7 committee for delaying us, but is NQF doing
8 anything; because we have heard that this is
9 an issue for every measure. Is there anything
10 larger that you are doing on that?
11 DR. BURSTIN: Robyn or Elisa, do
12 you just want to mention what we are doing on
13 disparities? You want me to do it? Okay.
14 So NQF does have a separate
15 project -- Actually, Nicole is here. She is
16 early. Do you want to just describe what we
17 are doing on disparities?
18 MS. McELVEEN: Hi. I'm sorry, the
19 question was to just briefly describe --
20 DR. BURSTIN: Describe what we are
21 doing overall as it relates to the issues
22 around stratification and disparities,

1 probably the work on the Commission paper and
2 what the committee is looking to do.
3 MS. McELVEEN: Sure. We have
4 recently convened a Disparities Steering
5 Committee. There are essentially two phases
6 happening in this project. The first is a
7 commissioned paper that is looking around
8 methodological issues related to disparities
9 measurement, such as implications around risk
10 adjustment and stratification, as well as
11 identifying criteria to select measures as
12 disparities sensitive within the NQF
13 portfolio.
14 Another component to that paper
15 includes information around public reporting,
16 and then the second phase to that is a
17 traditional consensus project around selecting
18 measures for disparities. That will happen
19 within the next month.
20 DR. BURSTIN: The paper was done
21 by Joe Bettencourt and a team at MGH. She
22 said it so well that maybe we should actually

1 share it with this group as well.
2 DR. NISHIMI: I was going to say
3 that. I think the thing to keep in mind is
4 this is just guidance, though. It is not like
5 it is hard and fast things that the NQF policy
6 is going to demand one way or another. So if
7 people have thoughts on it, once they look at
8 this paper, please share it with us.
9 DR. BURSTIN: So one of the key
10 considerations going forward, Kurt, in terms
11 of process is whether we will try to
12 prospectively have a set of criteria. As
13 people review a measure, you automatically
14 say, as you probably would have for several of
15 the ones we just talked about, this is a
16 disparity sensitive measure; this measure
17 should always be stratified. We can draft
18 additional information on that.
19 DR. NISHIMI: We would like to get
20 there, but we are not there yet.
21 DR. STANGE: Okay. Any comments
22 on that discussion on the disparities, before

1 we move on to publicly voting on the cervical
2 cancer screening? Madeline?
3 DR. NAEGLE: Just the thought that
4 I had, which came up earlier when we were
5 looking at another measure is that we don't
6 think about vulnerable populations so much in
7 disparities, and I think that is something
8 that we do need to consider, that ethnicity
9 and minority correlate with vulnerability
10 some, but the group of sexual minorities that
11 Linda raised, very important, and also older
12 people.
13 In a number of the measures that
14 we have looked at, we see that there are not
15 significant numbers of older adults included
16 in our numerator or denominator. I think that
17 this is going to be a growing issue as the
18 population ages, and one that we come across
19 very often.
20 So I would like us to give some
21 thought also to vulnerable populations as part
22 of that disparities group.

1 DR. NAEGLE: I just have a quick
2 comment or a question, and I hope it is
3 appropriate. When you go forward to do this
4 on a population or community level basis,
5 BRFSS doesn't break it down in those age
6 brackets. It is different. So it is
7 something that Sarah's team is going to have
8 to probably wrestle with.
9 DR. STANGE: Any further comments
10 before we vote on the cervical cancer? Okay.
11 DR. WINKLER: Kristin, go ahead.
12 We are voting.
13 DR. STANGE: Twelve to nothing,
14 Yes. Then we are moving on to the cervical
15 cancer screening for high risk populations.
16 Is that the next one?
17 DR. WINKLER: The next measure --
18 again, this was a measure that Dr. Medows had
19 done a primary review on -- is measure 579.
20 This is annual cervical cancer screening for
21 high risk patients.
22 This measure identifies women ages

1 12 to 65 diagnosed with cervical dysplasia --
2 that is CIN-2 and, I assume, 3 -- as well as
3 cervical carcinoma in situ or HIVAIDS prior to
4 the measurement year who still have a cervix
5 and who had cervical cancer screen during the
6 measurement year.
7 This measure is brought to us from
8 Resolution Health. Do we have anybody from
9 Resolution Health on the line? I thought we
10 did. Rufus, do we have anybody from
11 Resolution Health on the line, do you know?
12 OPERATOR: If anyone would like to
13 ask a question, please firmly press the * key.
14 DR. WINKLER: Is anybody from
15 Resolution Health on the line?
16 OPERATOR: And if anyone from that
17 organization is on line, please firmly press
18 the *key followed by the digit 1.
19 DR. WINKLER: Elisa, have we heard
20 anything from Resolution Health?
21 OPERATOR: And we do have two
22 participants that are from Resolution Health.

1 The first is Allen Leavens.
2 DR. WINKLER: Great. Allen, can
3 you hear us?
4 MR. LEAVENS: Yes. We were having
5 trouble getting through.
6 DR. WINKLER: Great, thanks. Glad
7 you could join us. I just introduced your
8 measure 579, cervical cancer screening for
9 high risk patients. Do you want to take just
10 one or two minutes to briefly talk about the
11 measure before we begin the discussion?
12 MR. LEAVENS: Sure. I will let
13 Kevin start, and then I will fill in as
14 needed. Kevin, are you on?
15 OPERATOR: One moment, please.
16 Mr. Bowman's line is now open.
17 MR. BOWMAN: Hi, can you hear me?
18 DR. WINKLER: Yes, thank you.
19 MR. BOWMAN: Excellent. So this
20 measure is similar to the previous measure for
21 NCQA cervical cancer screening, however with
22 high risk individuals. The measure was first

1 introduced in 2004. It has been endorsed
2 since 2008, and it is based on a specific
3 outline from the American College of
4 Obstetrics and Gynecology.
5 The guideline is women infected
6 with HIV should have cervical cytology
7 screening twice in the first year after
8 diagnosis and annual thereafter. Also, women
9 treated in the past for CAN-2, CAN-3 or cancer
10 remain at risk for persistent or recurrent
11 disease and should continue to be screened
12 annually, so essentially going after the high
13 risk, vulnerable populations on top of the
14 typical cervical cancer screening in non-high
15 risk patients.
16 DR. WINKLER: Again, this is a
17 measure for Dr. Medows' lead, and I will try
18 and step in as much as possible.
19 Again, this is a different
20 population than general screening of the
21 asymptomatic population. This is for folks
22 who have particular high risk conditions,

1 particularly either abnormal PAP smear or
2 treatment in the past for dysplasia or CIS or
3 patients with HIVAIDS. Those patients tend to
4 have a four to five times increases risk of
5 cervical dysplasia and invasive cancer
6 compared to the general population.
7 I believe what is not specified,
8 but I do see the codes for patients who have
9 undergone transplant, because they are
10 immunocompromised. They represent a higher
11 risk group.
12 This is a measure for all levels
13 of analysis based on primarily administrative
14 claims or electronic clinical data such in
15 EHR, and the current performance reported by
16 the folks from RHI is 78.5 percent.
17 The issue here is that, for the
18 general population, screening has been
19 recommended to lengthen for patients under 32
20 every two years. So it is no longer
21 recommended for annual screening for the
22 general population. However, for this

1 specific higher risk group, ACOG still
2 recommends annual screening. Their evidence
3 review of that is level B evidence.
4 So there is a little bit of a
5 difference between the ACOG recommendation and
6 the Task Force which basically says the
7 evidence for more frequent screening is not as
8 solid.
9 DR. BURSTIN: Although just one
10 reminder, which Mary cautioned me as well, is
11 that, just remember, the USPSTF does not make
12 recommendations for high risk. So it is not
13 conflicting. They just are silent on it.
14 DR. WINKLER: Correct. Yes, it is
15 just that the developer did mention that in
16 the submission. So I just wanted to point it
17 out to you, that they didn't support increased
18 cervical screening, including for those with
19 high risk factors. But again, as both Mary
20 and Helen have pointed out, that is really not
21 their purview. They are looking at screening
22 the general population.

1 ACOG, of course, is the American
2 College of Obstetrics and Gynecology, and
3 their recommendations are for annual screening
4 for the high risk patients.
5 DR. QASEEM: They are in the
6 process of revising that as well, and I don't
7 know what they are going to say, but they are
8 in the process of updating it.
9 DR. STANGE: Any further comments?
10 Any comments on this measure? Linda?
11 DR. KINSINGER: Including women
12 who already have CIN-2 or 3, it doesn't seem
13 to need any screening any longer. That is
14 really management, follow-up, surveillance.
15 I am confused as to why that group is included
16 in this measure, because it is a screening
17 measure.
18 DR. WINKLER: Can folks from RHI
19 respond to that? Did you hear the question?
20 MR. BOWMAN: Yes. I think it is a
21 fair statement. It would seem broad in terms
22 of, I guess, the terminology, but --

1 DR. WINKLER: We can hardly hear
2 you. Can you speak a little louder?
3 MR. BOWMAN: Sure. It is a fair
4 statement in terms of if we are talking about
5 the specifics of the terminology in terms of
6 screening, but essentially this population has
7 high risk factors that we are just trying to
8 include a broader group.
9 We could essentially take out that
10 one population, if we are trying to put them
11 in another measure that is looking at
12 surveillance specifically, follow-up
13 surveillance, but if we are trying to be
14 comprehensive and include all the high risk
15 populations, we felt it was appropriate to
16 keep them in this measure.
17 DR. STANGE: I think that is a
18 reasonable point definitionally, but as far as
19 a quality measure, I think it i kind of nice
20 to have it in there. It seems to be a nice
21 balance. So it makes a lot of sense to go up
22 on the interval for the general population,

1 but then, really, this is a way of balancing
2 it.
3 Definitionally, you could put that
4 as a separate quality measure, if you want to
5 make this purely prevention, but if it is an
6 overall quality measure, then this is an
7 expedient way to do it, it seems to me.
8 DR. WINKLER: Is the question
9 really about using the term screening as
10 opposed to perhaps something else could be
11 used?
12 DR. STANGE: You could just add
13 follow-up in the cervical cancer screening and
14 follow-up.
15 DR. KINSINGER: For women with
16 HIV, it really is screening. For the other
17 women, it is not. So maybe it is
18 screening/something, follow-up. I don't know.
19 So it may be just semantics.
20 DR. STANGE: Matt, is your card up
21 for this?
22 MR. STIEFEL: Yes. KP's guideline

1 here is a little different. It is more
2 nuanced. It is all -- They are consensus
3 based. There is not a strong body of evidence
4 supporting that nuance, but i can tell you
5 what KP's nuance is here, if it is useful. I
6 am not expert in this, but this is from our
7 National Clinical lead for prevention. I am
8 going to read it.
9 "For immunosuppressed or HIV
10 positive women, cytology and HPV testing are
11 recommended six months following treatment per
12 se in two or three, and again at 24 months
13 with colposcopy for any positive result.
14 Routine screening every three years can then
15 be resumed indefinitely. For immunosuppressed
16 or HIV positive women, if HPV testing is not
17 done, two cytology tests at six and 12 months
18 after treatment per se, and two or three
19 recommended with colposcopy for any positive
20 result, then annual cytologic screening
21 indefinitely." And in the third part, at
22 least cytology with or without HPV testing is

1 recommended for women who are immunosuppressed
2 or HIV positive.
3 So it is a more nuanced
4 stratification of the population.
5 DR. STANGE: That is closer to
6 what I do, actually, clinically, but is that -
7 - Are you okay with this one for the quality
8 measure?
9 MR. STIEFEL: Well, the problem is
10 the goal or recommendation of annual
11 indefinitely is more aggressive than what we
12 do.
13 DR. WINKLER: Actually, in the
14 ACOG writing, it says for 20 years. So
15 indefinite does have an end, but not short
16 term.
17 DR. BURSTIN: Amir, do you know
18 the timing of the update of the guidelines on
19 which this is based?
20 DR. QASEEM: You know, I honestly
21 don't know, but I think they are working with,
22 actually, the American Cancer Society right

1 now, and my understanding is probably like a
2 few months.
3 What is their age range when they
4 say go in high risk in ACOG guidelines?
5 DR. WINKLER: I don't believe they
6 have an age range, because it is based on the
7 diagnosis. It is diagnosis of dysplasia or
8 cancer, diagnosis of HIV or transplant. So it
9 is age independent.
10 DR. STANGE: Is there something
11 more helpful we could do than vote yea or nay
12 on this, given the evolution of what is going
13 on? Matt?
14 MR. STIEFEL: Could I just ask the
15 developers if they reviewed and considered
16 this stratification or if the recommendation
17 is based on a more just generic world for this
18 population?
19 DR. STANGE: So did developers
20 hear Matt's question, and after you respond if
21 you could turn your Mute on. For the
22 developers, that will help us in the room.

1 MR. BOWMAN: I'm sorry. I had a
2 little trouble understanding the question.
3 MR. STIEFEL: I just read KP's
4 version of this guideline which stratifies the
5 population to include for subsets three-year
6 screening, if other conditions are met, and I
7 curious if you -- I don't know if you heard
8 what those exclusions were or the
9 stratification, if you considered that or not.
10 MR. BOWMAN: We did consider it,
11 but again relying on the ACOG guidelines, they
12 indicated that the annual screening was
13 indicated, and we did see the 20-year time
14 frame for HIVAIDS. However, given the
15 populations that we are analyzing, we would
16 not have the ability to have the data to look
17 back to see when an initial diagnosis first
18 occurred. So to limit it to 20 years would
19 not be practical for the measure.
20 DR. QASEEM: Just quick, to what
21 Helen asked. Could we ask these folks? Maybe
22 they know when the guidelines are going to

1 come out?

2 DR. WINKLER: To our developers,

3 are you familiar with the fact that ACOG is

4 updating their guidelines, and do you have a

5 time frame for that?

6 MR. BOWMAN: I am not certain of

7 the time frame. We know the last update was

8 2009. However, I am not certain when the next

9 -- the latest guideline update is to come out.

10 However, we certainly follow those releases,

11 and would be prepared to update the measure,

12 should their recommendation change.

13 DR. QASEEM: Would it be something

14 feasible that -- and I don't know what other

15 options, maybe approve or whatever, but based

16 on -- If something is going to come out soon,

17 maybe we can -- This is for three years or

18 something. It is not going to make sense that

19 we approve something, and it is going to be

20 changing.

21 DR. BURSTIN: Agreed. I think we

22 may just want to table this until we get the

1 information.

2 DR. WINKLER: We will find that

3 information out and see what the time frame is

4 from ACOG, and we can get back to you.

5 DR. STANGE: Any objection to

6 that? Okay, so it is tabled.

7 DR. BURSTIN: And, actually, it

8 would be helpful if you could also send in

9 that information, Matt. I assume it will have

10 some additional references that might be

11 helpful for the committee to take a look at.

12 For the developer on the phone

13 from RHI, I think our feeling is we would like

14 to find out the timing of the ACOG update. So

15 I think we are going to table a decision on

16 this measure for today. Any concerns about

17 that?

18 MR. BOWMAN: No, that sounds fine.

19 DR. BURSTIN: Okay, thank you.

20 DR. STANGE: So looking at the

21 schedule here, we have done phenomenal catch-

22 up work. What I would like to ask the group -

1 - We have three measures on our morning
2 agenda. It is 11:20 now. Do people need
3 another quick break or do you want to try to
4 forge ahead and get these three done and, if
5 we get them done quickly, then take an early
6 break for lunch maybe, if that doesn't mess up
7 the phone thing, and then if we keep forging
8 ahead, save a little time at the end for some
9 more discussion about next steps or the bigger
10 picture thing.
11 So anybody need a break now?
12 Okay. So lt's forge ahead. So I guess the
13 next one is osteoporosis in older women. So
14 that is number 37.
15 DR. WINKLER: The next measure is
16 37, osteoporosis testing in older women, again
17 from NCQA. This is the percentage of female
18 patients aged 65 and older who reported
19 receiving a bone density test to check for
20 osteoporosis.
21 This measure -- Who is our reviewer?
22 Oh, it is Kurt. Okay. And again, Sepheen is

1 here.

2 MS. BYRON: I just want to check.

3 Judy Ng, are you on the phone? We have

4 someone calling in from NCQA as well.

5 DR. NG: I am on the phone.

6 MS. BYRON: Great. It is really

7 low. I wonder if you can speak a little

8 louder. Judy?

9 DR. NG: Yes.

10 MS. BYRON: Oh, that is better.

11 Okay, great.

12 All right. So this is the

13 osteoporosis measure. Again, it is in a HEDIS

14 measurement set, and Judy, did you want to add

15 a little description of this?

16 DR. NG: Sure. This measure -- It

17 comes from a survey, the Medicare Health

18 Outcomes Survey, which is a health status

19 survey administered to random sample Medicare

20 beneficiaries and health plans every year.

21 This particular question in the

22 survey assesses female members aged 65 and

1 older who responded affirmatively, yes, to a
2 question in the survey asking if they have
3 ever had a bone density test to check for
4 osteoporosis, and the question says that this
5 test is also thought of as the brittle bones,
6 and the test could have been done to the
7 person's back, hip, wrist, heel or finger.
8 DR. STANGE: I will step in s the
9 person from the committee who looked at this.
10 The only two issues I had: I just had a
11 question of why this is a self-report measure.
12 It just seems like it would be incredibly easy
13 to do with administrative data, and reduce the
14 reporting burden.
15 Then the other thing is from my
16 reading of this Saturday New York Times, in
17 the Business section, the front page talks
18 about two FDA Advisory Panels.
19 I was looking at the names, but
20 the one on women's health and the one more
21 specifically on this have actually raised
22 questions about the long term safety and

1 efficacy of the major treatment, once you
2 identify this screening, which would be
3 bisphosphonate therapy, and saying there is
4 really no evidence of the long term effects
5 of this for safety, and no significant
6 advantage of continuing it beyond five years.
7 There has been some problems with
8 weird femur fractures for women without
9 trauma, just standing around, and their femur
10 breaks, which could be pretty disconcerting,
11 and then rare osteonecrosis of the jaw, which
12 is still rare, but a big problem.
13 So the screening looks effective.
14 It is low rates, but what do you do about it,
15 now that we are not doing estrogens very much
16 for this purpose is actually a little bit in
17 question. So that was the only issue I would
18 raise.
19 There is just uncertainty . The
20 bisphosphonates have been around a short
21 enough time that we don't actually have long
22 term efficacy or safety data, but there are

1 just some concerns emerging. Sarah?
2 MS. SAMPSEL: Hey, Judy, it is
3 Sarah Sampsel. This measure is currently one
4 of the Medicare stars measures as well. So a
5 plan's performance is being measured and,
6 obviously, we are receiving some payment on
7 them if we perform appropriately. But
8 Medicare is putting out for public comment
9 removing the measure from the star program.
10 Have there been discussions with
11 CMS on if it is just while the GMAP is
12 reviewing the measure or, you know, what
13 really is the status on this measure, also
14 included in stars, and do you have any other
15 insight behind CMS' rationale for removing it?
16 DR. NG: I think possibly what
17 that might be -- and this is not just specific
18 to this measure, but as I said, because this
19 measure comes from a specific health outcomes
20 survey, CMS is thinking of revamping the
21 survey and possibly making some changes to it.
22 Of course, that would directly affect any of

1 the measures in there, including this one.

2 So that might be part of the

3 larger context behind what you are hearing in

4 terms of this measure possibly being removed

5 or possibly being updated or changed.

6 DR. STANGE: Why would it be

7 removed?

8 DR. NG: I can't speak directly to

9 that, but again I think it is connected to

10 this idea that CMS wants to update the Health

11 Outcomes Survey in the future, and since this

12 question is in the survey, there is a

13 possibility that there might be changes to it,

14 and one of those changes could be removal.

15 DR. STANGE: Just also, why is

16 this a self-report measure?

17 DR. NG: This is one of those

18 measures that, I believe, when it was first

19 formulated some years ago and added to the

20 survey, the idea was that osteoporosis in

21 general was a condition that was undertreated,

22 under-discussed, under-managed, and with the

1 USPSTF Guidelines that every woman 65 and
2 older should have some kind of bone mineral
3 density test, this measure was trying to get
4 at how well the plans were even addressing
5 this topic in any sense.
6 Since plans don't have -- You
7 know, because the USPSTF Guidelines don't put
8 in a specific interval for frequency for
9 screening, I think what this measure did was
10 it also went along with it and just want to
11 see, if you are 65 and older, did you at least
12 have a test at anytime.
13 A person in a health plan can
14 change plans and, therefore, it is not -- If
15 they change plans and whatever plan they are
16 currently in when the survey is administered
17 would not be able to capture through just
18 administrative if the person had a screening
19 before.
20 DR. STANGE: That makes perfect
21 sense. So is the amount of uncertainty about
22 the context around this such that this should

1 be deferred to?

2 DR. NG: Well, at the moment I

3 don't think CMS has direct intention to remove

4 this measure. My only -- My guesstimate for

5 why someone may have heard that is possibly

6 because it is connected to CMS plans to

7 possibly update the survey as a whole, but I

8 have not -- You know, with working with the

9 GMAP, with some of our technical advisory

10 groups, and working directly with the Health

11 Outcomes Survey team at CMS, we have not heard

12 any single person say directly that they want

13 to remove this particular measure.

14 They do want to update the survey

15 and make it more effective which, of course,

16 could introduce changes, but I have not heard

17 anyone say directly that this measure should

18 be removed. And because we are working with

19 them in the coming year to help guide them on

20 some of these changes they want, this is

21 something I can easily bring to their

22 attention as well, that this is a -- It seems

1 the general feeling is people may not want
2 this measure to be removed from the survey.
3 DR. STANGE: So we will have Mary
4 follow up on that, and then Jackie and then
5 Matt.
6 MS. BARTON: I think the
7 extraordinarily rare side effects of one of
8 the medications that is used to treat a
9 condition is not necessarily a compelling
10 argument to remove a screening measure.
11 So I think that, when looking at
12 the question of what can be done to protect
13 the health of women over the age of 65, the
14 idea that preventing potentially daily
15 function affecting fractures like a hip
16 fracture or spinal fractures is still
17 relatively high in the priority list of most
18 clinicians who take care of women in this age
19 group.
20 So I think, given the fact that
21 exercise, calcium, calcitonin perhaps -- you
22 know, another set of things are also effective

1 and could be effective, or even estrogen, in
2 helping people to maintain their bone density
3 and to prevent those sometimes life changing
4 fracture events -- I actually think that the
5 gestalt evidence for supporting continued work
6 in improving plans' improvement in this area
7 is absolutely intact, notwithstanding the
8 FDA's concerns about those bisphosphonates.
9 DR. STANGE: Thank you. I was
10 kind of scanning for any possible concerns,
11 but what I said about it was very unbalanced,
12 and thank you for balancing that. Jackie?
13 MS. MERRILL: That was really my
14 comment. You don't screen if you can't treat,
15 but you are right. There are other
16 alternatives. It is just the idea that, if it
17 is going to be removed from the CMS survey,
18 the plans can still independently ask for it
19 using this measure. So that is a reason to --
20 you wouldn't do it?
21 MS. SAMPSEL: So plans -- You
22 know, if we have a Medicare Advantage -- If a

1 plan administers a Medicare Advantage plan,
2 the Health Outcomes Survey is one of those
3 quality measures for that Health Outcomes
4 survey.
5 If this measure is removed from
6 that survey, we really don't have incentive to
7 continue -- You know, surveys are incredibly
8 expensive and a high burden. The information
9 we had, Judy, was actually from CMS that they
10 are considering removing this, and they are
11 not really even talking about in their
12 materials changes to the HOS. They are
13 considering dropping this particular measure
14 from stars ratings.
15 So I guess what I would encourage
16 NCQA to do is, even though you work with the
17 HOS group, is that HOS group working with the
18 stars group, because we do know CMS is a
19 pretty -- let's just call it a large
20 organization, and there may be some
21 communication issues, because the
22 communication we have as a plan is we may no

1 longer be incentivized to be tracking this
2 measure.
3 DR. NG: Okay. I know that the
4 HOS team within CMS is reaching a lot more to
5 the stars team. So I think there will be a
6 lot more improved communication in the future,
7 and that is a great point to bring up.
8 DR. WINKLER: Just a question.
9 This measure is based on survey, and the whole
10 question around here is the ongoing use of
11 this measure within surveys. Previously NQF
12 has endorsed a measure that came from NCQA,
13 measure 46 which is osteoporosis screening or
14 therapy for women age 65 years and older and
15 who have had a -- those patients who have had
16 a central dexa measurement ordered or
17 performed at least since age 60 or a
18 pharmacologic therapy prescribed within 12
19 months.
20 This is based much more on the
21 traditional medical records and is not a
22 survey. However, apparently, they have kind

1 of -- We didn't get a full submission for
2 maintenance review, and so this is sort of an
3 alternative way of measuring this kind of
4 process of care.
5 So, Sepheen, did you want to
6 comment on that, because we weren't able to
7 bring it to the committee, because you all
8 said you weren't ready or able to submit it to
9 us at this point in time. What is going on
10 with that measure?
11 MS. BYRON: I will ask Judy to
12 fill in, if she has anything, but there are
13 actually two separate measures. So one is the
14 survey measure that is in -- and as Judy
15 described, and the other one is the health
16 plan measure. Judy, do you know what the back
17 conversations might have ben around that?
18 DR. NG: I am not completely
19 certain, but I think the other measure you are
20 referring to may possibly be -- I don't know
21 if that is the osteoporosis management in
22 women who have had a fracture measure. If so,

1 that is another measure of ours that sort of
2 tracks women who have already had a fracture,
3 and that gets more at whether or not they had
4 a bone mineral density test or some kind of
5 drug to treat that fracture.
6 What that measure gets at, really,
7 is how well plans are managing women who have
8 already had a fracture and, therefore, are at
9 a much higher risk for a second fracture or
10 additional fractures.
11 That measure intent is a little
12 bit different from this one that is in the
13 survey.
14 MS. BYRON: Judy, this was a
15 measure that was presented to the CPM
16 yesterday?
17 DR. NG: That is correct.
18 MS. BYRON: So it could have been
19 that, at the time of submission we --
20 MS. BARTON: I think the bar to
21 bring things to this committee was population
22 measures, things that were relevant to the

1 general population, which, clearly, the
2 osteoporosis screening for all women 65 and
3 older fit, and I believe that probably the
4 thinking was that a measure that asks health
5 plans to document that they treated the people
6 who they found an abnormality in is completely
7 and squarely outside of the population health
8 agenda.
9 DR. WINKLER: But that wasn't the
10 measure we are talking about. This is
11 screening for patients that either had the
12 dexa or not, because they were already on
13 therapy, which is not about treatment.
14 MS. MERRILL: But anyway,
15 assurance is part of public health mandate.
16 So it is within the purview.
17 DR. WINKLER: I think that we can
18 talk further with NCQA and see what the issue
19 around that measure is, but --
20 DR. BURSTIN: That is 49?
21 DR. WINKLER: It is 46.
22 DR. BURSTIN: Forty-six was -- I

1 thought that was what this one was. That is
2 not what this one is? Okay.
3 DR. STANGE: So then, if there are
4 two measures that the main difference is the
5 measure data collection, does that mean that
6 plans can choose which one they do? Is that
7 the advantage for having two measures?
8 DR. NG: Actually, if it is the
9 measure I just described, the measure actually
10 -- They are two different data collections,
11 but they are actually quite different in that
12 one of the measures, the survey measure we are
13 talking about today, targets all women age 65
14 and older, asking them about screening.
15 The other measure really targets
16 women who already have had a fracture. A
17 risky event happened to them, and that one
18 really gets at how well that plan is managing
19 these women who, because of the fracture, are
20 at additional risk for a second fracture.
21 That measure gets more at did you treat them
22 in some way, either with the MD test to

1 monitor or for other purposes or with drugs.
2 DR. WINKLER: We are not talking
3 about the post-fracture measure. There is
4 another NCQA measure that has been through
5 NQF, and I just handed it to Mary, the title
6 and the description. Maybe she can comment on
7 it.
8 MS. BARTON: We will go back and
9 figure this out, because it was endorsed in
10 2007, and I am not aware of why it was not
11 submitted this time.
12 DR. STANGE: And welcome to your
13 new job, Mary, one week into the job. So does
14 this mean we need to table it? I think we
15 have had some assurance about the patient
16 report measure but not enough that we wouldn't
17 approve it. So it is only this context that
18 is the issue, it sounds like.
19 MR. STIEFEL: This is the only
20 other one where the KP guideline is a little
21 different and based on shared decision making.
22 Again, I am not expert in it, but from our

1 national clinical lead it is, while we
2 recommend screening, it is with shared
3 decision making with a member and a
4 calculation of the frax score to determine
5 ten-year risk, and giving the decision to the
6 member.
7 MS. MERRILL: I feel very
8 uncomfortable about the three measures, and I
9 feel very uncomfortable about moving measures
10 forward that seem to have controversy involved
11 with whether they are needed or not. So that
12 is what I think.
13 DR. STANGE: I would like to --
14 Since I am the one who maybe brought the
15 controversy up, I really think that Mary's
16 view of that was much more balanced than mine.
17 I really brought up some -- I think her
18 characterization that these side effects is
19 very rare compared to how incredibly common
20 osteoporosis and fractures from that are.
21 I think that is how we should look
22 at this.

1 MS. MERRILL: Part of it is that
2 the data is being captured in another way that
3 has less burden, which is it is included in
4 that second measure, you know, people screened
5 and treated.
6 DR. STANGE: I think that is the
7 bigger issue. That is the uncertainty that we
8 have, is that there is another measure that
9 captures the data in a different way, and that
10 it is really -- Seems to me, that is the
11 difference in reporting burden. Do you
12 capture the people that got it elsewhere and
13 self-report or do you capture that through the
14 data from the health plan where that is
15 reported through the health data. It almost
16 is an exclusion criteria.
17 It sounds like it would be helpful
18 to NCQA, if we think this is a measure that
19 meets the importance and evidence and
20 usability criteria, to move it forward. There
21 is a reconciliation issue about this and
22 another recommendation that has a different

1 data collection.
2 DR. BURSTIN: And also this
3 question of whether it is going to continue to
4 be collected which, I think, is kind of an
5 important issue.
6 DR. STANGE: So from your point of
7 view --
8 DR. BURSTIN: To allow us to have
9 more time to figure out the differences
10 between the measures, because I do think there
11 is a survey measure and, if the other one is
12 not survey based, we need to understand.
13 MS. BYRON: Right. I am looking
14 at this, and it is a clinician level measure,
15 and I wonder -- I am not certain, but we have
16 a lot of measures that we had submitted as
17 physician level a long time ago, and that was
18 before we were able to check different levels
19 of measurement based on one measure.
20 So sometimes we have got measures
21 that are physician level and then that are
22 health plan level, and they are both NQF

1 endorsed. Some are used in the PQRS. some
2 are used -- which is the Physician Quality
3 Reporting System for CMS.
4 We did develop a whole host of
5 measures when that program was launched by
6 CMS, so that physicians would be able to
7 report on quality measures, and they were --
8 Most of them were based on HEDIS measures.
9 So we will talk offline and make
10 sure that we are certain about what happened
11 here.
12 DR. STANGE: So we will defer this
13 then until you can bring it to us in a
14 consolidated way, and I would guess that we
15 are going to have some of the same issues
16 about the steroid use that have become some
17 population of high risk steroid use. So we
18 should probably defer that.
19 DR. BURSTIN: That is another NCQA
20 measure.
21 DR. STANGE: But I just sense
22 that, since we are going to want to look at

1 the whole package, we should probably defer
2 that, too.
3 MS. MERRILL: Isn't that your
4 goal, is to try to look at groups of measures
5 together and try to see what is redundant,
6 what is creating burden, and what is
7 unnecessary?
8 You know, this is the first time I
9 have been at this meeting, and I have to say,
10 it is bewildering, and it also seems like
11 there is a lot of -- I'm searching for the
12 word, but there is some sort of like
13 redundancy, and the different competing
14 interests are at play.
15 DR. STANGE: That is a big agenda,
16 clearly.
17 So the last one then we will try
18 to get done before our lunch break is the
19 screening for the American Automotive
20 Association -- I mean for abdominal aortic
21 aneurism.
22 MR. MASON: So on the other

1 osteoporosis one, if someone is on the phone,
2 they should be told they can get off the
3 phone. Right?
4 DR. WINKLER: They are the measure
5 developer for this coming up measure, too.
6 So, hopefully -- Are the folks from Active
7 Health on the line? Who are we expecting?
8 Rufus, is anybody from Active Health on the
9 line?
10 OPERATOR: That was Active Health?
11 DR. WINKLER: Correct.
12 OPERATOR: And we have Sarah
13 Lackner on line.
14 DR. WINKLER: Okay, great. Did
15 you hear the discussion about the osteoporosis
16 steroid use measure?
17 DR. VIR: Yes, we did.
18 DR. WINKLER: Great. Okay. So we
19 are moving on to measure 629, male smokers or
20 family history of --
21 DR. VIR: Can I ask a question
22 before you go on? In terms of the

1 osteoporosis steroid, was there anything
2 specific that you wanted us to address?
3 DR. WINKLER: No. I think we want
4 to be able to look at all measures addressing
5 osteoporosis together as a group, and there
6 are questions about some of the other
7 measures.
8 DR. VIR: Okay. Yes, thank you.
9 And you will let us know when that will be?
10 DR. WINKLER: Yes.
11 DR. VIR: All right. Thank you
12 very much.
13 OPERATOR: And we also have Lindee
14 Chin on line.
15 DR. WINKLER: Great. Thanks,
16 guys. Let me just introduce the measure.
17 This is male smokers or family
18 history of abdominal aortic aneurism -
19 screening for AAA, percentage of men age 65 to
20 75 years with history of tobacco use or men
21 age 60 years and older with a family history
22 of abdominal aortic aneurism who are screened

1 for aortic abdominal aneurism.
2 This measure is from Active
3 Health, and our developers, did you want to
4 just say one or two sentences to introduce
5 your measure before we begin discussion?
6 DR. VIR: Yes. Can you hear me?
7 DR. STANGE: Yes.
8 DR. VIR: This is Dr. Bani Vir. I
9 am one of the medical directors with Active
10 Health on the clinical research and
11 development team. We just wanted to say good
12 morning and thank you for reviewing our
13 measure and giving us this opportunity.
14 This measure is directed toward
15 male smokers or men with a family history of
16 abdominal aortic aneurism to consider
17 screening for AAA. It addresses men ages 65
18 to 75 with a history of tobacco use or men age
19 60 and older with a family history of
20 abdominal aortic aneurism, and measures
21 whether or not they have been screened for
22 AAA.

1 DR. WINKLER: Sarah, I believe you
2 are our reviewer for this.
3 DR. VIR: I'm sorry. It is
4 difficult to hear you.
5 DR. WINKLER: I was talking to a
6 committee member, to Sarah Sampsel.
7 MS. SAMPSEL: On this measure, as
8 the form was completed, I think there are a
9 few things to bring to the Steering
10 committee's attention.
11 One would be consideration of
12 actual impact, and while there is a USPSTF
13 recommendation for part of this population,
14 not the full population in the measure, from
15 my reading, as well as, you know, it is four
16 to eight percent of older men and a half-
17 percent to one and a half percent of older
18 women.
19 So in thinking about importance,
20 does this meet the importance criteria would
21 be one consideration. I don't know how large
22 all of Active Health's population is for the

1 field results, but there was only
2 identification of about 3,000 members.
3 I also think there are some, I
4 guess, feasibility issues or scientific
5 acceptance issues having to do with
6 identification of this population through
7 whatever mechanism. Smoking is one thing, but
8 history of -- or family history of something
9 else that is very difficult to administer,
10 depending on who it is.
11 I don't even think a medical
12 record would provide that information a good
13 portion of the time, but I could be wrong.
14 So, really, in my review, while I
15 do think there is evident support for the
16 measure, thinking about overall impact and
17 need for the measure as well as some of the
18 feasibility issues in deployment would be a
19 concern of mine.
20 DR. BURSTIN: One point of
21 clarification: Under the impact criteria, it
22 is not just purely numbers. It is also the

1 severity and the impact. So I think just in
2 this case small numbers, high impact in terms
3 of ruptured AAA would have been reasonable.
4 Nothing about the evidence per se.
5 DR. VIR: I just want to mention
6 that our initial data was test data and, since
7 then, we have had a run on a total population
8 of over 13 million lives, and from that we
9 found over 31,000 people falling into the
10 denominator, and only about 18,000 people fall
11 into the numerator, which shows a compliance
12 of about 57 percent on this particular
13 measure.
14 DR. STANGE: Any comment on the
15 feasibility issues of the data collection of
16 family history? That does strike me as
17 something that is not reliably available from
18 medical records.
19 DR. VIR: Right. We get most of
20 our family history information through direct
21 patient derived data that is collected from
22 discussions with nurses in our Duties

1 Management Program, as well as from our
2 personal health record.
3 DR. BURSTIN: So this came through
4 a project, actually, Reva led a couple of
5 years ago on clinically enriched claims based
6 measures. So they actually -- This was a
7 clinically enriched measure that could pull in
8 data from THE, CHRs as needed.
9 DR. VIR: Correct.
10 DR. QASEEM: I think Sarah brought
11 up a really important point about family
12 history, and I am not going to go into that.
13 One thing I wasn't really -- I think we all
14 agree, the mortality benefit is there between
15 65 and 75 for one-time screening. Repeat
16 screening has no benefit. Right? At least in
17 my opinion, the repeat screening, once it
18 comes up negative, it does not have shown any
19 impact on mortality.
20 I am not really sure if that is
21 being captured over here, because the
22 numerator statement, the way it reads right

1 now says men who have had AAA screening. But
2 I think we need to be a little bit careful.
3 WE cannot keep on screening for folks for AAA
4 once come out negative, and I am seeing a
5 little bit limitation, aside from the history,
6 the way it is currently written.
7 DR. VIR: We only look for the
8 screening to be done once, and then it is
9 considered complete.
10 DR. STANGE: So that would be
11 clarified by 2.a.1.1. Instead of having men
12 who have had AAA screening, men who had one-
13 time AAA screening?
14 DR. VIR: Yes. When it comes to
15 screening, with the way that our rules around
16 this particular measure are built, you can
17 maybe see. We submitted all of our code sets
18 that we use to capture the information to
19 complete this measure.
20 It is only one time, and then it
21 is considered complete. That is built into
22 our rule.

1 DR. STANGE: I think Amir is just
2 looking at unintended consequence of over-
3 screening. if you just make it clear to
4 people -- No, it is nothing about what you are
5 doing. It is just communicating it.
6 DR. VIR: Sure.
7 MS. SAMPSEL: I think in 2.a.1.2
8 it says anytime in the past. So maybe it just
9 needs to say one time in the past or at least
10 once. I don't know.
11 DR. VIR: We can certainly change
12 that, if that would --
13 DR. STANGE: Linda.
14 DR. KINSINGER: We have thought
15 about this issue a lot for the VA, because,
16 obviously, this is -- You know, this is where
17 the studies were done. This is the population
18 that this applies to.
19 The issue we have run up is that
20 many men have had abdominal CTs for other
21 reasons. Sometimes the abdominal aorta
22 diameter is read. Sometimes it is not, but if

1 they had a stand on where the diameter was
2 read, there is no reason to put them through
3 another screening test of an ultrasound, but
4 it is inconsistent.
5 Then we developed some guidance
6 from our radiologist to be sure to always read
7 the aortic diameter, if they can, when a study
8 is done for any reason. But this measure
9 doesn't pick up any of that. So it might
10 encourage people who have essentially
11 functionally had a screening test done, but it
12 wouldn't be counted that way, and so they
13 would have to go back and have an ultrasound
14 done.
15 DR. VIR: Actually, if you look at
16 our numerator details, we allow for
17 completion. If you have had a CT scan, an
18 ultrasound, any sort of imaging that would
19 capture abdominal aortic size, you are
20 considered complete.
21 DR. STANGE: That makes sense to
22 me. It is hard to imagine a radiologist not

1 commenting on any risk greater than six
2 centimeters on an abdominal CT scan.
3 DR. KINSINGER: Well, but it is
4 three.
5 DR. STANGE: It's three, really?
6 DR. KINSINGER: Yes, it's three.
7 I mean, that is the -- The cut point is 3
8 centimeters, and they may or may not comment
9 on -- particularly, if it is less than three,
10 they may not comment that it is less than
11 three. They may not say anything about it.
12 DR. STANGE: Right. But it is
13 really an issue of if it would be missed. So
14 do you think it is not true that a radiologist
15 wouldn't call something that was -- In my
16 experience, they mostly over-call things.
17 DR. KINSINGER: It is just that,
18 if it was normal and not stated, then it
19 wouldn't show up. It would appear as if it
20 had not been done, when in fact it had been
21 done.
22 DR. STANGE: But, no, here for

1 this quality measure, if you had a CT scan, it
2 is assumed. The abdomen is assumed. You are
3 positive for having had the screening test
4 done. I mean, they don't go and look to see
5 whether it has been called out.
6 DR. VIR: That is right. They
7 only look that the study was done. We don't
8 look for the fact that the radiologist has put
9 in a reading for the exact centimeter size or
10 diameter size. We are assuming -- and, you
11 know, from a clinician standpoint, I have
12 never found in my years of practice that a
13 radiologist does not comment on an aneurism
14 that he sees. So we consider it complete if
15 they have had the study alone.
16 DR. KINSINGER: Our radiologist --
17 The chief of radiology was concerned that,
18 unless it was specifically commented on, you
19 couldn't -- He was uncomfortable assuming that
20 it had been evaluated and read. I don't know
21 whether he actually pulled data on it, but
22 that was his strong feeling, was that is an

1 assumption he as not comfortable making.
2 DR. VIR: I understood. We hope
3 that we will -- In our situation, we would
4 like to give the physicians and people being
5 measured on this particular performance
6 measure -- we would like to give them the
7 benefit of the doubt and allow for credit to
8 be given where it is due.
9 Sometimes the diameter is not
10 always in data that is capturable. So we do
11 give credit if you have ordered the study and
12 done the study.
13 MS. MERRILL: Where is that
14 described? I don't see it.
15 DR. VIR: I'm sorry?
16 MS. MERRILL: Where is that
17 located?
18 DR. VIR: Where is what located,
19 the imaging study?
20 MS. MERRILL: In the documents.
21 DR. VIR: In the numerator
22 details, Section 2.a.1.3.

1 DR. STANGE: So, Linda -- Let's
2 let Linda look at that and think about whether
3 that is a fatal flaw from your point of view
4 or whether for a screening measure that is
5 giving them credit for having had a CT scan
6 done once is adequate.
7 While Linda is doing that, are
8 there other issues people want to bring up in
9 anticipation of a vote on this?
10 DR. KINSINGER: Does an ultrasound
11 for gallstones count?
12 DR. VIR: I don't believe that it
13 has to be an ultrasound specifically on the
14 aorta.
15 DR. KINSINGER: So what is the
16 definition of abdominal imaging procedure?
17 DR. VIR: That is one of our codes
18 that specifies -- That element particularly
19 specifies only certain codes that would be
20 specific for a AAA. It wouldn't count all
21 types of abdominal ultrasound. That would be
22 an add-on within this element that we have not

1 -- we didn't break it out for you here, but it
2 is in the element.
3 DR. WINKLER: Apparently, there is
4 a set of codes that go with that, and if it is
5 important to you, we will be sure we get it
6 added in.
7 DR. STANGE: Linda, would you be -
8 - It is an important issue that you are
9 raising. Would you be okay with us voting on
10 it, on this contingent that you are looking at
11 that and seeing that it is not underreporting
12 like counting -- I personally would be willing
13 to think that, if you had an abdominal CT scan
14 reported, that is probably for screening
15 purposes adequate. But I would totally agree
16 with you that gall bladder ultrasound I
17 wouldn't count, be confident that a
18 radiologist would pick that up. But would you
19 be willing to have us vote on this, contingent
20 on your looking at that in more detail and, if
21 you think it is inadequate, then we will bring
22 it back to the group?

1 DR. BURSTIN: I think it is
2 actually up to the developer to tell us
3 whether or not write-up or quadrant
4 ultrasounds are included or not. I mean,
5 because you order those differently. They
6 wouldn't capture the aorta.
7 DR. VIR: That is right, and we
8 could certainly provide the components of this
9 element for you.
10 DR. BURSTIN: I'm sorry. We
11 couldn't hear you.
12 DR. VIR: I said we could
13 certainly provide the components that make up
14 this element, the various studies for this
15 particular element, if you are interested in
16 ruling out the fact that a gall bladder study
17 or something that is nonspecific could be in
18 there. We could certainly do that for you.
19 DR. WINKLER: Because it is part
20 of the specifications, we really do need to
21 have that level of detail for people.
22 DR. VIR: Sure.

1 DR. STANGE: Would you be okay
2 with us voting with that contingency, Linda?
3 You have the power to pull back the vote.
4 DR. KINSINGER: Yes.
5 DR. STANGE: Any other comments
6 before we vote? So vote yes or no, with Linda
7 said, whoa, that numerator measure is
8 inadequate.
9 DR. WINKLER: All right. It is
10 nine Yes and three No. But we will need the
11 details of those code lists to include in this
12 document so everybody, all the audiences, will
13 have the opportunity to see that.
14 DR. STANGE: And Linda is a
15 subcommittee of one to look at that and, if
16 you think that is inadequate, I guess then we
17 will table it and bring it back to the next
18 consideration.
19 MS. SAMPSEL: Can I make another
20 request, and I guess it is of Active Health,
21 because the other -- and I guess the question
22 first, though, is to NQF.

1 On the steroid use osteoporosis
2 screening form, I don't think there was any
3 data in there on what testing results or what
4 has been deployed, and from this conversation
5 it sounds like there may be more data on some
6 measures. I think, if that is being tabled,
7 it would be nice to see some actual data out
8 of the databases.
9 DR. WINKLER: Did the folks from
10 Active Health hear that comment?
11 DR. VIR: Yes, and we are working
12 on getting that data.
13 DR. WINKLER: Thank you.
14 DR. VIR: Then as far as the code
15 sets go for the details, will we receive any
16 sort of information about who to send that to
17 or should we just send it --
18 DR. WINKLER: We will send you a
19 prompt, but certainly, anything about the
20 project can be sent to Elisa.
21 DR. VIR: Great. Thank you.
22 DR. STANGE: So, Rufus, could you

1 open it up for public comment on any of the
2 last three measures we have talked about?
3 OPERATOR: And again, if you would
4 like to ask a question, please formally press
5 the * key followed the digit 1.
6 We have no questions on our roster
7 at this time.
8 DR. STANGE: From in the room,
9 Mark is going to come up and give us a
10 comment.
11 DR. ANTMAN: Yes, thank you. I
12 have had the opportunity since the discussion
13 of measure 41 a little bit earlier to confer
14 with our clinical experts, the PCPI's clinical
15 experts for preventive care, and quite
16 frankly, they are uncomfortable with making a
17 quick decision on the committee's
18 recommendation for complete harmonization with
19 the standard time frame recommended by the NQF
20 for immunization measures.
21 So I am wondering -- With the
22 committee's indulgence, I wonder if I may ask.

1 So our plan is to go back to our full Work
2 Group and ask for them to carefully consider,
3 number one, willingness to simply revise our
4 measure to match the NQF recommended time
5 frame of October 1 to March 31st for the
6 influenza immunization measure, or if they
7 feel that there is a strong reason to not
8 match that time frame, to modify our measure
9 as it is currently specified to try to
10 harmonize more closely, but not necessarily
11 match that time frame exactly, because there
12 is a -- The co-chairs have expressed to me a
13 point of view that there is good reason to,
14 and there was a good reason for the Work Group
15 to advocate for the February 28th end time.
16 But we are -- The co-chairs and I are hesitant
17 to give you a firm conclusion on that without
18 going back to the full Work Group.
19 So my request, and I will try to
20 be quick about it, is that if you would be
21 willing to take a fresh look at the measure
22 and look at the other -- whether or not the

1 measure met the other criteria for potential
2 endorsement and, contingent on our coming back
3 to you with a conclusion on our further
4 discussion with the Work Group, we would
5 greatly appreciate that, but rather than
6 simply move ahead with a non-recommendation of
7 the measure based, as I understand it, on
8 quite simply that one disharmony with NQF
9 recommendations.
10 DR. WINKLER: Mark, the other
11 issue, I think, was the handling of the
12 exclusions. The way it is presented, it
13 really looks like the exclusions are in the
14 denominator, and that did not match up either.
15 DR. ANTMAN: I'm sorry. Thank
16 you. So is this the time for more detailed
17 discussion of that or -- I know that you are
18 up against the lunch hour, and I don't want to
19 disrupt your agenda.
20 DR. STANGE: It makes perfect
21 sense that holding a gun to your head and say
22 get us an answer on that in the next few

1 minutes doesn't make sense. I mean, you need
2 to go back to your group. So I think that is
3 why we tabled it, so you have time to really
4 do that.
5 DR. ANTMAN: So by all means. So,
6 Reva, thank you for that reminder. By all
7 means, we can take that second issue back to
8 the group as well.
9 DR. BURSTIN: And, actually, as
10 long as we have a few minutes, if Amir or
11 Linda or anybody else wanted to make specific
12 comments that Mark could take back to the Work
13 Group, this would actually, I think, be time
14 well spent.
15 MS. MERRILL: Was the Work Group
16 involved in the development of the NQF
17 harmonization standards? They were not
18 included in the Work Group? I mean, is there
19 any reason to petition this group to modify
20 standards?
21 In other words, if your group
22 feels so strongly that the date should be

1 February 28th, why wouldn't other people feel
2 the date should be February 28th?
3 MR. ANTMAN: Again, there was a
4 strong point of view in the Work Group for --
5 I'm sorry, for the PCPI Work Group. Sorry, I
6 should be clear. There was a strong point of
7 view for March being a longer time frame than
8 necessary, and not representative of actual
9 clinical practice of the major of practicing
10 physicians.
11 MS. MERRILL: That is my point.
12 Then perhaps you would wish to petition, you
13 or others.
14 DR. BURSTIN: It is not so much an
15 issue of petitioning to change the standard
16 specifications. That work was done based on
17 the evidence and what the guidelines said.
18 All the other measures have now come in with
19 the same time frame, with the exception of
20 this one.
21 So it is less an issue of the
22 standard specifications. It is more about

1 harmonization. We don't want measures that
2 have different time frames and different
3 settings. We would be fine hearing back from
4 the committee as to why they feel strongly,
5 but I think, actually, some evidence, Mark, on
6 what is the additional burden or what would be
7 the additional exclusions to go an additional
8 month to be consistent would be really
9 helpful?
10 I don't know that you have that
11 information, but it is hard to just make that
12 assessment without having some evidence that
13 it is actually a significant burden when you
14 are then not harmonizing across the entire set
15 of measures that have the exact time frame.
16 But I actually think the exclusion issue is
17 the bigger issue, about not being able to see
18 the proportion of patients who decline in a
19 way that is really accessible in the strata
20 that were presented in the other measures.
21 That was exactly the issue we
22 presented yesterday. Reva presented on how

1 incredibly different those performance scores
2 are when you include declination as numerator
3 category.
4 DR. QASEEM: Mark, i need to say a
5 few words. I am not still following it, and
6 maybe you can't because of whatever the
7 confidentiality. Why can't you include more?
8 I am not really understanding the issue over
9 here.
10 DR. ANTMAN: Well, Amir, I think I
11 spoke to it as well as I could earlier, and
12 again I am at a disadvantage with not having
13 our clinical experts available to speak to the
14 issue.
15 Rather than my trying to justify
16 it again, I would rather be able to go back to
17 the Work Group and have us articulate that
18 more formally.
19 DR. STANGE: We all certainly
20 understand the vagaries of committees. You
21 can see people saying, damn it, we are just
22 being asked to do one more thing. I never do

1 it then. You know, just give me that one
2 month. But there is additional -- One thing
3 you could take back is there is additional
4 burden from having different measures. That
5 would be something for them to consider.
6 DR. ANTMAN: If I may be clear,
7 the PCPI absolutely recognizes the
8 disadvantage of disharmony among measures, and
9 we have done everything we can to harmonize
10 with other NQF endorsed measures or go to
11 other measure developers related to
12 potentially endorsed measures, and try to
13 harmonize wherever we can. But again, I am
14 hesitant to speak for the Work Group, given
15 that they are willing to --
16 DR. BURSTIN: I think you need to
17 at this time. I think, really, the key thing
18 now is to lay out the key issues, have you
19 bring it back. I am sure we will get a letter
20 from PCPI with a response, and we will bring
21 it back to this group. But let's just get the
22 issues clearly identified for him.

1 DR. STANGE: Right. So toward
2 that, we are going to wrap up, but any issues
3 from Linda and then Amir?
4 DR. KINSINGER: Just one quick
5 issue, Mark. The reason you gave was that, if
6 there is low availability of vaccine, that
7 people who are not in the high risk group
8 would not likely be vaccinated in March. But
9 in fact, in the years where there has been
10 vaccine shortages, it has typically been early
11 in the season, and by late in the season often
12 there is vaccine to be wasted.
13 So saying that only March would be
14 excluded is what doesn't make sense, because
15 if there is vaccine shortages, it could happen
16 throughout the season and, more typically,
17 early in the season rather than at the end of
18 the season. So that is why that explanation
19 doesn't really quite fly, to me anyway.
20 DR. QASEEM: Kurt, mine is more of
21 a process issue. The issue that I had all the
22 time doesn't change. In this case, we voted

1 no to the measure. Looking at what we have
2 done this morning, it was more of a tabling
3 issue than a no issue.
4 I was just going to ask if NQF
5 staff could clarify a little bit, that why was
6 this no whereas others was tabled?
7 DR. WINKLER: I think there is a
8 difference, because you voted on the measure.
9 Now in all the process, we try and be as open
10 and back and forth negotiation as possible.
11 So it is not at all unusual if measures get a
12 no vote, if the work group -- or if the
13 measure developer hears the discussion and
14 they go back and modify, respond to it in some
15 way, and want to re-present it. We leave that
16 door open, but what you have said is, no, not
17 as is.
18 The others, I think, were elements
19 of we can't make a decision, because we don't
20 have all the information. For instance,
21 things are controversial around breast cancer.
22 I mean, you are right. At times it might be

1 subtle, but I think in this particular case,
2 it was crisp.
3 What you are saying is we don't
4 want the measure as written and presented to
5 us today, and there is an opportunity for them
6 to go back and hear and potentially respond,
7 and perhaps present us with a revised measure.
8 That is something that we do relatively
9 frequently, but it would be a revised measure,
10 not a re-discussion of the same old thing.
11 DR. QASEEM: I agree with that,
12 and I think that does apply for some of their
13 measures as well, and then to be just
14 politically sensitive, would it be more
15 reasonable to just say that we are tabling the
16 discussion rather than saying no?
17 DR. WINKLER: I don't think those
18 are the same thing. A no is no for this, and
19 I think that is a very clearcut decision on
20 the committee's part. Tabling means we are
21 not sure, because we don't have enough
22 information or something else needs to happen

1 before we can make a decision.

2 DR. QASEEM: And the only reason I

3 brought it up was in that case I think there -

4 - with the breast cancer one especially. I

5 feel like then maybe we should vote on it,

6 because in that case I think the way the

7 measure read currently, there were issues with

8 it, and I don't think -- As I said, it is a

9 process issue, and I don't really care that

10 the end result is the same, but it may be --

11 That was the point I just wanted to raise.

12 DR. BURSTIN: If I could just

13 respond to that, I think there are issues when

14 there are externalities to the measure itself,

15 which I think there is an issue in the breast

16 cancer measure. I think in this case, it is

17 actually internal decisions by the PCPI Work

18 Group.

19 You have spoken to where you

20 disagreed with what the PCPI Work Group

21 decided, and I think they then need to go back

22 and consider whether they could modify the

1 measure, bring it back to us.

2 The breast cancer one, there is

3 just too much swirling around. I think they

4 clearly need to go back, revise the measure

5 completely, not just a little discussion with

6 the work group. They are going to completely

7 redo that measure by the time you have it back

8 to us. So, to me, it is really a deferral of

9 a totally new measure rather than revising

10 what was on the table and refused.

11 DR. ANTMAN: My concern is that --

12 not to quibble, Reva, with what you said about

13 how the No is defined at this point, but my

14 concern is that, if the Steering Committee

15 recommendations simply go forth with a No

16 recommendation for this measure, there is no

17 acknowledgement of the fact that -- other than

18 the two issues which we have said we are

19 willing to consider further and come back with

20 revisions for, there is no acknowledgment of

21 the fact that the measure, hopefully, met all

22 of the other criteria, since you didn't go

1 through the process of voting on importance,
2 on testing data, etcetera.
3 So if the report will convey that,
4 then I am perfectly happy with that, but
5 please understand my concern is that, if the
6 report says that it is a No recommendation,
7 then that will be difficult to argue against
8 later on.
9 DR. BURSTIN: This is not done, I
10 think, is the point. We are not putting
11 anything in a report right now. This is the
12 assessment of the Steering Committee for the
13 measure as presented. We used to have
14 approve, approve with modifications, refuse.
15 We are not really doing that as much anymore,
16 since we are trying to get the work moving
17 along. But I think there is nothing in this
18 discussion that says PCPI cannot go back, and
19 I think the committee would need to revote on
20 the revised measure.
21 Without being able to see the
22 revised measure, it is hard to vote to approve

1 with modifications, because we don't know what
2 modifications you can do.
3 MR. MASON: To a point Reva made
4 earlier, she is going to send these all back
5 to us, and we are going to have to do Yes,
6 Yes, No, No, for every single one of these yes
7 or no, endorse. So --
8 DR. ANTMAN: Thank you all.
9 DR. STANGE: I would like to bring
10 this to a close soon. But, Matt?
11 MR. STIEFEL: Is our task going to
12 be to answer every single question for every
13 single measure or just say whether or not we
14 agree with what you summarize?
15 DR. WINKLER: I think it is more
16 the latter.
17 MR. STIEFEL: Okay. thank you.
18 DR. BURSTIN: And in fact, we are
19 going to ask you to -- although you guys
20 didn't vote on every single element. We are
21 also going to ask you to agree that the Work
22 Group's assessment -- that you agree. So you

1 don't have to vote on every single one, but
2 you have to say -- and actually, that is the
3 difference also, Mark, is that the Work Groups
4 made that assessment. We are going to ask the
5 full committee to agree, concur. That's the
6 word, thank you.
7 DR. STANGE: And I heard Matt's
8 thank you as thank you for answering his
9 question, and then a deeper thank you on
10 behalf of the whole committee. So thank you,
11 that deeper thank you.
12 DR. WINKLER: We do want the final
13 report of what goes out for the result of here
14 to reflect the entire committee. So part of
15 your obligation as a committee member is
16 really to look at that and be sure that it
17 does reflect.
18 If you have a differing opinion,
19 then please let us know. We certainly will
20 want to capture that. You may not be the
21 majority and you may not be the one that sways
22 it, but by the same token, we want to be sure

1 that your issue, concern, anxiety, whatever it
2 is, is captured in the discussion elements as
3 well, so that what is presented to our
4 audiences truly reflects all the different
5 perspectives around the table that comprise
6 the Steering Committee.
7 This is sort of a way of taking
8 the tediousness of voting 1,000 times away
9 from you, but the converse is we need you to
10 really pay attention when you see the report
11 and really reflect on what is presented.
12 DR. STANGE: So it is 12:14.
13 Thank you, thank you, thank you. We are back
14 on schedule. So we are going to revisit some
15 immunization measures which will bring
16 together some of the -- We will do those
17 individually, and then we will do the overall
18 look at the harmonization/consolidation issue,
19 I think, for the pneumococcal ones, but the
20 childhood could have raised some other issues,
21 I suppose, although I am not sure.
22 The other thing we said we were

1 going to do yesterday -- I think it was Matt's
2 suggestion -- is that we use this process of
3 looking at the existing clinical preventive
4 service measures just to ask the question,
5 does this inform the other work about
6 developing population measures.
7 We clearly said that just adding
8 them up doesn't get us a population measure.
9 We have already decided that, but we will go
10 through these. We will do the
11 harmonization/consolidation, and then,
12 hopefully, we will have done the other quickly
13 enough that we will be able to pause and just
14 take a step back and say, did we learn
15 anything from this that informs the other
16 discussion that we are doing; and if a miracle
17 happens and we have a little time and
18 everybody is not racing out the door, we will
19 just ask if there is anything else about next
20 steps or any further reflections on the larger
21 process.
22 So let's take a break for lunch.

1 Oh, bag lunches. They are ready for people.
2 Do people want to come back at 12:45 or do you
3 want to have a shorter thing and do a working
4 lunch, and would that work with our people
5 that we have to have on the phones for the
6 next discussion? It would? Fifteen minutes
7 and come back or a half-hour lunch? Okay, 15.
8 Bring a lunch back. So be back at the table
9 in 15 minutes, at 12:30.
10 (Whereupon, the above-entitled
11 matter went off the record at 12:15 p.m. and
12 resumed at 12:35 p.m.)
13
14
15
16
17
18
19
20
21
22

1 A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

2 12:35 p.m.

3 DR. STANGE: Let's get started
4 again. Rufus, I guess, if you can open up the
5 lines, please. For those on the phone, I just
6 want to let you know what you are missing
7 visually. We got bag lunches with these
8 really great party hats, and so just to get a
9 good visual of us with our party hats on, we
10 are doing the final measures.

11 We are going to walk through them,
12 I think, in order of the pneumococcal ones.
13 Then we will consider the
14 harmonization/consolidation issues, if there
15 are any among those, and then close with
16 childhood immunizations.

17 After that, we are going to
18 consider what we have learned from discussing
19 these specific measures that might relate to
20 our larger, more formative task about
21 developing population health measures. Then
22 if we have time, we will close with any last

1 considerations for that larger agenda. So,
2 Reva?
3 DR. WINKLER: Just as a reminder,
4 as part of the previous harmonization efforts
5 there are standard specifications for the
6 pneumococcal immunizations. They look
7 remarkably similar in the numerator, and the
8 denominator is lined up with ACIP with the
9 specific populations, greater than 65 or long
10 term care facility or younger with high risk
11 conditions. So just as a reminder.
12 The first measure we are going to
13 look at is measure 43. It is pneumonia
14 vaccination status for older adults. This is
15 again from NCQA. This is the percentage of
16 patients 65 years and older who ever received
17 a pneumococcal vaccine.
18 This is another survey measure,
19 and the level of analysis is clinician, group,
20 plan, facility, integrated system, etcetera.
21 So Sepheen, are you here again?
22 MS. BYRON: We also have staff

1 calling in. Do we have NCQA staff on the line
2 yet? They might be in process. All right.
3 Well, this is as Reva described
4 it. It is a survey measure, and it asks about
5 pneumococcal vaccine and whether or not they
6 have had it.
7 DR. WINKLER: I believe Amir is
8 the primary discussant, but this measure was
9 reviewed by folks on the rest of that Work
10 Group. Jackie or Linda, do you have any
11 comments? I don't see where Amir disappeared
12 to -- or Jason? This is the survey measure.
13 This is what is up here. Use your microphone.
14 It is measure 43. If you would like, we can
15 wait until Amir comes back.
16 DR. STANGE: If he is prepared, we
17 want to focus discussion on it.
18 MS. MERRILL: I don't see a lot of
19 the points there, which is a good sign.
20 DR. WINKLER: Rufus, are you
21 hearing us?
22 OPERATOR: Yes, ma'am. Please go

1 ahead.

2 DR. WINKLER: Thank you.

3 DR. KINSINGER: I looked at this

4 briefly, and I didn't have any issues with it.

5 I thought it looked pretty straightforward.

6 MS. MERRILL: Yes. There is one

7 study, a cohort study coming out of Canada,

8 that found that PPV did not significantly

9 reduce risk of death or subsequent

10 hospitalization, but that is death as an

11 outcome.

12 DR. KINSINGER: One thing I would

13 like clarification on is the valence of these

14 different pneumonia vaccines that we are

15 considering. I am assuming that all of these

16 in this series of measure proposals are the

17 valence 23, even though sometimes they cite

18 studies that are valence 7. I don't have

19 enough expertise about vaccines to know if

20 that makes a difference or not. I am assuming

21 it does.

22 Basically, valence 23 is 23

1 different immunizations in one shot.

2 MS. MERRILL: Twenty-three valence

3 is the one that is recommended currently for

4 this age population. There is discussion

5 about -- Actually, there is now a 13 valence

6 vaccine that may, in fact, be better, but ACIP

7 has not yet voted on that.

8 DR. STANGE: Any concerns about

9 this measure?

10 DR. BURSTIN: Just for

11 consistency, there is a standard specification

12 for pneumococcal vaccine. So I guess you

13 would want to know that it is aligned.

14 MS. MERRILL: It is the 23.

15 DR. SPANGLER: I don't have any

16 issues either. It looked like it aligned well

17 with the standard specifications.

18 DR. WINKLER: I guess one question

19 is the population is just the age 65 and

20 older. It does not address other populations

21 for which the vaccine is indicated. What is

22 the survey vehicle typically used for this?

1 MS. BYRON: This is an HOS
2 measure.
3 DR. STANGE: So we might need to
4 come back to that issue when we have discussed
5 all the pneumococcal vaccines.
6 MS. MERRILL: So this is just
7 looking at the population over 65, not looking
8 at the risk populations from five to 64 that
9 it is recommended for. So why would we not
10 want to have this be an inclusive vaccination
11 that is stratified?
12 DR. STANGE: That is the issue
13 that we will discuss once we have discussed
14 all of the pneumococcal vaccines. Any other
15 comments before we vote on this one. Sarah?
16 MS. SAMPSEL: The one point would
17 be that, since this is administered through
18 the HOS, this comes back to a data source
19 issue as well. So HOS is just administered to
20 the Medicare Advantage population, which is
21 typically 65 and older.
22 Then the other thing I just wanted

1 to bring up is this also has a BRFSS survey
2 which it is in alignment with, so on more of
3 the population health level.
4 DR. WINKLER: I guess the other
5 issue is this is applicable to the Medicare
6 Advantage population, but how much of that
7 compared to the entire Medicare population?
8 What is the relative utility, I guess?
9 MS. MERRILL: Well, doesn't that
10 fall into the issue we are going to discuss
11 later?
12 DR. STANGE: So let's keep track
13 of these issues that we need to discuss with
14 harmonization. Amir, we are actually just
15 about ready to vote on the first measure 43,
16 but anything you want to have us consider?
17 DR. QASEEM: And I was reviewing
18 this. Right?
19 DR. STANGE: Yes.
20 DR. QASEEM: I was? Okay. Let me
21 just open it. I'm so sorry. Forty-one, you
22 said?

1 DR. STANGE: Forty-three.
2 DR. QASEEM: Oh, 43? I think you
3 probably have already discussed most of the
4 issues, and so there is nothing, really,
5 probably to add, nothing major.
6 DR. STANGE: You don't have any
7 major concerns about this?
8 DR. QASEEM: Yes. I think it is
9 probably okay.
10 DR. STANGE: Everybody good to
11 vote?
12 MS. MERRILL: Can we just see the
13 other comments that reviewers made? Oh, yes,
14 there was a contradiction there. So the
15 developer, you should realize that you
16 contradict yourself there; 4.b.1 contradicts
17 2.a.1. One says only electronic sources, and
18 the other one says paper sources. Somebody
19 didn't catch that.
20 DR. STANGE: Let's go ahead and
21 start our clock for voting. I guess we are
22 ready to vote here. So 11 Yes, zero No.

1 DR. WINKLER: The next measure is
2 617, pneumococcal vaccination. This is from
3 Active Health. This is the percentage of
4 patients 5 through 64 with a high risk
5 condition or age 65 years and older who
6 received a pneumococcal vaccine.
7 The high risk conditions laid out
8 are the same that you saw in the standard
9 specifications, diabetes, heart failure, COPD,
10 end stage renal disease, asplenia.
11 This measure is specified for
12 multiple levels of analysis, including
13 clinician, plan, integrated system. It is
14 based on administrative claims or electronic
15 clinical data, EHRs.
16 Are the folks from Active Health
17 on the line?
18 OPERATOR: We do have Lindee Chin.
19 DR. CHIN: Hi. Can you hear me?
20 DR. WINKLER: Sure. Just one or
21 two sentences about the measure?
22 DR. CHIN: Sure. This measure is

1 looking at the percentage of patients, again
2 like you stated, age 5 to 64 with a high risk
3 condition or older than 65 who have received
4 a pneumococcal vaccine. You can see the rest,
5 I guess, in front of you. I am not sure what
6 you are looking at, but you probably see the
7 form that we submitted.
8 DR. WINKLER: Jackie? Oh, sorry.
9 MS. MERRILL: Okay. So this
10 measure, as I understand it -- and it is not
11 always easy to understand what you are trying
12 to get at -- is inpatient and outpatient. So
13 this includes inpatient and outpatient, and it
14 is the percentage of patients in those age
15 criteria.
16 So you are really saying who were
17 screened and received prior to discharge, if
18 indicated. So it seems like there is a whole
19 bunch of things that are just left out of this
20 description of the measure.
21 DR. CHIN: We -- Oh, I'm sorry.
22 MS. MERRILL: So you have got

1 patients who are being seen, but you are not
2 just asking them did you get the vaccine, and
3 that is what you are looking at. You are
4 looking at -- You are asking them, and you are
5 also -- if they say no, you are giving it to
6 them, and then you are including that in the
7 numerator. Is that correct?
8 DR. CHIN: Well, we are not
9 looking at it, in particular, if they have
10 been in the hospital or out of hospital, a
11 diagnostic event. So we are just looking at
12 everyone who meets the denominator criteria
13 and whether they have received an
14 immunization. Either we ask them, if they
15 talk to our nurse, or we receive codes and
16 claims for that.
17 MS. MERRILL; Okay. So just based
18 on administrative data. So you don't get into
19 any of that. It is just yes/no?
20 DR. CHIN: Yes, or if they talked
21 to one of our nurses and they told us they
22 received the vaccine.

1 MS. MERRILL: Okay. All right.
2 The other something is 1.c.14 on page 4, the
3 controversy of contradictory evidence. There
4 is a statement that there is no contradictory
5 evidence, but in fact, I believe that there is
6 some evidence that it is not that efficacious.
7 There are some studies showing that they are
8 only really given -- Ten percent of people
9 actually get protected from the vaccine. So
10 that was not addressed by the developers in
11 terms of contradictory evidence.
12 In that sense, too, I don't see
13 any sense of where you evaluated the
14 developer's assessment of the quantity,
15 quality and consistency of the evidence, and
16 that may just be because the form changed in
17 the time.
18 DR. CHIN: Yes. We had a
19 different form when we submitted originally.
20 MS. MERRILL: Yes. But that is an
21 important thing to address, because there is
22 evidence. There is a fair amount of evidence

1 that -- not saying -- it is not a good use.
2 You would imply that it is not a good use of
3 scarce resources to give this vaccine. So I
4 should think you would want to address that.
5 DR. CHIN: Okay.
6 MS. MERRILL: But otherwise, the
7 reliability and validity testing seemed fine.
8 There is extensive validation rules, extensive
9 documentation of data elements. It is really
10 quite a lot of work to put this one together.
11 DR. STANGE: So open to regular
12 discussion. Linda?
13 DR. KINSINGER: This seems to have
14 the same issue about the denominator
15 exclusions as the influenza measure that we
16 just talked about. So they exclude patient or
17 provider feedback indicating allergy or
18 intolerance to the pneumococcal vaccine in the
19 past, and patient or provider feedback
20 indicating there is a contraindication to the
21 pneumococcal vaccine.
22 It looks to me like -- I mean,

1 those again are supposed to be in the
2 numerator, not in the denominator.
3 DR. STANGE: Any comment from the
4 measure developer?
5 DR. CHIN: Yes. These measures
6 are also based on what we do in our clinical
7 decision support. So we don't alert
8 physicians if they have told us that the
9 patient has an allergy or there is a
10 contraindication that they need the vaccine.
11 So this is sort of measuring that population
12 who can get it.
13 DR. STANGE: But the issue of
14 whether that is in the denominator or the
15 numerator -- So the other measures we looked
16 at treat that in the numerator.
17 DR. WINKLER: This is a question
18 of harmonization and a question of to what
19 degree have you looked at the standard
20 specifications and in harmonization with other
21 measures of pneumococcal vaccination.
22 DR. CHIN: Are you talking -- I'm

1 sorry. You are asking whether we should move
2 this into the numerator? I know we had talked
3 about that on a previous call, that this
4 should be in the numerator.
5 DR. WINKLER: Right.
6 MS. MERRILL: So people with
7 complications are put into the numerator.
8 People who are excluded from getting the
9 vaccine are put into the numerator. You have
10 them in the denominator.
11 DR. CHIN: yes. We could move
12 that population out as a separate group into
13 the numerator. We would just break that apart
14 from our clinical decision support.
15 DR. STANGE: Sarah?
16 MS. SAMPSEL: My question is
17 actually about the testing results. So your
18 results were right around 10 percent, and do
19 you -- and I didn't see it in here, but do you
20 do any type of medical record validation of
21 those results; because it seems like a really
22 low rate, especially -- You know, maybe it is

1 just because it is in this high risk
2 population, but have you compared that to
3 other results?
4 DR. CHIN: Actually, we just ran
5 the measures again on our over 2 million
6 population, and we got a 23 percent
7 compliance. The denominator is about
8 1,400,000-plus people and about 306,000 did
9 receive the vaccine, who came out to be 23
10 percent.
11 We don't necessarily validate it
12 with medical records, because we are getting
13 claims from -- We are getting information from
14 various sources. So it is not just someone's
15 charge. We are getting it from health plan
16 claims. We are getting it from whether the
17 patient told us they got the vaccine or if
18 they entered that information as well into
19 their personal health record.
20 MS. MERRILL: Also, if they are
21 excluding those people that should be in the
22 numerator, the rate would go up then, too.

1 Right? Because they have got all those people
2 in the denominator now.
3 DR. CHIN: Yes. Right now they
4 are excluded.
5 DR. STANGE: Any other concerns?
6 MS. MERRILL: So our
7 recommendation would be?
8 DR. WINKLER: What we are talking
9 about again is another harmonization issue.
10 I think previously, we have been looking at
11 the harmonization or the lack of
12 harmonization, as we did previously, in the
13 overall endorsement. so just consistent. If
14 your issue is around the standard
15 specification, that is a specification
16 harmonization. It fits both under scientific
17 acceptability and usability.
18 So it will factor into your
19 overall evaluation and vote on the measure.
20 MS. MERRILL: So there are some
21 additional rationale for why it may not be
22 ready for endorsement yet, which is the

1 discussion of the younger age group, the 5-18.
2 Are you covering them in some other way?
3 DR. CHIN: I'm sorry? The 5 to
4 18?
5 MS. MERRILL: Right, 5 to 18.
6 DR. CHIN: Right. That is
7 included in the denominator.
8 MS. MERRILL: All right.
9 DR. BURSTIN; It says five to 64
10 with high risk condition and over 65.
11 DR. WINKLER: Whose comment was
12 that? Jason, Linda, Jackie, Amir?
13 MS. MERRILL: It might be mine.
14 DR. WINKLER: Okay. Can you
15 clarify a little bit what the issue was?
16 MS. MERRILL: I didn't see that
17 they were including all patients -- Why not
18 include all patients? Why are you just
19 looking at the high risk patients, because it
20 is recommended for the five to 18 group.
21 Right?
22 DR. CHIN: Right. Our denominator

1 has both patients 65 and older as well as
2 those five to 64 with a condition. I don't
3 know if you have the same page numbers. It is
4 on page 8 and 9.
5 MS. MERRILL: This is also a
6 childhood immunization, too. Right? Children
7 get this. The younger group get it. They do
8 not? Are you sure? Are you sure it is not in
9 the CDC recommendations?
10 DR. QASEEM: I don't think so. We
11 could pull it up pretty easily, though.
12 DR. CHIN: I'm sorry. What are
13 you looking for?
14 DR. BURSTIN: We are just
15 clarifying what the evidence says on the ACIP.
16 I think we are okay. I am still left
17 wondering. Does this meet standard
18 specifications in terms of the ability to see
19 numerator exclusions?
20 MS. MERRILL: As it is written
21 now, it doesn't. So they have to -- We can
22 say that other elements of it -- We should

1 probably see it again, because the testing is
2 based on a faulty denominator. So that means
3 that the testing results are also going to be
4 different.
5 DR. WINKLER: I think we need to
6 vote on what is presented to us. They would
7 have the same option that PCPI would, if they
8 wanted to reformat the measure, reconstruct it
9 and bring it back addressing these issues, but
10 I think at this point what we really need to
11 do is look at what is put in front of us.
12 DR. STANGE: So I think we are
13 ready to consider this measure for a vote.
14 This is the vote. It is nine No; four Yes.
15 DR. BURSTIN: So for the sake of
16 Active Health management, that was primarily -
17 - the No vote was primarily related to the
18 fact that it did not match the standard
19 specifications around having the transparency
20 in the numerator details. So again, should
21 you want to reconsider that, we would be happy
22 to follow up.

1 DR. CHIN: Okay. Yes, we can take
2 that back. We can change the measure and work
3 on that. We will follow up with this.
4 MS. MERRILL: I would suggest also
5 discussing the contradictory evidence, too, in
6 your reapplication.
7 DR. CHIN: Okay.
8 DR. WINKLER: The next measure is
9 1653. T his is pneumococcal immunization for
10 hospitalized patients. This really is very
11 similar to the flue vaccination measure we saw
12 this morning. Again, we don't have our
13 developer on the line, but again this was a
14 measure that was done in pneumonia patients,
15 and again, you know, why a narrow slice.
16 Broaden it to everybody that is applicable.
17 So this is the revised measure
18 brought back to us, and Amir, I think, this
19 was yours.
20 DR. QASEEM: I think, without
21 getting into the issues that we already talked
22 about in terms of measures and harmonization,

1 my main concern with this measure was I felt
2 like something that I voiced this morning,
3 that the denominator I am struggling with a
4 little bit, because I think what is happening,
5 the hospital is -- If you are going to ask for
6 definitive documentation of vaccination rather
7 than patient self-report -- and this morning
8 we actually did approve many of the measures
9 where patient self-report was being used.
10 Right?
11 I think it is really important
12 that we keep that in mind. If a patient self-
13 report does say that they have been vaccinated
14 in the past, they should be excluded from the
15 denominator, because what currently is going
16 to end up happening is that, if you are going
17 to ask for definitive documentation, most of
18 the hospitals that feel like that they are
19 double and triple vaccinating folks when it
20 comes to pneumococcal vaccination, especially
21 -- and without getting into the nursing home
22 patients and the issues with that, many of

1 them cannot give the history, and family
2 members, they don't want to say, well, yes,
3 they were vaccinated elsewhere.
4 So it is more of an issue of -- I
5 felt like that the denominator needs to very
6 clearly say that, if a patient self-report
7 says they have been vaccinated in the past,
8 maybe they need to be excluded.
9 DR. WINKLER: The standard
10 specifications include patients who are
11 immunized or have been immunized in the past.
12 So they are counted as patients who are
13 immunized. So we know their vaccination
14 status, rather than excluding them from the
15 denominator, because then you lose track of
16 those patients.
17 DR. QASEEM: Okay. So this
18 measure, if patients say that they have been
19 immunized in the past, they will not be --
20 they will get credit for it? Okay. Then I
21 am okay with it. That is how -- I didn't read
22 this measure. Then I don't have a problem,

1 because that is not my read of this measure at
2 least when I looked at it; because in the
3 denominator exclusions, the way it has it is
4 patients who expire, ICD, blah, blah, blah.
5 I am not seeing that. Maybe I missed that
6 information.
7 DR. WINKLER: Well, the numerator
8 statement, and I think it is not as explicit,
9 and that is perhaps something we ask for
10 clarification, but it is inpatient discharges
11 who were screened for status and received the
12 vaccine prior to discharge, if indicated.
13 DR. QASEEM: That exactly. So the
14 way it reads right now is the problem is the
15 way it is being interpreted.
16 DR. WINKLER: Right.
17 DR. QASEEM: They are seeing that
18 you need definitive documentation.
19 DR. WINKLER: Go down to numerator
20 details. It says, the following patients are
21 included in the numerator: patients who
22 receive the vaccination during

1 hospitalization; patients who receive the
2 vaccination anytime in the past; patients who
3 were offered and declined during this
4 hospitalization; and patients who have a -- I
5 am going to say that the word is
6 contraindication - or allergy sensitivity to
7 the vaccine, blah, blah, blah.
8 This is under numerator details,
9 2.a.1.3.
10 MS. MERRILL: Tell me if this is
11 something you want to discuss later, but this
12 is that idea of saying the same things in the
13 same way. So if they are quoting directly
14 from the specification, then we can say it
15 meets the specifications.
16 DR. WINKLER: Right.
17 MS. MERRILL: But if they
18 interpret the specification and -- So this is
19 really for all the developers. Interpreting
20 the specification creates problems for
21 everybody.
22 DR. WINKLER: Right.

1 DR. STANGE: What I heard from
2 Helen before is that that is not a rule they
3 are going to make, but that is certainly
4 something that can be said, that if you want
5 your measure to have an easier go of it in
6 review, that is what you would do.
7 DR. BURSTIN: And given it is the
8 same developer for the influenza in the
9 hospital, we should make sure those numerator
10 details line up as well.
11 MS. MERRILL: It would be
12 acceptable to cite what is in the
13 specification and then say we operationalized
14 the specification this way, and then you put
15 all the things that were there. But if you
16 don't state that you are meeting the
17 specification and we have to sift through it,
18 and then we might not understand what you
19 mean, and then you get all these kinds of
20 problems.
21 DR. WINKLER: That is an excellent
22 point.

1 DR. STANGE: Any other points
2 related to the vote?
3 DR. QASEEM: So I was reading the
4 numerator details. Sorry, it took me a little
5 while to find this information. So I am still
6 not seeing it, that if it says anywhere the
7 patient is self-reporting that they have been
8 vaccinated, then they don't have to be
9 vaccinated. This is the problem, is with the
10 interpretation. Right now, the way the
11 hospitals are using is a patient is thinking
12 I may have gotten, maybe I got it, they are
13 getting vaccinated.
14 DR. BURSTIN: I think it may be --
15 and this may be a question back for Obama, but
16 I think it may be that there is a lot of -- It
17 is unclear what "if indicated" means.
18 DR. QASEEM: How about that?
19 DR. BURSTIN: So I think that this
20 may need to be a bit more clear, because I
21 think the fact that all those things are in
22 the numerator details, to me, implies that

1 they are going to, in fact, be -- So they
2 specifically have under numerator details, you
3 have received it anytime in the past. So I
4 think that automatically means it is a
5 numerator -- it will be in the numerator along
6 with it. But I think, given the overuse of
7 vaccines, I think it is a really important
8 point, Amir.
9 DR. WINKLER: I think you are
10 bringing up possibly one of the unintended
11 consequences, that perhaps to be sure that you
12 hit the performance targets you just vaccinate
13 everybody, and regardless of whether they need
14 it or not sort of thing. I think you are
15 raising a concern we have seen with other
16 measures that are similar, as an unintended
17 consequence of the measure.
18 DR. QASEEM: And the only reason
19 is an anecdotal problem. Maybe in your own
20 practices, you may have seen it, but I am
21 seeing at the hospital the patients are -- We
22 just did it, and we saw that the patients were

1 getting extra vaccinations. There is
2 definitely overuse going on.
3 DR. STANGE: Helen, how do we
4 handle this? I'm sorry, Sarah.
5 MS. SAMPSEL: Can I just make one
6 more point, and that is on their testing
7 results. They are already showing performance
8 at 98.6 and 97.6 percent. So my question
9 would be: What is the opportunity for
10 improvement or is this actually showing that
11 overuse issue, and that is how it is captured?
12 DR. WINKLER: Remember that the
13 testing data was done only on a population of
14 patients with pneumonia and not the entire
15 hospital population.
16 MS. SAMPSEL: Okay. Then that
17 begs another question, that if NQF is no
18 longer doing time limited endorsements,
19 shouldn't we wait to see testing results or
20 something on this?
21 DR. WINKLER: Well, our testing
22 requirement is it is okay to test on a subset

1 of population. I mean, we try and make the
2 testing requirement as flexible as possible
3 and not be overly prescriptive. So one of the
4 things that is allowed is being able to test
5 on a subpopulation.
6 DR. WINKLER: Actually, what it
7 really is, is that NQF allows testing at
8 either the measure at the data element level
9 or of the score. In this instance, I think
10 the data elements are the same. They have
11 just broadened the population.
12 I guess the question should be
13 whether we would expect there to be any
14 difference in the reliability of the measure.
15 It is a broader population, certainly.
16 I think it is a reasonable
17 question to ask Oklahoma. My guess is they
18 have potentially got some additional pilot
19 data on the non-pneumonia patients that would
20 be worth looking at.
21 DR. STANGE: The point that --
22 just follow up on that, and then Mike is next.

1 Sarah's point about the really high rates --
2 really, you don't get rates like that if you
3 are not -- you are having a lot of over-
4 vaccination. So I think it really supports
5 Amir's concern.
6 Helen, so is this something we ask
7 for clarification? How do we handle this in
8 the vote? Is this something that we can say
9 that, if your assumptions about what is in the
10 numerator and how that is measured are
11 correct, we can approve this, but -- I mean,
12 how do we handle this?
13 DR. WINKLER: It is not unusual to
14 have questions go back to developers that help
15 clarify. So you can vote, and we will get
16 this information back and respond to some of
17 these questions. Again, as we have said
18 multiple times, this is our first pass through
19 these. It is a dialogue, and so raising these
20 issues so we can clarify them and find
21 additional information is really one of the
22 first elements.

1 If this had a fatal flaw somewhere
2 else, though, for which you wouldn't want to
3 approve the measure, then all that extra work
4 is not probably worth the effort, but if that
5 is really the one issue you are concerned
6 about and isn't a fatal flaw for the measure,
7 but you really want to be better informed
8 about it, you can go ahead and make your
9 decision, and we can ge that information. We
10 will go get it.
11 DR. STANGE: Michael is next, and
12 then Jackie.
13 DR. STOTO: I have, basically, a
14 philosophical question about these high rates
15 for vaccines and preventive services in
16 general. I think that people in preventive
17 medicine think that the reason that we are
18 doing so well is because we are paying
19 attention to this, and that if we stop paying
20 attention to this by not having a measure, we
21 would drop off.
22 Even though these numbers may not

1 reflect the general picture, I think it is a
2 philosophical question in saying how much
3 weight should we give to that for these
4 preventive measures?
5 DR. STANGE: I didn't hear anybody
6 arguing for not continuing to measure this.
7 I think it was just that was being used as
8 evidence that there is probably over-
9 vaccination going on to get to that high a
10 level. Jackie?
11 DR. BURSTIN: NQF does have an
12 option. We put it forward this past year,
13 that for measures that are otherwise --
14 MS. SAMPSEL: It is a variation of
15 an old measure, isn't it?
16 DR. BURSTIN: Let me just finish
17 my statement. Reva is making a technical
18 point. That is probably true, but we have
19 created something called reserve status,
20 reserve endorsement.
21 So for measures that are otherwise
22 reliable, valid, etcetera, really important

1 but at those really, really high thresholds of
2 performance, they can be moved into that
3 reserve status, meaning people can
4 periodically go back to them and do
5 surveillance.
6 At the next three-year window we
7 can reassess whether it remains at that high
8 performance or if periodic surveillance would
9 suggest that, actually, exactly that decrement
10 occurs.
11 There is very little on the health
12 services research literature at all, a tiny
13 little bit I have seen from the VA, about
14 whether or not performance actually falls when
15 you kind of take your eye off of it. I would
16 be curious if Matt or Sarah have any
17 experience with this, but it is a really big
18 issue.
19 So we have at least for now tried
20 to move some of those into reserve status.
21 Reva's point is this is technically a new
22 measure, because it is an expanded population,

1 but again I think the bigger issue I we don't
2 actually know what the numbers are, and I
3 think we need to get that from Oklahoma.
4 MS. MERRILL: There may be a typo
5 in both the brief description of the measure
6 and in the denominator, in the denominator
7 statement. So you have got the criteria say
8 five to 64. You have got six to 64 in both
9 places. I don't know if that is just a typo.
10 DR. STANGE: As we approach a vote
11 for this -- Sarah, your card is a leftover?
12 Okay.
13 As we approach a vote for this,
14 Helen, could you restate for us the criteria
15 for how we might consider the concerns here?
16 DR. BURSTIN: I think there is
17 really two separate issues. The first is
18 that the high level of performance that they
19 provided to us is only in patients with
20 pneumonia where, you could argue, certainly,
21 probably have a much higher rate of
22 vaccination, because they are in there, and

1 you want to make sure they get vaccinated or
2 have been vaccinated.
3 When you go into the broader
4 population, my guess would be the level is
5 probably not as high, but you sure need to
6 know that, and I think we need to know that
7 really in advance of endorsing this measure.
8 We don't know what current rates of
9 performance are for the general population.
10 If, in fact, it remains equally
11 high, if they can share with us that it
12 doesn't actually matter, and the general older
13 population and we are still shooting everybody
14 up as they walk in the door, then I think we
15 would need to consider whether it could be in
16 reserve status.
17 DR. STANGE: Actually, my question
18 was about the other issue, about we think that
19 the things that are in the numerator are
20 probably being measured appropriate, but we
21 just want some clarification of that.
22 I guess you are suggesting that we

1 include how concerned about that we are, as
2 whether that bumps over from a Yes to a No or
3 how do we handle that?
4 DR. BURSTIN: I think it is up to
5 the committee. How much do you feel like you
6 can't really assess this measure without
7 knowing what the current levels of performance
8 are. Importance of measure to report is a
9 must pass criterion.
10 If you don't actually know the
11 measure gap -- and I was actually just looking
12 to see whether they provided anything from the
13 literature. It doesn't have to be from their
14 measure per se, but what is the known measure
15 gap in terms of performance?
16 DR. QASEEM: What we did this
17 morning -- do you think this would fall in the
18 criteria of table it and get some more info?
19 I feel like we are doing it with a lot of
20 measures. We are going to have a busy
21 February meeting.
22 DR. STANGE: I will you my larger

1 concern with this group is. If this was the
2 main task of this group, I would be in favor
3 of that. I think we have other tasks that are
4 really going to take a fair amount of energy,
5 and we have -- with the balance of our
6 energy, without any advance prep, really, we
7 had an open discussion of a large new area
8 that, I think, we think is important that we
9 want this committee to address.
10 So I think we need to do the right
11 thing here with each measure, not gloss over
12 and push things on, but also this is not the
13 only task of this committee. I would say it
14 is not the most important task. It is not the
15 unique task of this committee. Others could do
16 this. Others could this work, other
17 committees, but -- Okay, that is a personal
18 opinion.
19 DR. WINKLER: One comment is this
20 aspect of these measure evaluation is going to
21 be moving forward. You are not going to be
22 seeing any of this in February. So this is

1 moving forward directly after this. We are
2 going to wrap it up over the next month or
3 two.
4 The other thing is you can make
5 your vote conditional on review of that data,
6 the information from Oklahoma, that there is
7 an opportunity for improvement in a broad
8 population.
9 PARTICIPANT: Hello? Hello?
10 DR. WINKLER: Hello. Yes, who is
11 on the phone?
12 PARTICIPANT: I don't know. I
13 think I lined up here. I'm sorry.
14 DR. WINKLER: Okay. Rufus? Okay.
15 So you can make your vote
16 conditional on looking at data, see what they
17 have got, and clarification on the numerator
18 specifications to be sure we have got it, and
19 perhaps maybe clarify the language that makes
20 it more crisp in terms of what their intention
21 is.
22 DR. STANGE: Linda?

1 DR. KINSINGER: I wanted to go
2 back to the question about performance gap,
3 because as Helen says, they say the most
4 recent national CMS rate is 93.3 percent. Is
5 there a sense generally of how large that
6 performance gap needs to be to say it is large
7 enough? That seems like a pretty small
8 performance gap to me.
9 DR. BURSTIN: Some of it depends
10 on how large their overall population is. So
11 that it could be a significant opportunity for
12 improvement, just given the number of
13 hospitalized older patients, but again that is
14 a judgment call. We don't have a specific
15 threshold for exactly that percent.
16 i would also be curious -- I was
17 actually just reading the exact same paragraph
18 you did. It is not clear to me how they know
19 what the recent national CMS rate is. Is it
20 of the older measure of pneumonia or is it
21 this measure, and that is what is not clear.
22 DR. KINSINGER: So it says it is

1 from the CMS Hospital Compare website, the
2 sentence before.
3 DR. BURSTIN: I believe that is
4 only pneumonia.
5 DR. QASEEM: Kurt, would it be
6 reasonable for first the committee motion can
7 be whether we should table it or not, and then
8 if the majority feels like we shouldn't table
9 it, then we can vote. But maybe we do need a
10 motion. I think it seems like there is a lot
11 of issues going on here.
12 DR. STANGE: I think that is
13 helpful, Amir. so all in favor of tabling
14 this? We will do that as a first level, and
15 if the majority doesn't want to table it, then
16 we will consider the next step. so all in
17 favor of tabling this, raise your hand,
18 please. Raise it high, and hold them high.
19 So it seems to me that is
20 something -- We have a majority, a slight
21 majority, but that is something, if we have a
22 substantial minority that feels like they are

1 not sure enough on what they are voting on, it
2 is a reason to table it. So it sounds like
3 that trumps the other consideration. So --
4 DR. BURSTIN: I think these are
5 very straightforward questions to ask CMS.
6 The issue is there has been some issue with
7 Oklahoma, and some furloughs and things. So
8 it is not an issue of their unwillingness to
9 participate. They were not able to
10 participate, and there is no one from CMS.
11 So I would just feel better having
12 you actually make the assessment with some
13 real information.
14 DR. STANGE: Just thinking about
15 all these committees doing this, it is hard to
16 keep the overall reporting burden for all
17 measures in mind, and it seems like that is
18 where the performance gap really is, and is an
19 issue. Voting on one measure at a time, it is
20 easy to go over that. So I don't -- It almost
21 seems like there needs to be some larger
22 process to handle that.

1 Okay, next measure.
2 DR. WINKLER: Okay. We have got
3 the last measure. This is measure 525. This
4 is from CMS, percentage of home health
5 episodes of care during which patients were
6 determined to have ever received pneumococcal
7 vaccination.
8 Do we have somebody from CMS on
9 the line for this measure? Ms. Cassia? She
10 was here with Keziah. They were here with us
11 yesterday. Anybody? They knew about it,
12 right? Doesn't sound like it.
13 In many respects, this measure is
14 the parallel measure for a pneumococcal
15 vaccination that it was for influenza for
16 patients in the home health community.
17 Whose measure was this to look at?
18 Okay, Jackie.
19 MS. MERRILL: Remember that
20 comment I was making for 617, is what I meant
21 for this one. So this is percentage of home
22 health episodes of care during which patients

1 were determined to have ever received.

2 So this implies that they are

3 screened, and they receive it, if they need

4 it, and then they have ever received it. If

5 that is the case, it would be nice to say

6 that.

7 Other issues: Another is just the

8 level of precision in the document. So in

9 1.c.1 you say, "As CDC recommends PPV for

10 Americans 65 years older and those with

11 selected chronic conditions, those between 5

12 and 64 with selected chronic conditions." It

13 is kind of --

14 DR. STANGE: So I think that is a

15 larger point that we will take forward. So

16 things that can inform our vote on this

17 measure, I think, is what we want.

18 MS. MERRILL: Okay. So their

19 system for grading the body of the evidence:

20 they cite CDC saying that there is a limited

21 number, but there are randomized controlled

22 trials. So I think that the body of evidence

1 is fair to good.
2 Oh, in this measure they are
3 requesting follow-up for stratifying for
4 disparities. So that is actually a request
5 that they are making. They want guidance on
6 that, and it is also one data source.
7 Otherwise, I don't have issues with it except
8 just for that sort of rigor in the preparation
9 of the document. Anybody else?
10 DR. STANGE: Jason, did you have
11 any comment on this one? What we are
12 specifically wondering, is that your comment
13 under the rationale?
14 DR. WINKLER: About meeting the
15 standard specifications? You raised the issue
16 yesterday that we immunize people, not
17 episodes. So is that the same issue?
18 DR. SPANGLER: Yes, same issue
19 about persons and episodes.
20 DR. WINKLER: I think we can deal
21 with that in the same way we are going to be
22 dealing with the immunization. We are going

1 to put them side by side and look at the
2 details that you have asked us.
3 We've got the big picture
4 harmonization, but there are little detail's,
5 and I think clarification -- and an episode
6 really does represent a person -- would be
7 important in communication for folks.
8 DR. STANGE: So this population
9 has a unique data source, and that is probably
10 why it is a separate measure. Any other
11 considerations before we vote?
12 MS. MERRILL: There is a comment
13 about 4.c.1, audit for errors. Data accuracy
14 could be audited, but they have not done it,
15 apparently.
16 DR. STANGE: Mike?
17 DR. STOTO: It's funny. I spoke
18 at the resolution for the one yesterday that
19 had the same format.
20 DR. WINKLER: You approved it, but
21 again it is part of this follow-up where we
22 want to put these smaller details side by side

1 and really evaluate and see if we can get them
2 to harmonize, and to Jackie's point about the
3 language, so that audiences can readily see
4 they are the same instead of having sort of
5 unusual language that is hard to interpret.
6 DR. STOTO: I just want to be as
7 consistent as we can.
8 DR. COOK: Hi. This is Keziah
9 Cook from Acumen. I was on a non-speaking
10 line earlier.
11 DR. WINKLER: Hi, there. Thanks
12 for joining us, and thanks for speaking up.
13 We have been discussing the measure. A lot of
14 the issues that came up yesterday with the flu
15 vaccination measure are again discussed.
16 I think, again, using the
17 terminology around episodes is just difficult
18 for broad audiences who don't have the insight
19 or terminology from the home health world, and
20 the notion that we don't immunize episodes; we
21 do immunize people.
22 So some way of making that

1 communication in the specifications is
2 probably necessary, as we expect broad
3 audiences to read this and understand exactly
4 what is going on.
5 Jackie, were there -- Your other
6 points were just some clarifications in the
7 care with which some of the wording in the
8 document -- and the characterization of the
9 evidence.
10 MS. MERRILL: the other thing was
11 the developer's request for guidance from the
12 group on the stratification by disparities.
13 DR. WINKLER: I think they are
14 asking for guidance from this group, being
15 open. I would just point out that this -- If
16 you look on page 3 of the submission form, you
17 will see that the data is stratified by race,
18 by age, and by gender, and clearly, they are
19 able to do that.
20 I guess -- Are you guys asking for
21 whether this is the right kind of
22 stratification, whether it should be something

1 different?

2 DR. COOK: No, we collect the data

3 to stratify the measure, but the measure as it

4 received time limited endorsement was not a

5 stratified measure. It would be publicly

6 reported for all home health patients rather

7 than separate for different groups of home

8 health patients.

9 So we collect the data, and we can

10 certainly track the disparities internally.

11 The question is whether there is interest in

12 publicly reporting a stratified measure?

13 DR. WINKLER: I think that,

14 considering the discussion of disparities and

15 how important they are and such the high

16 priority -- I've got heads nodding all the way

17 around the table that you can't see -- we

18 certainly would want to encourage and whatever

19 we can do to get stratified results reported.

20 Yes.

21 DR. HITTLE: This is David Hittle

22 from the University of Colorado. I am on the

1 same team as Keziah.

2 When this was publicly reported,

3 it publicly reported on a tighter basis, each

4 home health agent, and are you suggesting that

5 it should be stratified at that level or more

6 at the population level?

7 DR. COOK: I think that is part of

8 our question for the committee, is we did find

9 evidence of disparity was the appropriate way

10 to address this in the reporting.

11 DR. NISHIMI: I really think that

12 is up to you to identify whether, in fact, you

13 have enough n at the facility level. The

14 report that is on the website right now from

15 the Disparities and Cultural Competency

16 Steering Committee would give you some

17 guidance on whether that is feasible, but

18 absent looking at the individual data for your

19 measure for individual facilities, it is sort

20 of hard to give you any specific guidance.

21 But from the Disparities and Cultural

22 Competency Steering Committee prospective,

1 that paper should be helpful.

2 It is on the web, and Elias, I am

3 sure, can send it to you.

4 DR. HITTLE: I can say, actually,

5 right up front that the n would probably be

6 too small for about 80 percent home health

7 agents out there.

8 DR. NISHIMI: Right. So I would

9 just look at that guidance and then you should

10 be able to take it from there.

11 DR. HITTLE: Thank you.

12 DR. STANGE: But the question of

13 reporting aggregate data -- certainly those

14 kind of data are helpful in looking where we

15 put our efforts and from policy decisions. So

16 I don't see a downside to reporting that.

17 Are people ready to vote? So the

18 vote is 10 Yes; three No.

19 MS. MERRILL: With the

20 recommendation that they define the home

21 health episode to conform with the standards.

22 So they have to define that so we know it is

1 an individual patient's episode.

2 DR. STANGE: Yes, thank you,

3 Jackie.

4 MS. MERRILL: You're welcome.

5 DR. COOK: I'm sorry. I think I

6 missed some of that discussion. Could you

7 just briefly recap what your recommendation

8 was for redefining a home health episode?

9 MS. MERRILL: The home health

10 episode has to be defined so that it conforms

11 with the standard. so in other words, you

12 have to define the home health episode as that

13 which is involving one patient, because what

14 we are interested in is the immunization for

15 one patient, not for an episode.

16 An episode is a thing. We are

17 interested in the individual patient.

18 DR. COOK: Right. So can I flip

19 that back to you quickly, just so that I can

20 make sure I am understanding? So for any type

21 of encounter measure where you are measuring

22 the immunization status of a patient who has

1 an encounter -- so a visit to a physician, a
2 hospitalization -- if that patient has
3 multiple encounters, is it appropriate for the
4 immunization status to be established during
5 each encounter?
6 MS. MERRILL: No.
7 DR. COOK: So if a patient is
8 hospitalized, but their doctor previously
9 established their immunization status, they
10 shouldn't be counted in a hospitalization
11 measure of immunization?
12 I am just confused, because, you
13 know, a patient can receive home health from
14 multiple different entities. So he might have
15 a home health episode in January with one home
16 health agency, a home health episode in
17 October with a different home health agency.
18 The same patient, but they had two episodes.
19 DR. WINKLER: I think this is
20 another question of harmonization, because
21 truly, the situation will arise with
22 hospitals, for multiple hospitalization. I

1 think this is an opportunity for additional
2 harmonization, and we can take that
3 conversation offline and kind of see how those
4 line up.
5 DR. COOK: Okay. That makes
6 sense. It is not something that is specific
7 to how home health episodes are defined,
8 though. It is the circumstance that arises
9 when patients have multiple encounters with a
10 provider type.
11 DR. WINKLER: Right. Thanks.
12 DR. STANGE: We have one final
13 measure, which is childhood immunization, but
14 before we do that, I have asked Reva, since I
15 have kind of lost track of it, what the issues
16 are across these measure regarding
17 harmonization and potentially consolidation.
18 So we need to have a discussion of that.
19 DR. WINKLER: Of the four
20 measures, one of the measures, the one from
21 Active Health, were concerns about not
22 conforming to the standard specs. So that one

1 is off the table for the moment. It is
2 possible they will bring us back a revised
3 measure that does conform.
4 What we have left is measure 43,
5 which is the survey measure, which is only for
6 patients over 65 and really is implemented
7 only in the Medicare Advantage programs, and
8 asking about patients who received
9 immunization.
10 We have the home health measure we
11 just discussed, some clarification there, and
12 also wording to help facilitate understanding
13 that harmonization is or isn't there.
14 Then the other measure is the
15 measure for hospitalization where we have
16 tabled it, because there are numerous
17 questions. some of those address the
18 harmonization issue, and some do not, and some
19 are other questions.
20 So that is where we are at this
21 point. So I think there are enough open-ended
22 questions that those three measures, we will

1 see what we can clean up the information.
2 MS. BYRON: Yes. You noted that
3 the flu shot measure was 65 and up, and I just
4 wanted to --
5 DR. WINKLER: Pneumococcal.
6 MS. BYRON: Oh, I am sorry. Okay.
7 We are talking not about flu?
8 DR. WINKLER: No, we are talking
9 about pneumococcal.
10 MS. BYRON: Okay. I am totally
11 confused. Sorry about that.
12 DR. STANGE: So it sounds like you
13 have a charge to go forward from the
14 discussion we have had. Is there anything
15 else that would be helpful at this point from
16 us looking across the measures?
17 DR. WINKLER: I think we need
18 additional information on enough of the
19 measures that we will need to come back to you
20 to see if there is any further change in your
21 recommendations going forward before we go
22 final.

1 DR. STANGE: So we will go ahead
2 and do number 38, the last one, the childhood
3 immunizations. Then we will open for public
4 comment, and then we will take a deep breath
5 and just step back and just consider what we
6 have learned from this discussion on some
7 specific clinical preventive service delivery
8 measures, how that might inform our larger
9 work on developing population health measures.
10 So Number 38.
11 DR. WINKLER: Michael, I
12 apologize. I don't have the form right in
13 front of me to read it. So if you would just
14 introduce the measure in your discussion, and
15 then Sepheen is here from NCQA to discuss it.
16 DR. STOTO: Well, you all have got
17 a lot better at this, this morning when I was
18 away. I also realize I missed some things in
19 my first review. So, hopefully, I will pick
20 them up now.
21 This basically is a measure that
22 NCQA has already been using -- I guess has

1 already been endorsed, right? -- to measure
2 childhood immunization status. What they do
3 is they look at 10 different vaccines that are
4 recommended for kids to be given before the
5 age of two.
6 They look at kids in their second
7 birthday. They have a second birthday in the
8 measurement year, and they see whether or not
9 they have had the appropriate number of those
10 vaccines, of each of those vaccines,by their
11 second birthday. So for some it may be two,
12 for some maybe three or one, and so on. But
13 then they report it many different ways.
14 To tell you the truth, I have lost
15 track of how many different ways, because
16 there are 10 different vaccines, and there is
17 either two combinations or someplace else it
18 says 10 combination rates. So either way, it
19 is a whole bunch of numbers. It is not just
20 one rate, even though it is only one measure.
21 I frankly, don't know which ones
22 it is. I went back to some of the NCQA

1 reports following the combos, and there were
2 nine of them there. I think that is a big
3 issue is, you know, what is the number.
4 It seems to me that it would be
5 useful to say here is the main measure. Then
6 you maybe you want to be able to break it out
7 by vaccine types. Do you want to respond to
8 that?
9 MS. BYRON: I'm sorry. I just
10 missed that question. Nine rates or -- Oh,
11 combos.
12 DR. STOTO: Yes. There are many
13 different rates.
14 MS. BYRON: Right.
15 DR. STOTO: Ten different
16 vaccines, and some two to 10 different
17 combinations of those vaccines.
18 MS. BYRON: Yes. The combinations
19 are -- There's two assist plans and others who
20 are looking at measure rates to trend, because
21 over time as more vaccines are added to the
22 immunization schedule, we have added new

1 vaccines, but then you can't trend back with
2 original things.
3 So the combos -- Usually, you have
4 the combo one. That may be the first three.
5 Then you add the four. then you add number
6 five, and all the different combos allow you,
7 if you want to look at specific vaccines, to
8 track it, because of the way the measure is
9 set up. So that is why there are so many
10 rates.
11 DR. STOTO: Yes, and I think that
12 is a problem.
13 DR. STANGE: So I am clear for
14 this, not one overall measure and then sub-
15 measures. There are multiple summary
16 measures?
17 MS. BYRON: T here is an overall
18 measure, and then we provide the combos to
19 allow for trending. The combos take into
20 account the different -- all the different
21 vaccines.
22 DR. STOTO: So when you look at

1 the quality compass, look at the one I looked
2 at, the most recent one I could find, there
3 were nine different measures that were all
4 tracked.
5 DR. STANGE: Sarah is going to
6 comment on that.
7 MS. SAMPSEL: I think it is just a
8 semantics issue. It is all the same measure.
9 So technically, you are looking at 10
10 different vaccinations, but it is how they are
11 reported out, and the reporting out is what is
12 the trending issue, and that is what is really
13 important for plans.
14 So we only -- So WellPoint, while
15 we report all of them, we trend combo 2. So
16 it is kind of up to the plan, but they are
17 technically not different measures. It is all
18 the same measure.
19 DR. STOTO: Well, I understand
20 that point, but on the other hand, if I were
21 a consumer trying to compare two different
22 plans, I wouldn't know how to do it, because

1 some would look better on measure one, some
2 would look better on other measures. Some
3 would look better on the DPT. Some would look
4 worse on the HIB.
5 DR. STANGE: So what is the
6 counter-argument, and what is the advantage of
7 having the different reporting?
8 MS. BYRON: The different
9 reporting really -- As Sarah said, you might -
10 - As a plan, you might decide that you only
11 want to trend the combo that includes X, Y and
12 Z vaccine.
13 One year HIB was -- There was a
14 vaccine shortage, and so we did not require
15 HIB, the HIB vaccine. So there is an example
16 where having the other combinations was
17 useful, because then you could go to the
18 combos that did not include HIB and look to
19 see what your rates were in past years.
20 So it is really -- It is a
21 reporting out issue.
22 DR. STOTO: It seems to me that a

1 compromise here might be to say that the
2 primary measure is so and so, and that
3 probably would be the biggest combination, and
4 then say there are these other ways of
5 reporting it for trend purposes.
6 MS. BYRON: We could clarify that
7 and make sure that people understand that it
8 is the same measure, and it is just a
9 reporting out issue and trending issue.
10 DR. STOTO: Well, no, it is not
11 the same measure.
12 MS. BYRON: I'm sorry. So the
13 measure is did you get these immunizations by
14 the time you turn age two, and the
15 immunizations are aligned with the ACIP
16 recommendations. So it is aligned with the
17 immunization schedules.
18 Whether or not you want to trend
19 back on every single vaccination or you just
20 want to look at rotovirus plus HIB plus this
21 or that, you do using the combo rate. So I
22 realize it is confusing, and I realize that

1 there are a lot of different rates, and maybe
2 we could have just provided it on the total
3 measure.
4 DR. STOTO; We probably should go
5 forward, but to say that whether you got these
6 three vaccines and whether you got these 10
7 vaccines -- they are two different measures.
8 Okay.
9 Second -- and either way, I can't
10 figure out some of the documentation exactly
11 what is being spoken about.
12 Number two is about the
13 contraindications. They exclude a child who
14 has a contraindication to any of the vaccines
15 from the denominator. Now the issue is the
16 denominator rather than the numerator. So that
17 is the harmonization issue.
18 DR. WINKLER: This measure -- We
19 can talk about whether it needs to have the
20 same harmonization. This is the only measure
21 of childhood vaccination. You may wish to say
22 that maybe globally all vaccine measures of

1 all types should conform, and that is
2 something you all can do.
3 DR. STOTO: I don't think this is
4 -- I wouldn't worry about that so much. I
5 just wanted to point out that. There is,
6 however -- I find a sentence in here about
7 that, but I can't quite figure out what it
8 means.
9 An organization that -- This is in
10 2.a.1.8: An organization that excludes
11 contraindicated children may do so only if the
12 administrative data do not indicate that the
13 contraindicated immunization was rendered.
14 I have parsed that a couple of
15 times. I don't know what that means. So that
16 needs to be clarified.
17 Number three: In terms of the
18 evidence, what they basically do is say,
19 well,l the ACIP recommended this, and see the
20 ACIP reports. To some degree, that is about
21 all it can do, because there are 10 different
22 vaccines we are talking about there, and it

1 would be impossible to kind of summarize that
2 as all ACIP report, but the point is that we
3 really don't have much of an independent
4 review. I am not concerned about that.
5 DR. STANGE: You mentioned the
6 words, we have gotten better at this. One of
7 the things we have done is we have focused the
8 initial discussion on things that we think the
9 persons who have looked at it in detail --
10 what are the things that you think we really
11 need to pay attention to that are germane to
12 the overall --
13 DR. STOTO: Okay. I wouldn't put
14 that in that category.
15 They mention adverse effects and
16 say that adverse effects -- people worry about
17 it, but it is not a problem. I don't think it
18 is quite that simple, but again I don't think
19 it is so -- the adverse effects are big enough
20 to worry about.
21 The next point has to do with the
22 data sources. They say here data source:

1 administrative claims, electronic clinical
2 data: registry, paper records. So that is
3 kind of an odd mix of things, and they are not
4 any clearer about that later.
5 What they say later is that the
6 data comes from HEDIS and, of course, HEDIS --
7 it has to come from someplace, and there is
8 really no discussion about that.
9 I guess I don't think that is a
10 problem, because they have worked this out
11 pretty carefully at HEDIS, but I would like to
12 see a little bit more about that before I was
13 really confident about that. To what degree
14 do they -- It sounds like they rely on records
15 rather than recall, patient reports, but that
16 is not really stated here.
17 DR. STANGE: Is that true?
18 MS. BYRON: Yes, this is not a
19 survey measure. It is based on administrative
20 and medical record data.
21 DR. STOTO: But there were some
22 other ones that we looked at yesterday where

1 people were asked to self-report that they
2 have had a vaccine.
3 MS. BYRON: Right. That was flu
4 shot, not this one.
5 DR. STOTO: So I think that that -
6 - I mean I am glad to hear that is true. I
7 think that it would be better to clarify that.
8 So I am not particularly worried about that.
9 DR. STANGE: I think, like Jackie,
10 you are raising concerns that we can bring
11 forward and that the NQF staff can bring
12 forward, that if you want your measures to
13 have an easier time with the committees that
14 there are ways report this. So I think we can
15 take that as a general point.
16 DR. STOTO: The point here is that
17 we can't assess by ourselves the validity and
18 reliability of these data.
19 DR. STANGE: Right. Are there
20 other things we should consider in the
21 evaluation?
22 DR. STOTO: The only other point I

1 just want to make is that in the detailed
2 statement of this, they talk about encounters
3 with primary care providers and OB/Gyns.
4 Since these are kids, I don't understand why
5 the OB/Gyns are there.
6 MS. MERRILL: I think it is
7 because of the MCH clinics. That is why, but
8 I don't know, because I am having the same
9 issue in an immunization study that I am doing
10 right now, and based on that, I also want to
11 ask about these multiple data sources.
12 There is an incredible problem
13 with accuracy when you are using these
14 multiple data sources, because they all record
15 in a different way. How is that being
16 addressed? I mean, accuracy, completeness of
17 vaccines is a hideous problem, and how are you
18 going to be sure that you have accurate
19 reports? It is a very difficult problem.
20 MS. BYRON: Right. Well, the
21 measure was field tested in administrative
22 claims data and also medical record data, and

1 found to be a workable measure using those
2 data sources.
3 MS. MERRILL: Those data sources
4 were interoperable or they had data that could
5 be reused for this purpose, not formatted in
6 ways that couldn't be reused, because that is
7 usually the problem.
8 MS. BYRON: Well, our HEDIS
9 general guidelines -- and I could get back to
10 you on that -- outline what to do using the
11 different data sources. I will say that all
12 of the HEDIS measures are audited, and have to
13 pass that bar in order to be reported. So all
14 of those issues are assessed then.
15 DR. STANGE: I wonder if this is
16 one of the issues of it is such an important
17 measure, and anytime you are doing something
18 this global you are going to have messy data.
19 The question would be, is it the best we can
20 do in the situation, because it is not an
21 option here to not report it because the data
22 are messy.

1 So the question would be is it the
2 best that can be done with pulling together a
3 lot of sources that are somewhat messy, but
4 they give you the best estimate.
5 DR. BURSTIN: They actually
6 presented their testing results, and their
7 reliability scores are quite impressive. So
8 again, most of these things are charged for.
9 So the claims are there.
10 DR. STOTO: Right. I am not so
11 worried about the substance here. I just
12 think the documentation -- We are basically
13 asked to trust that NCQA got it right, which
14 they probably did, but except for those
15 reliability things that Helen mentioned, there
16 is really nothing in the documentation about
17 this.
18 DR. STANGE: It is really hard.
19 You have such well established measures, and
20 we were asked to do a lot of these measures in
21 preparation for this, to really document all
22 the ACIP data -- all the data the ACIP has

1 come up with to do each of the individual
2 immunizations were just overwhelming. So I
3 think we are hearing --
4 DR. STOTO: I am less concerned
5 about the ACIP. I mean, I think that -- I
6 trust the ACIP, and they cite that, and you
7 know, we could go look at it if we really
8 wanted to. Anybody else could. But because
9 they take data from these different sources,
10 as Jackie was saying, and I would like to see
11 more documentation what the validity and
12 reliability really are.
13 DR. STANGE: My hope from this
14 discussion, from both what Mike and Jackie
15 have raised for a number of measures, is that
16 the staff can take that forward, and they are
17 consulting with the measure developers, and
18 just give that as hints to them.
19 I think for our work here we are
20 focusing on are there things that are at our
21 level of concern about whether we think that
22 these measures have met the criteria. Jackie?

1 MS. MERRILL: If I am
2 understanding it correctly, the reliability
3 testing, the n is actually pretty small. So
4 probably the reliability test is from a single
5 data source, which you would be able to do.
6 I don't know -- I mean --
7 DR. BURSTIN: They have clearly
8 given claims based analyses. Reliability is
9 based on signal-to-noise ratios, and I think
10 that is essentially what they have been able
11 to provide, which is acceptable to us for a
12 large dataset like this.
13 MS. MERRILL: Does this n on the
14 first one -- If the n is 235 observations --
15 correct?
16 MS. BYRON: I'm sorry. Which
17 number are you looking at?
18 MS. MERRILL: I am looking on page
19 3, 1.b.2, Summary of Data Demonstrated.
20 MS. SAMPSEL: The n on NCQA
21 measures is typically the number the plan got
22 reported.

1 MS. BYRON: Right. The membership
2 for each of those plans is vast. So these are
3 actually -- The reliability was run on the
4 HEDIS measures, and is a very, very large
5 number, and the reliability was found to be
6 very high.
7 DR. STANGE: Any additional issues
8 we should consider before voting on this?
9 Ron, did you want to comment?
10 MR. BIALEK: Just a quick
11 question. I appreciated the breakdown of
12 disparities. That was helpful to see, and a
13 question I have is, in looking at the data and
14 the differences in reporting, was there any
15 work done looking at is there a difference
16 between the accuracy, the validity of the data
17 from a health plan versus an individual
18 physician versus a health department versus a
19 community and migrant health center?
20 I was just thinking, in those
21 settings you have different potential
22 populations that are being served.

1 MS. BYRON: We have the
2 reliability data at the plan level. I will
3 say that in prior work we had doing child
4 health measures development, we did also test
5 this measure, even though it is a longstanding
6 HEDIS measure, in physician practices.
7 I don't remember if we had the
8 reliability data run o those, but I can tell
9 you that the performance data was in line with
10 what we see for health plans, a little bit
11 higher for the physicians which is as expected
12 when you are looking at an individual
13 physician versus a wider health plan level.
14 DR. STANGE: I guess we are ready
15 for a vote. Thirteen Yes; one No.
16 So I think, if you are sitting
17 next to one, someone else feel free to pat
18 them on the back and pat yourself on the back.
19 Congratulations on doing two really disparate
20 tasks in two days here and doing them both
21 very well and with attention to detail, and
22 with attention to the big picture, which is a

1 hard combination to do.
2 I think the group process really
3 worked well. I feel like I as pushing us to
4 the point sometimes to get through things
5 where we could have glossed, and I think when
6 I started to in danger in that direction, I
7 felt like the group pushed back, and I think
8 everyone attended to their own part of the
9 process very well in a way that was very
10 helpful and striking the right balance there.
11 So take a deep breath, and just
12 reflect back to yesterday afternoon and this
13 morning, what we learned from thinking about
14 both the immunization measures and these other
15 preventive services, and think about these two
16 different -- these kind of next steps that we
17 talked about in our goals here.
18 Any ideas that you want to carry
19 forward and, just if we could, just not --
20 when you start with any ideas, just don't
21 start the sentence with Sarah. Otherwise, she
22 would probably quit. So could we just general

1 things that maybe both groups should consider
2 or one group. Mention a group name instead of
3 Sarah's name or any other general reflections
4 at this point. Sue?
5 DR. PICKENS: Well, I was just
6 thinking about this last thing, in particular,
7 and the opportunity to develop measures at a
8 national level that could generate calls for
9 appropriate data gathering nationally.
10 Looking at the state of Texas, we
11 had an immunization database. It is going
12 away, and to have something like that be
13 available nationally to develop population
14 based measures to know exactly where we stand
15 -- I think it is a really exciting
16 opportunity.
17 DR. STANGE: And the nexus might
18 be registries or something like that. Is that
19 what you are thinking? It might help drive
20 the establishment of those things.
21 DR. PICKENS: Not just registries
22 at, say, an institutional level, but at a

1 community level, having required data
2 collections. I know we collect all inpatient
3 data in Texas, and then the ability to extract
4 that data to do actual real measures of health
5 improvement, systems change, that kind of
6 thing.
7 DR. STANGE: And there are some
8 states that have tried to do statewide
9 immunization registries. Right?
10 DR. PICKENS: Texas did, but we
11 have lost that.
12 DR. STANGE: So that is a helpful
13 idea to bring forward. Matt?
14 MR. STIEFEL: Well, it is related.
15 It is just reflection about the distinction
16 between these patient level measures and
17 population measures, and what is different
18 about them.
19 The first observation is that in
20 the model that we looked at yesterday, we are
21 looking at one small box in that model of
22 population health, which is one contribution

1 of the health care delivery system in the
2 provision of preventive services. But when we
3 look at the whole framework, that is a pretty
4 small box with regard to population health.
5 So looking downstream from there
6 toward outcomes, I think, is a big part of our
7 task, so somehow taking all of these patient
8 population specific measures for immunizations
9 for flu and rolling them up to ultimately look
10 at how well are we dong in a given geographic
11 area, and you can't just add them together.
12 You need to come up with some sort
13 of registry, and then looking downstream from
14 that to look at mortality or morbidity related
15 to this condition is an important step in the
16 work of this group.
17 The other related thought, I
18 think, is the distinction between sort of
19 people and patients as a denominator, and in
20 the aggregation. If the denominator -- or
21 episodes, even further away from people -- If
22 the denominator is NCQA health plan data with

1 people as denominators, it is actually -- you
2 can envision aggregating, summing across
3 health plans to look to come up with a
4 geographic population, but if the denominator
5 are hospitals or doctor's offices or home
6 health or nursing homes' patients, you can't
7 add them together, because patients don't sum
8 to populations.
9 So I think, just off the top,
10 those are two, I think, important learnings
11 from this review.
12 DR. STANGE: That is very helpful,
13 big picture. As we look instrumentally at
14 what we are doing, we said we are going to go
15 ahead with this NQF measurement evaluation
16 criterion on population health measures that
17 has the -- starting with NQF current
18 evaluation criteria, and start to think about
19 cross-walking that to population, which is
20 what you were alluding to. Maybe there are
21 some where you could actually start to
22 aggregate, but what you are saying is that is

1 a very small box of the larger problem about
2 thinking about population health.
3 So having a separate work that
4 starts with the population and starts working
5 down through different subgroups, that having
6 those as parallel activities and learning from
7 the differences there, that the is the way we
8 set it up here probably is going to be a
9 useful way to go forward.
10 MR. STIEFEL: I said that without
11 saying Sarah, but it was implied.
12 DR. STANGE: Oh, she relaxed, and
13 then you jabbed her in the soft underbelly.
14 Ron, did you want to say something?
15 MR. BIALEK: Yes, I wasn't here
16 for most of today's discussion, which probably
17 helped things go more quickly. What I
18 grappled with yesterday and grappled with even
19 for the few minutes today are the discussions
20 and presentation of data and data sources.
21 So often in public health, we
22 downplay the data that we have, because it is

1 not perfect, and we are maybe hesitant to use
2 it because it is not perfect.
3 So what I see here in the
4 discussions of many of the clinical measures
5 is that there are many of the very same
6 problems with those datasets as we have with
7 public health datasets, and that in a number
8 of instances I could think about, the testing
9 that we did in terms of validity and
10 reliability for some of the clinical measures
11 may not even be as rigorous as we might do for
12 some of the population measures.
13 So I am thinking, as we get into
14 developing measures, we may want to be kind to
15 ourselves about the data and data sources that
16 we use in public health for population
17 purposes, and that, granted, there is less
18 research done with the data, because research
19 -- public health systems and services research
20 has not been well funded in the past, but just
21 because the research may not be as -- I
22 shouldn't say rigorous; research is rigorous -

1 - but as much as on the clinical side, it
2 doesn't mean we should discount the use of
3 those data sources that we have.
4 So it is just something I have
5 been thinking of a day and a half.
6 DR. STANGE: Another kind of
7 research way of restating that is that the
8 data on individual patients tends to be really
9 done focusing very much on internal validity
10 and just not really worrying about the
11 external validity, and that that could be as
12 big a problem or a bigger problem if you are
13 really trying to make policy decisions or
14 really have some bang for the buck or get some
15 value from investing resources. That is
16 potentially a bigger problem than having data
17 that are good enough but give you give you
18 that bigger picture about the population.
19 So that is going to be helpful to
20 give us permission to raise our gaze from the
21 usual kind of internal validity standard that
22 we have for research on individual people.

1 DR. WINKLER: Just to clarify,
2 this is not an unusual thing for steering
3 committees, but I just wanted to -- In terms
4 of your words, Ron, this committee is not
5 going to develop measures. You are going to
6 evaluate existing measures.
7 One of the things that is going to
8 be critical when we go forward with this call
9 for measures is it is likely we will need to
10 approach folks who may not be familiar with
11 NQF or the work that we do, and we are really
12 going to depend on your assistance to help
13 make that contact with those folks who may be
14 out there that we may not know about, because
15 we are moving into a space that just isn't our
16 usual place where we do business.
17 So we will be searching, and maybe
18 the searching we have done so far -- you know,
19 there is just a whole world out there we don't
20 even know is there. So we really are
21 depending on you all to help us discover what
22 might be out there, maybe not the usual

1 characters I think we are familiar with, but
2 there is often folks in the private sector or
3 nonprofit sector that are doing some great
4 stuff, who just may not have crossed our radar
5 screen. So we are really going to be
6 depending on you guys to help bring all these
7 folks together.
8 DR. NISHIMI: I just wanted to
9 echo what Reva said. Unless the measure comes
10 to us, tested, providing the evidence, and is
11 submitted, it doesn't get considered by you
12 all. I mean just in black and white. We
13 don't develop new things.
14 You could recommend, and I am sure
15 you will at the end of the day, the types of
16 measures that you would like to see others
17 develop going forward, and that will be very
18 important for the development agenda, but when
19 we get to that February meeting, if the
20 measure hasn't come in, there is nothing
21 really at that point that can be done.
22 So it will really be important for

1 you to beat the bushes for these measures.

2 DR. BURSTIN: Actually, a follow-

3 up to Ron's point of view, especially

4 important as we take a look at that evaluation

5 criteria. Please take a close look at the

6 reliability and validity requirements. I

7 think they would still work, but obviously,

8 your insights would be really helpful there.

9 DR. QASEEM: Again, this might be

10 a question for NQF folks and NQF staff. You

11 have already been hearing some of the

12 discussions that are going on in terms of

13 guidelines. Of course, guidelines are much

14 more of an advanced line of business where not

15 only accreditation but even National Guideline

16 Clearinghouse is going to start doing certain

17 things.

18 In terms of performance measures,

19 is NQF -- When we endorse measures, that is

20 good, but is it possible to have something

21 like that we endorse measures saying that --

22 and again, a simple way of saying it is maybe

1 some sort of star rating, that this is a one-
2 star measure, this is a two-star measure or
3 three-star measure, because really what we
4 reviewed -- many of the measures, they all --
5 I feel like we are putting them all in one
6 bucket over here in terms of some were better
7 than the others, but we all said yes to all of
8 them. Is it something -- Is it possible --
9 and I know it is a long way, and I know this
10 does not fall under this committee's charge
11 and all that, but something.
12 I think NQF is in a really good
13 position -- something that I have spoken
14 before. It is something we all need to start
15 thinking about. I think performance measures
16 is a young field, but we are in a good
17 position maybe. When we will be doing
18 performance measures, maybe it is not in our
19 committee's charge, but maybe we can still go
20 about doing it or we can say, well, we say yes
21 to this measure, but this is a one-star
22 measure or something like that.

1 DR. BURSTIN: It is an excellent
2 point, and actually, when we put these
3 measures out for comment, we put out a great
4 deal of detail. So you can clearly see, and
5 that is why the recent Evidence Task Force
6 Report moved toward the idea of having not
7 just a single rating overall for importance,
8 but quality, quantity and consistency of
9 evidence.
10 So I think that was a pretty
11 important step forward. Again, you are fairly
12 early in the overall process. So when those
13 measures go out for comment, people really do
14 scrutinize those: Huh, I got pretty moderate
15 to low evidence, and they passed it.
16 Those will get scrutinized, and
17 certainly, when it gets to our Consensus and
18 Approval Committee, they will take a very deep
19 dive on those kinds of issues.
20 We don't currently have sort of a
21 star rating for it, but we do try to at least
22 move it through the process with maximal

1 transparency so people can try to make those
2 assessments.
3 DR. WINKLER: I will just add in.
4 This is by no means the first time that sort
5 of question has been raised, and there has
6 been a reluctance for a lot of reasons.
7 Different stakeholders have different needs
8 for measures, and their threshold for what is
9 good enough for their particular purposes is
10 variable.
11 Clearly, over the course of NQF's
12 history, you have seen essentially the
13 criteria has helped to establish what that
14 threshold is, and that threshold is moving up
15 and, certainly, the most recent version of the
16 criteria that really speak to looking deeply
17 at the evidence, looking at the testing and
18 the results on reliability and validity, have
19 moved that bar up, so that the two groups of
20 pass/no pass, when applied to measures, say,
21 that we did eight years go, you would have a
22 totally different result. But that is the

1 evolution of this process.

2 So at this point, we really have
3 just the two, pass or not pass, though a bar
4 that is constantly being pushed up as the
5 maturity of the measurement enterprise
6 continues, and the reason is really our multi-
7 stakeholder audience.

8 MR. STIEFEL: Thinking about the
9 evaluation criteria for these measures versus
10 the population health measures, in the
11 evaluation of evidence and the reliability and
12 validity for these measures, a lot of that
13 evaluation is based on the evidence that this
14 measure is related to the outcome of interest.

15 When you are measuring directly
16 the outcome of interest, reliability and
17 validity take on a different meaning, I think.
18 So that is another nuance with the criteria.

19 Then the second part is just a
20 question for NQF. I am just curious if you
21 have -- With this huge number of measures for
22 things like immunizations for pneumonia and

1 flu, have you ever been presented with
2 measures of flu or pneumonia or mortality?
3 DR. WINKLER: A couple of things
4 around outcomes. What I did not do, to try
5 not to overwhelm you, is within the measure
6 criteria are slightly the caveats that apply
7 to outcome measures. So we don't need the
8 evidence, quality, quantity and consistency of
9 evidence if you are talking about an outcome
10 measure. All right?
11 MR. STIEFEL: It is at least
12 different.
13 DR. WINKLER: Right. There is
14 something different about it. So we don't
15 apply those criteria, but since all we talked
16 about were process measures, I didn't go there
17 for you and muddy the waters even more.
18 So outcome measures are evaluated
19 differently on evidence. It would be nice if
20 there were some evidence that you could do
21 something about the outcome, but even that
22 isn't an absolute, because there are many

1 times just outcomes are what people want to
2 know and to track just to figure out what is
3 going on.
4 In terms of reliability and
5 validity, we still -- Even outcome measures,
6 and in fact, reliability and validity of risk
7 adjusted outcome measures takes on a
8 methodological thing that is really quite
9 rigorous and extensive, and we actually pull
10 in statistical consultants to help us
11 understand all of the charts and numbers and
12 things to what are they saying, because it is
13 in a completely different language.
14 So that is an important part of
15 it, and they are done differently. So our
16 criteria are really appropriate to the type of
17 measure, with the flexibility that some
18 measures are process measures, but we are
19 really very much moving -- have a priority for
20 outcome measures.
21 I just completed a project last --
22 I don't know, whenever it was -- spring about

1 outcome measures. Actually, in NQF's
2 portfolio of about 700 measures, I would say
3 right now that 250 of them are outcome
4 measures.
5 So it is not -- They may not be
6 the kinds of outcome measures that you are
7 thinking about, like long term death or
8 quality of life. I think those are measures
9 people talk about really wanting to have. As
10 yet, we are not there. It tends to be things
11 like 30-day mortality after AMI or readmission
12 rates, but mortality rates are typically -- or
13 morbidity rates, complications after, oh,
14 various procedures and things like that.
15 So those tend to be those very
16 clinical and perhaps more short term. A lot
17 of it has to do with logistics. How do you
18 capture data for something that the outcome is
19 years away from -- How do you know who had the
20 X risk factor and ultimately what happened to
21 them?
22 So these are all the kind of

1 things. People talk about them. They would
2 love to have them.
3 MR. STIEFEL: I was just curious
4 if you had ever looked at influenza or
5 pneumonia.
6 DR. WINKLER: No. Nobody has ever
7 brought absolute rates of influenza and
8 pneumonia, but I don't see a reason why those
9 could not be, because I do believe those are
10 monitored at least in a surveillance fashion.
11 Correct?
12 DR. BURSTIN: I think part of this
13 really gets at this issue of what is
14 population health? So I think one of the
15 issues has been traditionally NQF has had a
16 level of accountability assigned to an entity,
17 so a clinician, a provider, a health plan,
18 whatever the case may be.
19 It is often difficult to look.
20 Those tend to be smaller numbers. It is hard
21 to really look at that, but again as you go up
22 in aggregation, you can start looking at a

1 geographic area, as we were talking earlier.
2 I think it would be great to potentially get
3 some of those, but then it is at a very
4 different level of accountability, and it
5 would be hard to assign accountability to, for
6 example, an individual hospital for the
7 community rates.
8 It is a shared accountability,
9 exactly the issue we talked about yesterday.
10 DR. STANGE: For Sarah, I would
11 just like to say that that is a really good
12 issue, and I think that we need to refer that
13 back to the committee that is run by Matt.
14 MR. BIALEK: I guess I have to
15 make up for my time not being here earlier.
16 I heard loud and clear that we
17 need to find organizations who can put forward
18 measures, who can meet the criteria. So a
19 question I have just to further understand and
20 to test an idea whether or not this would be
21 appropriate is, you know, we talked a little
22 bit about tobacco yesterday, and I talked a

1 little bit about tobacco taxation.
2 So there are a number of studies
3 that suggest that the tobacco tax does impact
4 in a positive way the smoking rates and life
5 and mortality and morbidity.
6 So if there were a measure
7 presented as to whether or not a state,
8 territory, tribe has a cigarette tax above a
9 certain level, and the measure basically then
10 is sort of a yes or no, they either have it or
11 they don't, when I think about the evidence
12 here, the criteria, the validity, reliability
13 to meet those various criteria, when I think
14 the nine aims and trying to put it through the
15 HHS quality aims and looking at it that way in
16 terms of vigilance, proactive, etcetera, I
17 think it would meet that as well.
18 So my question is: Would a
19 measure that is relative simple, which is yes,
20 no, 50 states, is that something that would be
21 appropriate or not appropriate to come before
22 this body?

1 DR. STANGE: So, Michael, then
2 Sarah.
3 DR. STOTO: I think that is a good
4 question. I don't know the answer to it, but
5 there is an alternative that, rather than
6 saying do you have the taxes, maybe you can
7 say something about what is the tax -- that is
8 a quantitative measure - or something about --
9 I guess taxing is not an enforcement issue,
10 but some other things may be how well is it
11 enforced. That could turn it into a
12 quantitative measure.
13 I am not sure that really gets at
14 what we need, but that is worth thinking
15 about.
16 MS. SAMPSEL: I think it is a good
17 question, too, because the other area that we
18 see a lot of this is with obesity, and
19 percentage of school districts that have
20 vending machine laws or stuff like that, which
21 are truly indicators of population health, and
22 they are what the obesity industry -- or the

1 industry that is trying to change the obesity
2 rate is trying to do, but yes, I mean, it is
3 just really hard.
4 Michael, regarding your
5 suggestions, I think yes and no gives you a
6 good versus bad, where tax rate you may not
7 know if that is good or bad. So those are
8 things that we would have to think about.
9 When you conceptualized population
10 health, were you thinking about things like
11 that, or no?
12 DR. BURSTIN: I think we felt like
13 we needed to get a read from the committee on
14 what they think are the proper parameters
15 here. I think in some ways those are
16 structural measures. We have structural
17 measures at the clinical level as well.
18 I guess the question is how
19 meaningful is it to have it as a performance
20 measure for a state. That is, I think, really
21 what it comes to.
22 Going back to the point as well

1 about Matt's model, in some ways, is that more
2 of a sort of a causal issue, and are we really
3 interested in -- I think BRFSS has a number of
4 cigarette packs sold per state. Is it kind of
5 better to maybe think about an outcome.
6 I am just trying to think about --
7 one of the same issues -- what is the best
8 measure to look at in that context, and is it
9 more a policy yes/no? I honestly don't know.
10 DR. STANGE: Well, I will go next,
11 and then Matt, and then Mike.
12 These last few things that have
13 been talked about, I have been thinking about
14 it from a scalability point of view. I think
15 it shows what might happen when sort of
16 starting from the clinical and going outward.
17 We start from the highest level and go
18 downward.
19 So I could actually envision some
20 of these measures being measured at a state
21 level, scalable easily to a county, scalable
22 to a smaller geographic community, with the

1 idea that some of what we want to stimulate
2 with these kind of measures is getting multi-
3 stakeholder groups to the table as opposed to
4 just one entity that can do it, but then it is
5 kind of irrelevant for the population.
6 You could actually sink down even
7 to the health care system level, defining what
8 are the schools in your catchment area. Well,
9 there's other health care plans. Okay, well,
10 then you talked to them about it.
11 So starting at that level and then
12 thinking about scalability, so that just
13 looking ahead to what we have decided we are
14 going to do, we have these two working groups
15 that are at least a next step. Who knows if
16 they will last very long, because these things
17 interact, but we will have one group -- that
18 is the next step -- who will look at these
19 kind of framing and scope and developing a
20 model of how we think about measuring
21 population health, and then a group that will
22 be actually looking at how to measure.

1 Both of those will be starting
2 with -- not starting from scratch, taking some
3 of these ideas, but going and doing an
4 environmental scan going forward.
5 We do have these people that are
6 doing the commissioned paper. That, in my
7 mental scan, is part of their work. So we
8 need to have these groups asking for what they
9 need, so talking to the folks doing the
10 commissioned paper, finding out what they
11 found.
12 Elisa and I will talk a little bit
13 after this about what the NQF staff is able to
14 do as far as supporting the work of the
15 committee.
16 We talked about the NQF draft
17 evaluation criteria that will also be
18 something that -- that work that is being done
19 to move that forward needs to inform and be
20 informed by the work of these two groups.
21 So what we are talking about is
22 setting up at least some next steps. So Matt

1 and Mike, and then Jackie and Sarah.
2 MR. STIEFEL: One of the things
3 that we have just been talking about isn't
4 explicitly included in your summary, which is,
5 I think, an important part of the conversation
6 yesterday of unit of accountability.
7 It may not fit in either of these
8 two working groups as articulated, but it is
9 a really fundamentally important question and
10 comes up when you are thinking about a state
11 where in the existing measures -- it tends to
12 have a very focused definition of the
13 accountable entity.
14 We talked yesterday a lot about
15 that accountable unit might be a multi-
16 stakeholder collaboration, and that is
17 probably not the same as the county or state
18 government; rather, the group of stakeholders
19 in the county or state that are vested in the
20 improvement of the health of that population.
21 It may be the combination of health plans and
22 hospitals and doctors and schools and

1 employers and social service agencies that
2 vets a unit, a multi-stakeholder unit, but it
3 is, obviously, a lot more diffuse and more
4 challenging, but in fact, may well be the
5 right unit of accountability.
6 So I think some work at the front
7 end of thinking about unit of accountability
8 for population measures will be necessary and
9 important. I don't think it fits in either of
10 these work groups. Maybe it can go to the LA
11 group.
12 DR. STANGE: I think that is
13 exactly it. So I think one of the
14 breakthroughs that we had yesterday and that
15 we need to make sure we convey this fully --
16 I think we conveyed and discussed it. We need
17 to fully convey it to the commissioned paper
18 groups, as they started out with the frame
19 that we are starting from a point of view of
20 where you are going to have a little bit more
21 rigid accountability, which is part of the
22 reason they have framed it in terms of health

1 care systems and public health systems.
2 I think the idea that was added
3 during the discussion yesterday was that it
4 could be multi-stakeholder groups, which is
5 quite liberating for the work of this group.
6 So I think that the group should take that
7 idea forward.
8 As you are framing the discussion
9 you might take the time and say, okay, now
10 let's frame it different. Let's start with
11 the end in mind. Who are the users for this?
12 Who is the accountability for this? That
13 might reframe the discussion.
14 So that idea will need to go
15 forward in the charge to the commissioned
16 paper, and I think it should be a starting
17 point or something that is discussed fairly
18 early on in both of the groups, but it is a
19 really important idea not to lose.
20 Mike, Jackie, and then Sarah.
21 DR. STOTO: Back to Ron's
22 question, two things. One is measures can be

1 specified so they are dichotomous at the
2 lowest level, but then become continuous when
3 you roll them up.
4 So you might say, you know, what
5 fraction -- A school either has a certain
6 anti-smoking policy or it doesn't, but you can
7 say what fraction of the schools in a
8 community do or what fraction of county health
9 departments do so and so. That is one way of
10 addressing it.
11 The other thing, a little more
12 general, is that I think, to the extent that
13 we could talk about the intensity of these
14 interventions, but not whether you have it or
15 not, not whether you have a program or not,
16 but how much of it you are doing, how well it
17 is working, something like that, if you can
18 capture that in some of these measures, that
19 would be better.
20 MS. MERRILL: I just got the email
21 that they made the formal launch of the FAB.
22 The Public Health Accreditation Board has

1 formally launched the accreditation process.
2 So now there is a bunch of standards,
3 measurement standards, that exist, and that
4 might be one place.
5 Some of those might -- I am not
6 saying all of them, but some of those might be
7 candidate measures for this group, and we
8 would have to then define the sponsor for
9 that,if it was going to be a community
10 coalition or -- But the question becomes like
11 where. Where does the -- the rollup question.
12 Where does the rollup happen.
13 So do we need collaborations at
14 the national level, say, between the Governors
15 Association and ASTO and the local boards of
16 health. That is kind of what I am seeing, is
17 that a group of partners like that would come
18 forth and put a measure, say a measure of the
19 smoking legislation laws in a given state.
20 Then that would be the measure,
21 and that group would put it forward, but then
22 that group would be responsible for seeing

1 that communities lower down bought into it and
2 made provisions to get the data.
3 So just trying to put a practical
4 face on it, but that is kind of how I see that
5 operating. But then the communities would
6 have something to hang on, but there is going
7 to be some cost involved for data collection.
8 So that is something else, I guess, we have to
9 think about. Just more conceptual ideas.
10 MS. SAMPSEL: I think my
11 additional comment had been -- and I believe
12 we have already talked to LA about looking at
13 the National Prevention Strategy, because a
14 number of their measures are structural
15 measures, and they are looking at this type of
16 thing. So I think we may want to really take
17 a serious look and consideration for those.
18 I really think, when we are
19 thinking about that determinant of health as
20 well as health outcomes, especially on that
21 determinant side, and you are talking about
22 obesity, who is accountable? Is it a parent?

1 Is it the school? Who? It is something we
2 are going to have to grapple with, and that is
3 why I think this group would be a good group
4 to try to start.
5 DR. STANGE: So we have Linda,
6 Ron, and Mary. Oh, sorry, that was Sarah. I
7 thought it was Linda. Sorry, Sarah
8 DR. LINDE-FEUCHT: I just want to
9 echo, actually, what Sarah just said. She was
10 reading my mind. I think the National
11 Prevention Strategy would be a great framework
12 for us to look at as we are going forward with
13 population health measures, and I am pretty
14 sure that tobacco, obesity and physical
15 activity are target areas in there.
16 The way the National Prevention
17 Strategy is set up, it talks about what
18 government can do, what you can do at the
19 community level, at the employer level. It is
20 broken down. The thinking has already been
21 done, and I know that there is work going on
22 now to put some energy into it as far as

1 implementation.

2 So I follow that in my job at

3 HRSA. So I can help be a link to that.

4 Anyway, as we are going forward, I think that

5 is -- That work has already been done. So we

6 may shorten our work or lessen our work.

7 DR. STANGE: That is a really

8 important point, and it parallels NQF's role.

9 They are not measure developers, but they have

10 this larger role, and this might not be the

11 group that develops the whole approach to how

12 you approach population health measurement,

13 but that takes what is out there and

14 synthesizes it in a way that uses the unique

15 platform of NQF to move that forward.

16 So that is a very helpful frame,

17 and it will keep us from reinventing the

18 wheel, if we take that to heart. Ron, Mary,

19 and Matt.

20 MR. BIALEK: Just to briefly

21 respond to Jackie, your comment about the

22 Public Health Accreditation Board standards.

1 One of the issues we may have is
2 that many of those standards have yet really
3 to be tested. So there is really not an
4 evidence base yet, which then, I suspect,
5 would not meet criteria that we have been
6 talking about for the evidence.
7 Back to the tobacco issue, one of
8 the reasons I posed the question is that I
9 think it is going to be difficult for us to
10 find measure sponsors, if you will, folks who
11 can really go through the rigorous process,
12 spend the time, the energy, the effort, the
13 money to develop the measure and present it.
14 A lot of that, I think, would fall
15 on CDC, and there is only so much CDC can do.
16 Some of it, if we have any workforce measures,
17 might actually fall on HRSA.
18 As I am thinking about external
19 bodies, and I suspect, if we were to approach
20 the Legacy Foundation and say -- you know,
21 Cheryl is the Executive Director there. There
22 could be some national measures on tobacco and

1 some of the policy issues that are so near and
2 dear to the hearts of Legacy and are evidence
3 based. -- would you be willing to develop them
4 and put them forward, that she probably would,
5 and I think it would be great if we were able
6 to give her enough guidance about what may fly
7 and what might not.
8 DR. STANGE: So as I call on Mary
9 and Matt, I will ask Jason if you would just
10 think about what Ron said in terms of partners
11 and measure developers, since partnership is
12 in your organization's name. If you want to
13 comment on that, I will welcome it. But first
14 Mary and Matt.
15 DR. PITTMAN: Thank you. I am
16 sorry I missed yesterday. It sounds like a
17 great discussion that went on, and I was
18 wondering whether you talked about some of the
19 environmental indicators that would relate to
20 clean air, clean water, safe food, toxic
21 sites. Did that come up in your conversation?
22 There is certainly another whole

1 set of indicators related to all of those
2 environmental standards and metrics.
3 DR. STANGE: So only alluded to,
4 and I think that is another thing we can give
5 the charge to Matt's committee. I
6 interrupted. Did you have more that you
7 wanted to say, Mary?
8 DR. PITTMAN: It seemed like our
9 frame was staying very close in to the medical
10 care side, and so I think, if we look at all
11 of the determinants of health that would have
12 an impact on population health issues, we are
13 going to have to broaden that frame.
14 DR. STANGE: So you might know
15 which committee you want to be part of.
16 DR. PITTMAN: I will need to look
17 them up.
18 DR. STANGE: Matt?
19 MR. STIEFEL: We have a big frame.
20 Speaking of harmonization, we were talking
21 about the prevention strategy. I was just
22 sort of curious about how that harmonizes with

1 Healthy People. Healthy People seems like a
2 great frame to start with.
3 I love the last decade's version
4 of it where it had at the top of the pyramid
5 length and quality of life and disparities.
6 What a great top of the pyramid for population
7 health. Then the problem is it goes down to
8 160,000 measures at sort of the next level
9 underneath it, and the hierarchy kind of
10 dissipates, but that is a very, I think,
11 useful framing that we ought to rely on, but
12 I am just not sure about even within HHS how
13 these are harmonized.
14 DR. LINDE-FEUCHT: They are
15 harmonized, and I can tell you that some of
16 the objectives in the prevention strategy are
17 Healthy People 2020 objectives. So although
18 people love to tell us that we don't talk to
19 each other in government or within
20 departments, we do try. We are aware of all
21 these strategies and try as best we can to
22 harmonize them. But for these two particular

1 ones, they are aligned.
2 MR. BIALEK: Sarah, isn't ODPH
3 coming out with leading indicators in the next
4 couple of weeks, which will then further
5 narrow down?
6 DR. LINDE-FEUCHT: Yes. Yes. I
7 mean, the IOM has already released the leading
8 health indicators, and then there is a review
9 process in the Department to get them adopted
10 and see if the Department is going to agree
11 with or modify them slightly. But, yes, that
12 is correct.
13 MS. SAMPSEL: I don't know if I
14 want to say this or not, but I actually
15 completed a crosswalk between the National
16 Quality Strategy and the National Prevention
17 Strategy and where those data sources are.
18 So I will put it into sharable
19 format, because right now it is in Sarah
20 format, and could share it with LA or the
21 group.
22 DR. STANGE: I think we would all

1 be interested in that, and don't get
2 perfectionist about it. We will just look at
3 it. So feel the love and permission to share
4 something early on. Madeline?
5 DR. NAEGLE: I think it was Ron
6 who mentioned workforce, and I am wondering if
7 we want to talk and think about workforce and
8 numbers in relation to achieving our
9 population oriented outcomes. It is a huge
10 area, but I think that there are some areas
11 where it has more significance than others,
12 and right now I am thinking about, obviously,
13 the growing geriatric population.
14 I think that we might want to
15 consider what is available and what we know
16 about that. HHS is a good source on that, and
17 that is something that was very closely tied
18 to the recent IOM report on the future of
19 nursing.
20 So when we look at the correlation
21 between staffing patterns, numbers of nurses
22 in schools, different kinds of providers,

1 classes of providers in different settings --
2 I don't know if we want to spend a little time
3 thinking about that or asking the people in LA
4 to think about how they might factor workforce
5 in looking at care delivery.
6 DR. STANGE: But it also sounds
7 like something that NQF might be able to get
8 another contract for outcome measures that
9 relate to medical -- well, health care,
10 education for a lot of different things that
11 relate to health, whether it is going to be on
12 health professionals.
13 DR. LINDE-FEUCHT: Right out of
14 that report and right on the top, we have not
15 made any inroads to the new documents on
16 professional education, another place where
17 Canada and the UK are far ahead of us. So
18 thinking about some of that might be
19 interesting.
20 DR. STANGE: Right. Thank you.
21 Jason.
22 DR. SPANGLER: I will respond to

1 you. I had a question first, though, to Helen
2 and to Reva. How aggressive is NQF in
3 reaching out to developers and saying, you
4 know, we are about to -- we are thinking about
5 endorsing these separate measures? Do you
6 guys go to people and say, look, please send
7 us a measure?
8 DR. BURSTIN: We are as aggressive
9 as we can be, which is why in some ways,
10 because this is a different universe with the
11 exception of CDC who routinely submits to us,
12 we would rely on you to help us do that
13 outreach.
14 DR. STANGE: Reva wants to get in
15 here. They are aggressive about even getting
16 the microphone about this.
17 DR. WINKLER: The only reason is
18 because it is such a standard part. We try
19 and do the environmental scan: Who is out
20 there? Who is doing something where we have
21 some usual sources. That is what we are
22 concerned about, is this -- What we are

1 looking for now may not be in our usual
2 sources. So that is where we are really going
3 to rely on you.
4 DR. SPANGLER: So I will go ahead
5 and say this, basically knowing that I am
6 volunteering to lead whatever I am saying.
7 Going along with what Ron said is,
8 depending on what we decide on, whether it is
9 smoking, obesity or whatever, we should
10 actually -- I mean, we could do this.
11 We know all the organizations like
12 Legacy. We know all the tobacco
13 organizations. We know all the nutrition and
14 obesity organizations. We know all the
15 physical activity organizations, and we could
16 put together a list of who we should actually
17 go to, to solicit measures for. So I guess I
18 am chairing that group who is doing that.
19 DR. WINKLER: Just absolutely. I
20 mean, this is something we really request of
21 all of our steering committees, but when we
22 are doing the usual stuff, we are talking

1 about the usual folks.

2 This is not the usual folks, and

3 so this is really an important role for you

4 all to play.

5 DR. STANGE: I want to thank

6 everybody for going rapidly through -- Okay,

7 sorry. Linda.

8 DR. KINSINGER: I just have one

9 quick question. Does a group like the

10 National Governors Association -- do they have

11 a health committee or is that -- I was just

12 thinking, we have got the business folks sort

13 of -- they were here represented yesterday,

14 but a political organization, if we are

15 looking at --

16 DR. SPANGLER: Well, Linda, I

17 would also include not only them but CSG,

18 Council of State Governments, NCSL, National

19 Council of State Legislatures. There is a

20 bunch that have health related -- Yes.

21 MS. MERRILL: Do they all work

22 together, those three?

1 DR. SPANGLER: I don't know how
2 much NGA works with them. I know CSG and NCSL
3 work together.
4 DR. BURSTIN: And part of what we
5 will do, as we work with you and develop that
6 call for measures, we will give it to you in
7 a way that you can send it out to whoever you
8 want. We can have it fully coordinated, if we
9 would like, or also you may just have the
10 contacts on your own you are going to want to
11 send out to.
12 Again, we want to bring a lot of
13 technical assistance on our side with the
14 developers, making sure they understand it,
15 which is why in some ways, because we are
16 speaking a slightly different language, as we
17 learned yesterday in a big way, it is
18 especially important that we make sure that
19 those evaluation criteria speak to those kinds
20 of measures, because otherwise, they will get
21 really lost in some of that reliability,
22 validity, evidence stuff, and then they will

1 get scared off.
2 We scare off many mainstream
3 measure developers. I don't want to scare off
4 others. Again, CDC does work with us very
5 closely. We have all the HAI measures, for
6 example. So we do have a good working
7 relationship with those folks.
8 I guess one of the real questions
9 is going to be do we want to go down the path
10 of -- this is a bigger issues for all of us --
11 a whole series of the chronic indicators from
12 CDC are things like that.
13 We just went through this process
14 -- actually, Reva had that tough nut as well -
15 - with the child health measures where we went
16 through a whole series of measures that
17 emerged from the National Children's Health
18 Survey. Many, many indicators emerged from
19 that.
20 It is a national survey. You can
21 bring it down to the state level. But again,
22 some of this is also volume. We also want to

1 be careful of not bringing in hundreds of
2 measures, if that is not what we want.
3 DR. SPANGLER: Speaking to Helen,
4 is there somebody or several people from CDC
5 that you work with a lot that maybe we should
6 use as a resource to help bridge some of those
7 questions or gaps that we have? Since you
8 work with them a lot, they know all the public
9 health population health stuff.
10 DR. WINKLER: It is interesting.
11 We do have a couple of contacts, but they
12 actually come from different departments
13 within CDC for different measures. So it is
14 interesting.
15 DR. STANGE: Mike?
16 DR. STOTO: I would suggest you
17 probably need very different people from CDC
18 than you have been working with before. For
19 instance, at national Center for Health
20 Statistics, they have got the Healthy People
21 group. That probably is one to talk to.
22 MR. BIALEK: Because this is so

1 new, would it be inappropriate for this
2 committee to sponsor a webinar with potential
3 interested parties? So that is something that
4 -- Okay.
5 DR. BURSTIN: I actually wrote it
6 down five minutes ago. That would be a great
7 thing to do. As we get the evaluation
8 criteria done and we have the call for
9 measures, it would be great. Actually,. that
10 would be something Jason especially could help
11 us with, get the right folks knowing about it,
12 and we could happily do a webinar to run.
13 DR. STANGE: That is a nice segue,
14 actually, to two things that we have left on
15 the agenda, to just one more time open for
16 public comment, and then Elisa is going to
17 give us a little summary of what she has heard
18 as far as next steps here.
19 So knowing that those are the two
20 thing son the agenda, anything else people
21 would like to say here? I am really grateful
22 for how people were engaged in the initial

1 discussion, how everybody stuck with it, and
2 then we have saved some time for this.
3 This is like my children are
4 grown, but sometimes you -- when your children
5 are babies, you know, they are cranky all day.
6 It is just a tough day. Sometimes you get to
7 the end of the day or sometime when they are
8 on your shoulder and in this quiet alert
9 phase, and that is when all the big thoughts
10 and stuff come out.
11 So I think we did the hard work,
12 and then we just -- by getting quickly through
13 the others, we just created this little quiet
14 alert space here. I mean, we are quiet, we
15 are tired, but everybody looks alert and
16 engaged to me at this late stage in the hard
17 work. I think that is the kind of thinking
18 that becomes part of what we are as a group,
19 and that will carry forward.
20 So I am grateful for what you all
21 did to just get to this point, and then how
22 you have used quiet alert space.

1 That is quite a segue into the
2 comment, public comment. So anybody on the
3 line for public comment?
4 DR. WINKLER: Rufus, does anybody
5 on the line want to say anything? Rufus, are
6 you still there? Rufus?
7 OPERATOR: Sorry, hit *1 for those
8 on the line.
9 DR. WINKLER: Thank you.
10 OPERATOR: Nobody has signaled.
11 DR. WINKLER: Nobody is
12 responding? Thank you. In the room?
13 MS. MUNTHALI: Thank you very
14 much. I just wanted to go over the next
15 steps. We have quite a bit of work ahead of
16 us. Everyone did quite a lot of work. so
17 there is some follow-up that we have to do.
18 One of the follow-up, the most
19 immediate follow-up things will be the call
20 that we have scheduled tentatively for
21 September 29th and the 30th. I think we have
22 included this in slides that you have had for

1 the orientation and work group.
2 This will be to follow up on some
3 of the measure issues that we had. There were
4 quite a few recommendations and suggestions
5 that you had for the developers. So what we
6 as staff are going to do in between that time
7 is follow up with the developers, and they
8 will also be participating on the call. So if
9 you have additional questions of clarity, they
10 will be able to address those during that
11 time.
12 Yes, Sarah?
13 DR. LINDE-FEUCHT: Do you have a
14 time set for that call, because my schedule --
15 I'm sure everybody else's -- fills up pretty
16 quickly, and that is in two weeks.
17 MS. MUNTHALI: Well, yes. so we
18 were waiting until this meeting to confirm
19 that we are indeed going to follow. So either
20 probably tonight or tomorrow, you are going to
21 get a survey monkey, similar to what you have
22 gotten from us before, with some times for

1 either one of those dates. It will be
2 majority rule, similar to what we have done.
3 We will do the 30th. Twenty-ninth
4 is out. So let us know if you can't do that
5 date, and we can possibly push it out a couple
6 of days, so maybe the first week in October.
7 Then one of the major deliverables
8 that is coming up is the due date for our
9 draft report.
10 DR. STANGE: Actually, just on
11 that last item. So I think it would be
12 important to not just have that be just about
13 the measures follow-up, but to be also about
14 the follow-up of these other issues.
15 So it is not reasonable probably
16 to have these small groups configured and have
17 met by then, but I think we want to maybe have
18 them configured by the time of the call, and
19 to be able to give a charge to the groups
20 about what they are doing.
21 I wonder if we want people from
22 the commissioned paper on that part of the

1 call.

2 MS. MUNTHALI: And the next slide

3 for Phase 2 has the work group follow-up call.

4 DR. STANGE: But I would say that

5 I think the call shouldn't be just about the

6 measure follow-up on September 30th. I think

7 we need to keep the other agenda item on

8 there. I think that will help us keep

9 people's interest.

10 MS. MUNTHALI: So we can do a two-

11 hour call, and so the first part do the

12 measure review.

13 DR. BURSTIN: She just has it

14 split out by phases. That's all.

15 MS. MUNTHALI: Yes. So the draft

16 report will be on our website for member and

17 public comment October 17 through November

18 15th, and we will make sure that we circulate

19 it, as Helen mentioned, to the committee for

20 your feedback at least two weeks before. It

21 will give you some time to review it.

22 Then following the draft report,

1 we will circulate any comments that we
2 receive, and staff will help the committee to
3 draft responses. Any comments that are
4 specific to the developers, we will send to
5 them, ask them to comment on that, and then we
6 will have a conference call where members and
7 public will be there to look at the comments
8 and look at the responses.
9 Then I think that is it. I am
10 having trouble looking at the last bullet.
11 Yes. So we have the comment there.
12 DR. STOTO: That all refers to the
13 preventive services measures.
14 MS. MUNTHALI: Yes. Yes, so Phase
15 1 which we are calling preventive service
16 measures. So this is Phase 2. This is the
17 discussion that you had yesterday and you
18 followed up with today, and we will be
19 scheduling those conference calls within the
20 next two to three weeks, and we will make sure
21 that LA County is there as well to
22 participate.

1 Then you will be providing
2 feedback to us on the call for measures for
3 Phase 2, which is the healthy behaviors, and
4 we will make sure that we have a good exchange
5 of feedback through email.
6 Then the first draft of the
7 commission paper, we are hoping, we will be
8 due by the end of November, but this may
9 change. These dates for Phase 2 are not as
10 strict as they are for Phase 1. So I just
11 wanted you to keep that in mind.
12 DR. BURSTIN: We will work to make
13 sure that the Work Group stays sort of
14 interdigitated with what LA is doing so that
15 you don't get a commission paper sent to you
16 in a month or a month and a half that doesn't
17 meet at all our discussion. So we will keep
18 those aligned.
19 MR. STIEFEL: Can you help us with
20 the Work Group logistics?
21 DR. BURSTIN: We will take care of
22 all that.

1 MR. STIEFEL: That is not on this
2 list.
3 MS. MUNTHALI: No. We are going
4 to -- Crystal and I will handle it tomorrow.
5 We are going to confirm who is on each work
6 group, and we will work all of that out.
7 DR. STANGE: And part of that will
8 be including people who didn't have the
9 benefit of this discussion today. So there
10 needs to be a way for people to identify with
11 groups, although I guess we could use the
12 starting groups from last time.
13 I want to thank Donald for keeping
14 the AV going, the committee people from NQF,
15 Elisa, Reva, Helen, Robyn, Kristin, Nicole,
16 and the man in the blue tie over there who has
17 been transcribing. His name I don't know. I
18 guess in the NQF staff I should include Bonnie
19 who had a consultative role but had some
20 history in helping to birth this process, and
21 those who stuck with us for the whole day, the
22 measure developers.

1 So thank you very much.

2 DR. BURSTIN: Thanks to Kurt for

3 yeoman's work today.

4 (Whereupon, the above-entitled

5 matter went off the record at 2:44 p.m.)

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

A

AAA 3:15 209:19 210:17,22 213:3 215:1,3,12,13 221:20
abbreviations 49:3
abdomen 219:2
abdominal 207:20 209:18,22 210:1 210:16,20 216:20 216:21 217:19 218:2 221:16,21 222:13
abeyance 150:10
ability 134:14,15 139:2 183:16 263:18 322:3
able 10:4 23:3 83:18 87:2,5,13 100:15 107:3 109:17 115:1 120:22 123:22 129:2 131:6,9 134:16 143:12 144:20 155:5 165:2 166:3,19 192:17 198:6,8 205:18 206:6 209:4 231:17 232:16 239:21 243:13 274:4 286:9 292:19 295:10 303:6 317:5,10 345:13 355:5 360:7 370:10 371:19
abnormal 175:1
abnormality 200:6
above-entitled 108:11 244:10 376:4
absent 294:18
absolute 335:22 338:7
absolutely 50:10 76:6 195:7 233:7 362:19
abstraction 144:12 144:14
academia 152:14
Academy 27:14
accept 149:13
acceptability 57:21 103:20 261:17
acceptable 41:22 270:12 317:11
acceptance 212:5
access 142:5
accessible 231:19
accommodates 72:3
accommodation 113:22 114:4
accomplish 84:7
account 304:20
accountability 338:16 339:4,5,8 346:6 347:5,7,21 348:12
accountable 346:13 346:15 351:22
accreditation 330:15 349:22 350:1 353:22
accuracy 156:10 290:13 313:13,16 318:16
accurate 29:4 121:14 161:11 313:18
achieving 163:15 359:8
ACIP 49:14 63:15 63:16 66:15 73:2 73:3 246:8 249:6 263:15 307:15 309:19,20 310:2 315:22,22 316:5,6
acknowledge 149:9
acknowledgement 238:17
acknowledging 146:9 148:20
acknowledgment 238:20
ACOG 125:6 134:9 176:1,5 177:1 181:14 182:4 183:11 184:3 185:4,14
act 45:10,12 90:13 90:14 136:17 150:11
actionable 10:18 11:8 12:1
active 2:15,19,22 3:15,19 117:11 118:19 119:19 208:6,8,10 210:2 210:9 211:22 224:20 225:10 253:3,16 264:16 298:21
activities 325:6
activity 65:18 66:8 68:5 352:15 362:15
actual 11:4 60:16 60:17 150:17,18 161:14 211:12 225:7 230:8 322:4
Acumen 2:16 291:9
ad 125:21
ADAMS 2:5
add 46:3 79:14 80:7 84:16,17 96:19,21 112:13 116:3 119:1,8 124:14 179:12 187:14 252:5 304:5,5 323:11 324:7 333:3
added 52:19,21 191:19 222:6 303:21,22 348:2
adding 30:19 31:18 32:13 34:17 111:19 112:2,12 243:7
addition 40:11
additional 13:3 42:7 53:13 73:6 88:7 106:6 107:6 125:21 138:3 146:2 169:18 185:10 199:10 201:20 231:6,7,7 233:2,3 261:21 274:18 275:21 298:1 300:18 318:7 351:11 370:9
additionally 28:4 30:5 66:13
address 32:19 39:19 85:21 131:6 141:10 209:2 249:20 256:21 257:4 282:9 294:10 299:17 370:10
addressed 256:10 313:16
addresses 210:17
addressing 28:10 192:4 209:4 264:9 349:10
add-on 221:22
adequate 221:6 222:15
Adjournment 4:21
adjust 52:4
adjusted 336:7
adjustment 168:10
administer 212:9
administered 187:19 192:16 250:17,19
administering 54:2
administers 196:1
administration 1:17 60:17
administrative 51:13 118:17,20 119:3,4,13 130:12 132:20 156:12 175:13 188:13 192:18 253:14 255:18 309:12 311:1,19 313:21
administratively 118:16
admitted 96:9
adolescent 52:17 117:21
adolescents 52:20
adopted 358:9
adults 3:19 48:2,4 49:4,5 170:15 246:14
advance 7:1,4 280:7 282:6
advanced 330:14
advantage 17:11 189:6 195:22 196:1 201:7 250:20 251:6 299:7 306:6
adverse 310:15,16 310:19
advised 34:9
advisors 153:6
advisory 27:12 49:12 153:4 188:18 193:9
advocate 227:15
advocates 26:5
affect 58:12 139:20 141:21 190:22
affirmatively 188:1
afternoon 80:14 320:12
afterward 140:18
age 25:6 31:13 48:6 48:9,12 49:10 51:4,6,19 52:6 53:3 55:6 92:20 110:4,20 117:10 122:16,19 123:20 123:21 124:3,5 126:13,19 128:1 129:16 131:8 135:12,13 146:2 147:12,21 154:13 155:2 171:5 182:3

182:6,9 194:13,18 197:14,17 201:13 209:19,21 210:18 249:4,19 253:5 254:2,14 262:1 292:18 302:5 307:14
aged 27:8 46:13 48:2,4 62:16 71:9 81:8 186:18 187:22
agencies 113:16 347:1
agency 297:16,17
agenda 7:17 46:9 77:22 80:11 108:7 109:20 186:2 200:8 207:15 228:19 246:1 329:18 367:15,20 372:7
agendas 133:6
agent 294:4
agents 295:7
ages 133:18 170:18 171:22 210:17
aggregate 163:1 295:13 324:22
aggregating 324:2
aggregation 323:20 338:22
aggressive 181:11 361:2,8,15
ago 33:16 34:8 44:17 72:7 77:18 80:19 82:3 110:13 110:14 114:2 157:1 191:19 205:17 214:5 367:6
agree 34:18 37:1 72:22 76:22 98:11 130:16,17 132:13 143:4 157:20 158:21 214:14 222:15 236:11 240:14,21,22
241:5 358:10
Agreed 184:21
agreement 65:12 99:9
ahead 43:2 48:18 62:4 64:16 171:11 186:4,8,12 228:6 248:1 252:20 276:8 301:1 324:15 344:13 360:17 362:4 369:15
AHRQ 61:1
aims 340:14,15
air 355:20
alert 258:7 368:8 368:14,15,22
algorithm 162:3,13
align 110:14 116:8
aligned 110:21 117:18,21 118:7 126:17 127:8 153:20 163:21 249:13,16 307:15 307:16 358:1 374:18
aligning 120:8 123:12
alignment 34:12 99:17 251:2
Allen 2:20 173:1,2
allergy 257:17 258:9 269:6
alliance 25:5 26:4,4
allow 29:4 64:20 68:7 122:17,22 205:8 217:16 220:7 304:6,19
allowed 274:4
allows 64:20 274:7
alluded 356:3
alluding 324:20
alongside 125:6
alternative 35:14 198:3 341:5
alternatives 195:16
ambulance 6:2
ambulatory 68:5 70:2 71:12 96:1 96:12,13 104:7
American 1:22 23:19 27:13 125:6 174:3 177:1 181:22 207:19
Americans 288:10
AMI 337:11
Amir 1:22 23:10,11 23:18 24:14 29:17 29:20 33:13 42:20 58:1 75:8 83:14 99:7 103:11 106:16 124:17 140:13 144:16 145:1,9 147:20 181:17 216:1 229:10 232:10 234:3 247:7,11,15 251:14 262:12 265:18 272:8 285:13
Amir's 44:5 101:2 275:5
amount 162:8 192:21 256:22 282:4
ample 63:18
analyses 106:6 160:6 165:2,22 166:4 317:8
analysis 29:3 35:16 53:15 61:9 64:15 107:4 175:13 246:19 253:12
analyzing 183:15
ANDREW 2:2
anecdotal 272:19
aneurism 207:21 209:18,22 210:1 210:16,20 219:13
Angela 157:2
ANN 2:8
annual 3:12 27:10 171:20 174:8 175:21 176:2
177:3 180:20 181:10 183:12
annually 174:12
answer 49:21 55:8 55:13 59:11,20 60:5 79:19 122:2 228:22 240:12 341:4
answered 55:6,9 60:19
answering 241:8
ant 95:18
anticipate 141:15
anticipating 64:12
anticipation 221:9
anti-smoking 349:6
Antman 2:13 62:22 63:4 64:17 67:6 68:22 69:12,22 70:7,11,19 74:1 75:7 76:6,22 80:4 80:12 226:11 228:15 229:5 230:3 232:10 233:6 238:11 240:8
anxiety 242:1
anybody 6:3 48:19 81:15 83:2 102:8 108:4 143:9 172:8 172:10,14 186:11 208:8 229:11 277:5 287:11 289:9 316:8 369:2 369:4
anymore 127:12 239:15
anytime 192:12 216:8 269:2 272:3 314:17
anyway 38:20 105:11 137:5,22 150:9 154:6 157:15 200:14 234:19 353:4
aorta 216:21 221:14 223:6
aortic 207:20 209:18,22 210:1 210:16,20 217:7 217:19
apart 149:20 259:13
apologize 112:10 115:13 116:5 167:6 301:12
apparently 105:14 197:22 222:3 290:15
appear 71:4 126:8 218:19
apple 157:13
applicable 54:1,6 54:18 251:5 265:16
applied 90:21 139:12,15,16 333:20
applies 103:18 216:18
apply 35:17 160:11 236:12 335:6,15
applying 160:5
appointed 7:15
appreciate 109:12 228:5
appreciated 318:11
approach 94:2 125:4 138:1 150:22 279:10,13 328:10 353:11,12 354:19
approached 33:18
approaches 15:13 15:21
appropriate 40:12 51:6 73:9 89:20 93:9 110:4 163:16 167:5 171:3 178:15 280:20 294:9 297:3 302:9 321:9 336:16 339:21 340:21,21
appropriately

190:7
approval 136:7 332:18
approvals 91:16
approve 38:8 42:5 44:12 89:17 105:20 137:8 147:7,8 153:7,7 184:15,19 202:17 239:14,14,22 266:8 275:11 276:3
approved 22:13 49:19 91:19 99:22 105:7,14 135:15 136:6 137:12,16 138:9 290:20
approving 91:14
APRN 1:19
area 126:2 195:6 282:7 323:11 339:1 341:17 344:8 359:10
areas 24:15 109:4 352:15 359:10
argue 239:7 279:20
arguing 277:6
argument 33:8 194:10
arises 298:8
articulate 9:16 15:21 16:20 232:17
articulated 346:8
artificial 154:17
aside 36:16 215:5
asked 71:14 142:3 183:21 232:22 290:2 298:14 312:1 315:13,20
asking 40:2 76:16 78:4 79:9 164:11 164:13,14,15 188:2 201:14 255:2,4 259:1 292:14,20 299:8 345:8 360:3
asks 42:11 97:8 200:4 247:4
aspect 21:14,16 87:21 282:20
aspects 18:10
asplenia 253:10
assert 28:9
assess 76:5,9 281:6 312:17
assessed 74:18,19 85:3 314:14
assesses 117:9 187:22
assessing 57:16,17 76:17
assessment 29:4 45:18,22 76:20 97:18 122:11 231:12 239:12 240:22 241:4 256:14 286:12
assessments 59:22 99:19 333:2
assign 339:5
assigned 22:6 155:4 338:16
assignment 19:21 95:5
assist 303:19
assistance 328:12 364:13
Association 207:20 350:15 363:10
assume 59:14 172:2 185:9
assumed 219:2,2
assuming 219:10 219:19 248:15,20
assumption 220:1
assumptions 275:9
assurance 200:15 202:15
ASTO 350:15
asymptomatic 174:21
attended 320:8
attending 133:6
attention 6:21 22:21 89:11 121:7 126:3 138:13 193:22 211:10 242:10 276:19,20 310:11 319:21,22
audience 334:7
audiences 120:22 224:12 242:4 291:3,18 292:3
audio 116:17
audit 290:13
audited 156:9 290:14 314:12
august 125:7
automatically 71:4 71:12 169:13 272:4
Automotive 207:19
AV 375:14
availability 24:22 234:6
available 9:12 25:10 54:4 64:4 65:20,22 66:11 74:6 80:14,15 88:18 131:18 213:17 232:13 321:13 359:15
average 48:11
awakened 6:1
award 161:16
aware 30:22 34:9 34:13 51:20 52:10 123:11 202:10 357:20
awareness 93:20
A-F-T-E-R-N-O-... 245:1
a.m 1:10 5:2 6:1 108:12,13

B

B 176:3
babies 368:5
back 6:10 8:15 13:9 13:20 16:11 44:7 45:5 48:16,18 72:14 76:13 77:1 79:8,20 81:3 82:7 91:15 92:4 97:19 100:3,22 101:12 104:14 106:5,19 106:20 107:5,6 108:8 111:15 116:22 121:5 125:21 127:6 146:16 150:5 183:17 185:4 188:7 198:16 202:8 217:13 222:22 224:3,17 227:1,18 228:2 229:2,7,12 231:3 232:16 233:3,19 233:21 235:10,14 236:6 237:21 238:1,4,7,19 239:18 240:4 242:13 243:14 244:2,7,8,8 247:15 250:4,18 264:9 265:2,18 271:15 275:14,16 278:4 284:2 296:19 299:2 300:19 301:5 302:22 304:1 307:19 314:9 319:18,18 320:7 320:12 339:13 342:22 348:21 354:7
background 20:9 26:13 93:8
bad 162:5 342:6,7
bag 244:1 245:7
balance 134:18 178:21 282:5 320:10
balanced 203:16
balancing 179:1 195:12
band 53:3
bang 327:14
Bani 2:22 210:8
bar 199:20 314:13 333:19 334:3
barium 115:8
Barton 2:13 116:3 124:18 141:22 194:6 199:20 202:8
base 354:4
based 8:3 19:2 21:17 24:22 46:12 71:5 73:7 91:16 93:11 130:20 133:5 151:6,7 153:3,4,5,13 158:7 162:1 166:14 174:2 175:13 180:3 181:19 182:6,17 184:15 197:9,20 202:21 205:12,19 206:8 214:5 228:7 230:16 253:14 255:17 258:6 264:2 311:19 313:10 317:8,9 321:14 334:13 355:3
basically 70:1 91:18 119:11 123:22 176:6 248:22 276:13 301:21 309:18 315:12 340:9 362:5
basis 40:22 171:4 294:3
BC 1:19
beat 330:1
beginning 68:9
begs 273:17
behalf 60:9 241:10
behave 52:13
behavior 31:5 38:15
behavioral 15:12

believe 33:15 37:21 46:18 60:21 61:3 63:18 64:5,8 69:2 70:13 80:5 114:15 115:4 121:8 134:21 163:11 175:7 182:5 191:18 200:3 211:1 221:12 247:7 256:5 285:3 338:9 351:11
belongs 76:8
ben 198:17
beneficiaries 187:20
benefit 139:10 145:22 214:14,16 220:7 375:9
benefits 128:10
best 45:17 46:2 62:3 88:4 119:7 119:14,22 132:14 147:18 165:16 314:19 315:2,4 343:7 357:21
Bettencourt 168:21
better 25:22 26:1 74:16 84:11 130:5 131:16 187:10 249:6 276:7 286:11 301:17 306:1,2,3 310:6 312:7 331:6 343:5 349:19
bewildering 207:10
beyond 15:9 31:19 79:5 167:1 189:6
BIALEK 1:13 318:10 325:15 339:14 353:20 358:2 366:22
bias 111:7
big 11:16 12:11 15:4 42:18 100:13 100:17 101:8 103:13 189:12 207:15 278:17 290:3 303:2 310:19 319:22 323:6 324:13 327:12 356:19 364:17 368:9
bigger 144:18 186:9 204:7 231:17 279:1 327:12,16,18 365:10
biggest 307:3
bilateral 132:4
biopsies 146:3
birth 375:20
birthday 302:7,7 302:11
bisphosphonate 189:3
bisphosphonates 189:20 195:8
bit 5:20 15:10,19 28:8 32:10 34:14 35:22 51:22 63:22 65:10 98:9 109:20 120:21 123:13 162:19 176:4 189:16 199:12 215:2,5 226:13 235:5 262:15 266:4 271:20 278:13 311:12 319:10 339:22 340:1 345:12 347:20 369:15
black 329:12
bladder 222:16 223:16
blah 145:22 146:1 146:1 268:4,4,4 269:7,7,7
blaze 165:9
blind 47:21
blue 375:16
board 24:12 152:16 349:22 353:22
boards 24:2,15 350:15
bodies 125:7 354:19
body 68:21 124:11 180:3 288:19,22 340:22
bone 186:19 188:3 192:2 195:2 199:4
bones 188:5
Bonnie 375:18
BOSSLEY 2:6
bothered 83:11
bought 351:1
BOWMAN 2:14 173:17,19 177:20 178:3 183:1,10 184:6 185:18
Bowman's 173:16
box 15:20 138:2 322:21 323:4 325:1
brackets 171:6
Braly 157:3
brand 52:22
break 106:14,16 108:8 159:11 171:5 186:3,6,11 207:18 222:1 243:22 259:13 303:6
breakdown 318:11
breaking 149:20
breaks 189:10
breakthroughs 347:14
breast 3:10 121:16 145:21 235:21 237:4,15 238:2
breath 301:4 320:11
BRFSS 14:14 97:8 171:5 251:1 343:3
bridge 366:6
brief 30:8 279:5
briefly 23:12 69:6 110:9 167:19 173:10 248:4 296:7 353:20
brilliance 111:3
bring 13:9 23:1 25:21 46:3 74:14 98:17 100:22 115:15 125:21 128:20 138:13 193:21 197:7 198:7 199:21 206:13 211:9 221:8 222:21 224:17 233:19,20 238:1 240:9 242:15 244:8 251:1 264:9 299:2 312:10,11 322:13 329:6 364:12 365:21
bringing 17:19 139:1 156:1 272:10 366:1
brittle 188:5
broad 16:12 18:3 34:3 37:5 58:14 177:21 283:7 291:18 292:2
broaden 265:16 356:13
broadened 82:8 274:11
broader 14:20 36:10 88:19 95:1 147:3 178:8 274:15 280:3
broadly 88:18
broken 352:20
brought 53:14 54:12 72:7,11 127:5 135:17 140:13 172:7 203:14,17 214:10 237:3 265:18 338:7
buck 327:14
bucket 331:6
Budget 164:6
building 44:21
built 41:16 215:16 215:21
bulk 65:17 66:8 67:9 68:4 77:3
bullet 373:10
bumped 5:6
bumping 58:8 138:4
bumps 281:2
bunch 254:19 302:19 350:2 363:20
burden 69:8 73:6 119:4,15 132:20 188:14 196:8 204:3,11 207:6 231:6,13 233:4 286:16
burdensome 67:14
BURSTIN 2:6 13:3 13:13 14:9 17:2 18:1 21:4,9 23:7 41:6 44:16 45:12 54:7,11 59:3,17 72:17 79:3 83:15 85:19 86:22 87:15 89:1,7 91:18 94:6 96:6,16 97:7 104:2,19 105:1,17 107:2 115:16 116:19 117:20 125:10 136:9 137:2,10 138:12 140:4 150:1 151:1 151:12 154:7 157:19 167:11,20 168:20 169:9 176:9 181:17 184:21 185:7,19 200:20,22 205:2,8 206:19 212:20 214:3 223:1,10 229:9 230:14 233:16 237:12 239:9 240:18 249:10 262:9 263:14 264:15 270:7 271:14,19

277:11,16 279:16 281:4 284:9 285:3 286:4 315:5 317:7 330:2 332:1 338:12 342:12 361:8 364:4 367:5 372:13 374:12,21 376:2
bushes 330:1
business 2:2 188:17 328:16 330:14 363:12
busy 49:18 281:20
button 107:17
Byron 2:14 48:20 48:21 51:9 52:18 53:4,21 54:9,14 54:22 55:4,15,19 56:1 58:20 61:10 110:10 112:4 114:6,18 115:10 116:2 117:15 118:2 121:22 123:8 126:15 128:13 130:4 131:4 135:10,17 136:7,19 139:5 140:11 141:12 151:4 152:9 155:18 158:5,21 159:16 163:10 166:10 187:2,6,10 198:11 199:14,18 205:13 246:22 250:1 300:2,6,10 303:9,14,18 304:17 306:8 307:6,12 311:18 312:3 313:20 314:8 317:16 318:1 319:1

C

C 158:7
CAHPS 48:7 49:6 49:7,8 54:2,8,9,10 55:7,16 56:4,5,6,7 59:19,21 60:3,8 60:20,22 61:2,11 61:14 90:6
cajole 91:12
calcitonin 194:21
calcium 194:21
calculation 203:4
California 24:10
call 9:7 11:3,4 19:9 20:22 58:9,15 83:8 196:19 218:15 259:3 284:14 328:8 355:8 364:6 367:8 369:19 370:8,14 371:18 372:1,3,5 372:11 373:6 374:2
called 71:1 219:5 277:19
calling 187:4 247:1 373:15
calls 17:20 321:8 373:19
Canada 15:11 248:7 360:17
cancer 3:9,10,11 109:11,13,19 110:3,5,17 121:16 125:6 141:6 145:22 154:20 155:3,9 159:22 160:1 170:2 171:10,15,20 172:5 173:8,21 174:9,14 175:5 179:13 181:22 182:8 235:21 237:4,16 238:2
candidate 3:8,13 3:18 4:8 350:7
CAN-2 174:9
CAN-3 174:9
capturable 220:10
capture 19:16 65:17 66:7 68:4 75:18 139:2 192:17 204:12,13 215:18 217:19 223:6 241:20 337:18 349:18
captured 52:15 53:4 204:2 214:21 242:2 273:11
captures 142:7 204:9
capturing 114:5 128:2
carcinoma 172:3
card 151:18 179:20 279:11
care 2:21 25:4 26:3 26:5,6,7,8 28:16 29:1,5 89:9,15 94:19 96:1,12 97:17 104:3 116:12 138:11 143:11 160:12,17 163:12 165:7,8 194:18 198:4 226:15 237:9 246:10 287:5,22 292:7 313:3 323:1 344:7,9 348:1 356:10 360:5,9 374:21
career 157:15
careful 22:20 89:11 120:17 215:2 366:1
carefully 227:2 311:11
carry 320:18 368:19
case 23:22 71:7,7 100:3 128:12 213:2 234:22 236:1 237:3,6,16 288:5 338:18
cases 116:5
Cassia 287:9
catch 116:7 185:21 252:19
catchment 344:8
categories 33:22 83:22 86:14 102:16 164:6
category 16:19 92:19 164:12 232:3 310:14
caught 108:6 123:12
causal 343:2
cause 73:20
cautioned 176:10
caveats 335:6
cc'ed 20:7
CDC 24:4 49:13 263:9 288:9,20 354:15,15 361:11 365:4,12 366:4,13 366:17
CDC's 27:12
center 1:14,15 318:19 366:19
Centered 54:12,15
Centers 27:1
centimeter 219:9
centimeters 218:2 218:8
central 197:16
CEO 157:3
certain 131:15 153:8 184:6,8 198:19 205:15 206:10 221:19 330:16 340:9 349:5
certainly 15:16 19:4 38:8 45:4 50:11 86:20 99:15 100:19 122:15 149:14 184:10 216:11 223:8,13 223:18 225:19 232:19 241:19 270:3 274:15 279:20 293:10,18 295:13 332:17 333:15 355:22
cervical 3:11,12 109:19 141:6 154:20 155:3,9 159:22 170:1 171:10,14,20 172:1,3,5 173:8 173:21 174:6,14 175:5 176:18 179:13
cervix 142:2 157:16 172:4
Chair 1:10,13
chairing 5:10 362:18
CHAIRMAN 106:9
Chairs 7:15
challenges 30:3
challenging 7:22 92:8 347:4
chance 19:6 23:1
CHANDLER 2:7
change 31:5 38:15 88:18 104:12,17 126:10 127:4 130:19 136:14 145:7 153:22 157:14 184:12 192:14,15 216:11 230:15 234:22 265:2 300:20 322:5 342:1 374:9
changed 51:3 101:19 191:5 256:16
changes 49:20 52:1 116:7 140:3 190:21 191:13,14 193:16,20 196:12
changing 7:5 184:20 195:3
channels 105:22
characteristics 57:9
characterization 203:18 292:8
characters 329:1
charge 5:19 7:12

13:22 97:6 260:15 300:13 331:10,19 348:15 356:5 371:19
charged 17:6,7 315:8
charges 20:3
charts 68:15 336:11
check 115:11 151:12 186:19 187:2 188:3 205:18
checkbox 129:3
Cheryl 354:21
chief 219:17
child 117:22 118:3 308:13 319:3 365:15
childhood 4:10 242:20 245:16 263:6 298:13 301:2 302:2 308:21
children 52:16 89:3 263:6 309:11 368:3,4
Children's 365:17
chime 69:3
Chin 2:15 209:14 253:18,19,22 254:21 255:8,20 256:18 257:5 258:5,22 259:11 260:4 261:3 262:3 262:6,22 263:12 265:1,7
chlamydia 3:10 117:8,12,18 118:5
choose 70:20 138:17,18 143:22 201:6
choosing 67:21
chose 68:5 115:1 137:3
chosen 68:1 69:21
chronic 288:11,12
365:11
CHRs 214:8
chunk 101:8
churning 6:6
cigarette 340:8 343:4
CIN-2 172:2 177:12
circulate 372:18 373:1
circumstance 298:8
CIS 175:2
cite 248:17 270:12 288:20 316:6
claims 119:13,15 143:15 175:14 214:5 253:14 255:16 260:13,16 311:1 313:22 315:9 317:8
clarification 86:18 115:17 212:21 248:13 268:10 275:7 280:21 283:17 290:5 299:11
clarifications 292:6
clarified 215:11 309:16
clarify 55:12 74:9 83:18 115:6,21 120:3 235:5 262:15 275:15,20 283:19 307:6 312:7 328:1
clarifying 263:15
clarity 370:9
class 45:17 46:2
classes 360:1
clean 300:1 355:20 355:20
clear 42:2 44:16 45:9 86:12 94:4 100:6 102:19 125:11 129:18 131:2 216:3 230:6
233:6 271:20 284:18,21 304:13 339:16
clearcut 236:19
clearer 311:4
Clearinghouse 330:16
clearly 18:6 86:2 200:1 207:16 233:22 238:4 243:7 267:6 292:18 317:7 332:4 333:11
climate 148:10
clinical 23:19 27:2 27:11 66:13 80:13 87:8 109:21 143:15 175:14 180:7 203:1 210:10 226:14,14 230:9 232:13 243:3 253:15 258:6 259:14 301:7 311:1 326:4 326:10 327:1 337:16 342:17 343:16
clinically 181:6 214:5,7
clinician 53:16,17 63:10 66:11 68:3 69:13 114:10,11 114:13 155:11 205:14 219:11 246:19 253:13 338:17
clinicians 68:7 194:18
clinics 313:7
clock 252:21
close 29:15 77:21 240:10 245:15,22 330:5 356:9
closely 227:10 359:17 365:5
closer 181:5
CMS 3:22 27:4
39:7 46:11 47:2 71:2 81:15,22 84:6 86:19 94:22 190:11,15,20 191:10 193:3,6,11 195:17 196:9,18 197:4 206:3,6 284:4,19 285:1 286:5,10 287:4,8
CMS/OFMQ 3:6 3:21
coalition 2:2 350:10
code 71:12 73:7 162:1 215:17 224:11 225:14
codes 51:13 118:21 175:8 221:17,19 222:4 255:15
cohort 248:7
collaboration 346:16
collaborations 350:13
colleagues 69:2 80:5
collect 164:4 293:2 293:9 322:2
collected 49:6 92:9 94:22 205:4 213:21
collecting 123:5 160:18 163:22 166:1
collection 91:2 163:18 165:11 166:8 167:2 201:5 205:1 213:15 351:7
collections 201:10 322:2
College 1:19,22 23:19 174:3 177:2
colonoscopy 110:18 112:8 114:1
Colorado 2:18
293:22
colorectal 3:9 109:11,13 110:2,5 110:17 160:1
colposcopy 180:13 180:19
combination 103:20 302:18 307:3 320:1 346:21
combinations 302:17 303:17,18 306:16
combine 10:15,16 164:19
combined 42:9 84:1
combines 15:11
combining 38:9 53:11
combo 304:4 305:15 306:11 307:21
combos 303:1,11 304:3,6,18,19 306:18
come 12:14 13:20 14:13 45:5 58:7 82:7 91:12 95:12 99:1 104:16 106:5 106:20 108:8 141:7 150:5 154:11 170:18 184:1,9,16 215:4 226:9 230:18 238:19 244:2,7 250:4 300:19 311:7 316:1 323:12 324:3 329:20 340:21 350:17 355:21 366:12 368:10
comes 31:6 37:18 39:15,16 88:9 128:5,22 187:17 190:19 214:18 215:14 247:15

250:18 266:20 311:6 329:9 342:21 346:10
comfortable 40:8 220:1
coming 16:11 68:20 77:21 161:14 193:19 208:5 228:2 248:7 358:3 371:8
comment 3:7,17 4:16 33:12 105:21 106:15 107:11 108:5 136:1,2,3 136:21 137:19,22 143:7,8 151:6 152:6,22 153:9,10 171:2 190:8 195:14 198:6 202:6 213:14 218:8,10 219:13 225:10 226:1,10 258:3 262:11 282:19 287:20 289:11,12 290:12 301:4 305:6 318:9 332:3,13 351:11 353:21 355:13 367:16 369:2,2,3 372:17 373:5,11
commented 219:18
commenting 218:1
comments 15:8 22:5 25:16 29:18 63:3 83:3 109:15 112:15 121:21 153:11 156:17 169:21 171:9 177:9,10 224:5 229:12 247:11 250:15 252:13 373:1,3,7
commercial 155:20 156:4
commission 168:1 374:7,15
commissioned 9:14 168:7 345:6,10 347:17 348:15 371:22
commit 10:4
committee 1:4,9 8:22 27:12 29:8 29:12 31:19 45:9 49:12,16 50:21 63:22 64:13 65:9 77:19 105:19 121:11 123:10 124:9 129:19 136:17 137:6,15 138:6 150:7,17 152:11 153:2,14 154:8 167:7 168:2 168:5 185:11 188:9 198:7 199:21 211:6 231:4 238:14 239:12,19 241:5 241:10,14,15 242:6 281:5 282:9 282:13,15 285:6 294:8,16,22 328:4 332:18 339:13 342:13 345:15 356:5,15 363:11 367:2 372:19 373:2 375:14
committees 24:5 232:20 282:17 286:15 312:13 328:3 362:21
committee's 9:21 138:13 211:10 226:17,22 236:20 331:10,19
common 20:10 146:1 203:19
communicating 216:5
communication 17:4 196:21,22 197:6 290:7 292:1
communities 113:18 351:1,5
community 7:6 12:19,21 113:11 171:4 287:16 318:19 322:1 339:7 343:22 349:8 350:9 352:19
comparability 138:19
comparable 97:4
compare 285:1 305:21
compared 175:6 203:19 251:7 260:2
comparison 91:21 120:5
compass 305:1
compelling 194:9
Competency 294:15,22
competing 41:21 45:7,17 85:12 103:22 105:6 106:8 133:1 207:13
complete 215:9,19 215:21 217:20 219:14 226:18
completed 211:8 336:21 358:15
completely 28:5 35:2 42:1 130:15 146:14 198:18 200:6 238:5,6 336:13
completeness 313:16
completion 217:17
compliance 93:21 213:11 260:7
compliant 55:10 140:19
complicated 166:12,12
complications 259:7 337:13
component 168:14
components 223:8 223:13
composite 97:1
comprehensive 178:14
comprise 242:5
compromise 307:1
computed 34:1 86:17
computer 43:1
conceptual 351:9
conceptualized 342:9
concern 35:9 38:8 45:10,11 53:11 59:4 72:6 77:17 77:18 78:13 80:18 85:8 87:19 111:21 212:19 238:11,14 239:5 242:1 266:1 272:15 275:5 282:1 316:21
concerned 66:2 77:20 124:4 127:14 129:15 132:7 219:17 276:5 281:1 310:4 316:4 361:22
concerns 53:13 79:5 84:15,21 106:7 112:1 115:14 116:14 120:12 129:8 157:10 185:16 190:1 195:8,10 249:8 252:7 261:5 279:15 298:21 312:10
conclusion 227:17 228:3
concur 241:5
condition 44:19 89:3 191:21 194:9 253:5 254:3 262:10 263:2 323:15
conditional 283:5 283:16
conditions 41:11 105:3 174:22 183:6 246:11 253:7 288:11,12
confer 226:13
conference 17:20 19:9 373:6,19
confidence 154:17
confident 222:17 311:13
confidentiality 232:7
configured 371:16 371:18
confirm 86:5 87:9 89:8 370:18 375:5
confirmed 84:6
conflict 23:13 68:1 97:15
conflicting 176:13
conflicts 24:1,7,13
conform 34:7 295:21 299:3 309:1
conforming 298:22
conforms 131:10 296:10
confused 86:22 177:15 297:12 300:11
confusing 55:11 115:18 307:22
Congratulations 319:19
congruent 147:13
conjunction 160:11
connected 191:9 193:6
cons 50:22
consensus 8:18 11:22 12:15 62:6 62:7 101:13 108:20 116:13 123:17 168:17 180:2 332:17

consequence 158:19,20 216:2 272:17
consequences 148:11,14 272:11
Consequently 71:11
consider 35:12,21 50:22 54:17 78:1 78:3 135:4 138:4 138:7 170:8 183:10 210:16 219:14 227:2 233:5 237:22 238:19 245:13,18 251:16 264:13 279:15 280:15 285:16 301:5 312:20 318:8 321:1 359:15
consideration 3:3,8 3:13,18 4:8 29:8 36:1 105:3 137:6 137:7 211:11,21 224:18 286:3 351:17
considerations 126:21 150:12 169:10 246:1 290:11
considered 28:20 52:8 112:7 158:4 182:15 183:9 215:9,21 217:20 329:11
considering 103:8 111:19 112:12 124:5 147:17 196:10,13 248:15 293:14
consistency 102:22 125:12,14 156:10 164:22 249:11 256:15 332:8 335:8
consistent 27:10,15 56:20 63:15 231:8 261:13 291:7
consolidate 94:12
consolidated 41:10 91:13 101:6 206:14
consolidating 11:11 90:9 94:11 98:9
consolidation 89:22 98:8 298:17
constantly 334:4
constrained 147:2
constructed 86:20
consultants 336:10
consultative 375:19
consulting 316:17
consumed 92:3
consumer 93:20 305:21
cont 3:18 4:9
contact 328:13
contacts 364:10 366:11
contest 37:18
context 109:1 134:1 147:4,18 160:15,16 161:2 165:20 167:2 191:3 192:22 202:17 343:8
contextualize 133:21 134:1
contingencies 150:12
contingency 224:2
contingent 147:9 149:17 222:10,19 228:2
continually 44:7
continuation 49:20
continue 42:17 44:12 157:5 174:11 196:7 205:3
continued 195:5
continues 27:19 112:16 334:6
continuing 135:11 189:6 277:6
continuous 349:2
contract 360:8
contradict 252:16
contradiction 252:14
contradictory 256:3,4,11 265:5
contradicts 252:16
contraindicated 309:11,13
contraindication 27:9 257:20 258:10 269:6 308:14
contraindications 25:12 34:1 74:20 308:13
contrast 111:20 115:8
contribute 19:4 132:17
contribution 322:22
controlled 288:21
controversial 130:22 149:8 158:15 235:21
controversies 127:2
controversy 122:5 127:18 129:12 203:10,15 256:3
convened 26:6 168:4
convener 7:1
conversation 16:2 30:16 42:18 124:21 130:9,10 158:14 159:6,8 225:4 298:3 346:5 355:21
conversations 198:17
converse 158:1 242:9
conversely 7:2
convert 86:15 144:20
converting 87:13
convey 120:22 239:3 347:15,17
conveyed 347:16
convinced 37:21 98:6
Cook 2:16 291:8,9 293:2 294:7 296:5 296:18 297:7 298:5
coordinated 364:8
COPD 41:10 253:9
correct 55:6 73:22 74:10 76:4 93:12 176:14 199:17 208:11 214:9 255:7 275:11 317:15 338:11 358:12
correctly 37:11,14 317:2
correlate 170:9
correlation 359:20
cost 351:7
Costco 51:16
Council 363:18,19
count 76:1 96:2,14 128:18 139:13 221:11,20 222:17
counted 74:2,5 75:11,17 76:3 77:5,6,8,10,13 96:15 141:19 217:12 267:12 297:10
counter-argument 306:6
counting 95:16 222:12
countries 16:15
country 113:16
counts 110:18 114:8
county 343:21 346:17,19 349:8 373:21
couple 8:12 25:18 35:10,11 63:3 69:2 111:13 214:4 309:14 335:3 358:4 366:11 371:5
course 32:11 39:11 103:7 177:1 190:22 193:15 311:6 330:13 333:11
cover 31:15
covering 262:2
co-chair 18:14
co-chairs 227:12 227:16
CPM 135:1,8 199:15
CPT-2 73:7
cranky 368:5
create 33:18 157:22
created 46:22 277:19 368:13
creates 269:20
creating 148:14 207:6
credit 41:12 163:5 165:14 220:7,11 221:5 267:20
crisp 236:2 283:20
criteria 19:19,22 21:18,19,20 22:9 23:2 36:15,17 39:12,18,21 40:1 40:5,9,14,16 41:1 42:6,12,15 43:3 43:13 45:15,16 50:6,10 56:18 57:8,16,22 78:8 79:17 84:16 90:3 95:8,13 100:5,6 102:3 105:4,5 106:5,8 109:6 121:2,9 168:11

169:12 204:16,20 211:20 212:21 228:1 238:22 254:15 255:12 279:7,14 281:18 316:22 324:18 330:5 333:13,16 334:9,18 335:6,15 336:16 339:18 340:12,13 345:17 354:5 364:19 367:8
criterion 103:17 281:9 324:16
critical 328:8
crossed 329:4
crosswalk 358:15
cross-walking 324:19
cross-wall 164:17
Crown 27:4
CROWNWeb 39:7 41:17 44:22 94:22
Crystal 375:4
CSG 363:17 364:2
CT 111:19,20 217:17 218:2 219:1 221:5 222:13
CTs 216:20
Cultural 294:15,21
culturally 167:4
curiosity 142:4
curious 14:2,7 73:2 183:7 278:16 284:16 334:20 338:3 356:22
current 27:11 97:11 120:10 145:3 148:9 154:15 155:19 175:15 280:8 281:7 324:17
currently 77:3 82:15 92:9 114:12 131:21 132:7 146:7 190:3 192:16 215:6 227:9 237:7 249:3 266:15 332:20
cut 218:7
cuts 40:21
cutting 73:4
CVS 51:16
cytologic 180:20
cytology 174:6 180:10,17,22
C-O-N-T-E-N-T-S 3:1
C-O-N-T-E-N-T-... 4:6

D

D 158:7
daily 194:14
damn 232:21
danger 320:6
data 27:4,22 28:1 36:3,7 41:16 45:2 45:3 51:13 56:19 62:1 63:19 64:4 68:13 70:9 73:13 73:15,17 74:6 82:11 91:2 92:8,9 92:16 93:13,18 94:21 96:15 97:11 97:12 101:4 112:19 113:6 118:17,20 119:3,4 122:15,15 123:6 129:2 130:13 131:17 133:21 138:22 139:2 140:10 142:5 144:10,11 157:18 160:19,22 162:12 164:7,19 165:1,11 166:17 167:1 175:14 183:16 188:13 189:22 201:5,10 204:2,9 204:14,15 205:1 213:6,6,15,21 214:8 219:21 220:10 225:3,5,7 225:12 239:2 250:18 253:15 255:18 257:9 273:13 274:8,10 274:19 283:5,16 289:6 290:9,13 292:17 293:2,9 294:18 295:13,14 309:12 310:22,22 311:2,6,20 312:18 313:11,14,22,22 314:2,3,4,11,18 314:21 315:22,22 316:9 317:5,19 318:13,16 319:2,8 319:9 321:9 322:1 322:3,4 323:22 325:20,20,22 326:15,15,18 327:3,8,16 337:18 351:2,7 358:17
database 44:22 142:6 321:11
databases 120:11 225:8
dataset 317:12
datasets 326:6,7
date 150:5,16 163:22 229:22 230:2 371:5,8
dates 72:10 371:1 374:9
David 2:18 293:21
day 3:2 5:7 6:7 327:5 329:15 368:5,6,7 375:21
days 20:20 319:20 371:6
DE 151:21
deal 61:7,8 107:1 166:19 289:20 332:4
dealing 289:22
dear 355:2
death 248:9,10 337:7
decade's 357:3
December 46:14 81:9
decide 14:17 132:21 306:10 362:8
decided 112:8 237:21 243:9 344:13
decision 112:13 123:15 126:16 127:21 128:2,6,20 129:4,13 130:8 136:4,22 139:2 147:4 153:15 185:15 202:21 203:3,5 226:17 235:19 236:19 237:1 258:7 259:14 276:9
decisions 152:15 237:17 295:15 327:13
declination 232:2
decline 231:18
declined 25:11 34:1 74:18 87:3,7 269:3
decrement 278:9
deep 301:4 320:11 332:18
deeper 241:9,11
deeply 333:16
defer 150:5 206:12 206:18 207:1
deferral 238:8
deferred 193:1
define 9:5 13:9 16:20 128:18 295:20,22 296:12 350:8
defined 238:13 296:10 298:7
defining 6:13 10:18 10:22 344:7
definitely 35:20 36:22 55:21 111:16 156:5 273:2
definition 71:22 221:16 346:12
definitional 18:7
definitionally 178:18 179:3
definitive 112:13 266:6,17 268:18
degree 100:20 258:19 309:20 311:13
delaying 167:7
deliberations 29:10
deliverables 371:7
delivering 66:18
delivery 301:7 323:1 360:5
demand 169:6
demands 133:2
demonstrated 26:17 317:19
denomination 101:9
denominator 34:3 34:6 40:21 47:10 54:21 55:2,5 57:14 59:5,12 61:5 69:22 71:5,5 71:8,13 73:21 74:2,10,11,22 75:1,6,10,17 76:1 76:10,15 78:9 98:2 99:10 106:22 122:14 127:17 131:22 132:1 141:11 143:11 170:16 213:10 228:14 246:8 255:12 257:14 258:2,14 259:10 260:7 261:2 262:7 262:22 264:2 266:3,15 267:5,15 268:3 279:6,6 308:15,16 323:19 323:20,22 324:4

denominators 324:1
density 186:19 188:3 192:3 195:2 199:4
department 8:4 9:13 17:6 125:3 318:18 358:9,10
departments 349:9 357:20 366:12
depend 328:12
depending 65:22 87:8 166:14 212:10 328:21 329:6 362:8
depends 143:1 284:9
deployed 70:6,8 225:4
deployment 212:18
derived 213:21
describe 102:4 167:16,19,20
described 56:14 198:15 201:9 220:14 247:3
description 86:8 187:15 202:6 254:20 279:5
descriptive 160:7
detail 100:10 129:8 150:16 222:20 223:21 310:9 319:21 332:4
detailed 26:19 86:8 228:16 313:1
details 35:19,22 64:1 66:15 85:8 86:14 129:1 217:16 220:22 224:11 225:15 264:20 268:20 269:8 270:10 271:4,22 272:2 290:2,22
detail's 290:4
determinant 351:19,21
determinants 15:17 356:11
determine 113:13 203:4
determined 25:11 287:6 288:1
develop 8:5,7,22 11:9 26:7 97:21 122:10 206:4 321:7,13 328:5 329:13,17 354:13 355:3 364:5
developed 39:14 60:9 217:5
developer 22:7 25:15 37:9 46:20 81:5 92:5 106:3 149:12 176:15 185:12 208:5 223:2 235:13 252:15 258:4 265:13 270:8
developers 5:6 25:1 41:13 44:18 48:1 48:15 68:2 72:21 91:11 101:13,18 104:12 106:19 108:21 182:15,19 182:22 184:2 210:3 233:11 256:10 269:19 275:14 316:17 353:9 355:11 361:3 364:14 365:3 370:5,7 373:4 375:22
developer's 256:14 292:11
developing 4:13 9:5 10:22 243:6 245:21 301:9 326:14 344:19
development 52:9 210:11 229:16 319:4 329:18
develops 353:11
devil 35:18
dexa 197:16 200:12
diabetes 253:9
diabetic 36:13
diagnosed 172:1
diagnosis 174:8 182:7,7,8 183:17
diagnostic 255:11
dialogue 275:19
dialysis 25:8 26:15 27:4 28:18 41:17 44:22 90:5 92:10 94:19 96:2,8,13 97:13
diameter 216:22 217:1,7 219:10 220:9
dichotomous 349:1
dicing 89:2
dictate 20:3
difference 41:14 74:12 156:5 176:5 201:4 204:11 235:8 241:3 248:20 274:14 318:15
differences 87:14 98:4 100:2,12 101:4 127:2 205:9 318:14 325:7
different 7:18 8:1 20:8 39:11 40:20 40:21 41:11 50:15 50:19 53:5 54:5 54:17 56:13 57:2 57:4 61:4 73:1 75:8 82:20 83:22 90:10 92:10,19,20 93:13 95:11,13,17 95:20,21 104:3,7 109:6 111:10 121:1 123:3,3 129:2 130:13 143:18 152:7 161:3 164:14 166:20 167:3 171:6 174:19 180:1 199:12 201:10,11 202:21 204:9,22 205:18 207:13 231:2,2 232:1 233:4 242:4 248:14 249:1 256:19 264:4 293:1,7 297:14,17 302:3,13,15,16 303:13,15,16 304:6,20,20 305:3 305:10,17,21 306:7,8 308:1,7 309:21 313:15 314:11 316:9 318:21 320:16 322:17 325:5 333:7,7,22 334:17 335:12,14 336:13 339:4 348:10 359:22 360:1,10 361:10 364:16 366:12,13,17
differentially 59:21 60:4
differently 40:22 53:5 60:6,19 89:16 223:5 335:19 336:15
differing 241:18
difficult 72:22 84:7 122:10 136:17 160:19 211:4 212:9 239:7 291:17 313:19 338:19 354:9
difficulties 93:17 128:15
difficulty 129:5
diffuse 347:3
digit 107:15 172:18 226:5
diminished 5:11
dinged 128:12
direct 193:3 213:20
directed 210:14
direction 8:3 32:1 34:10 137:15 139:4 320:6
directly 134:16 190:22 191:8 193:10,12,17 269:13 283:1 334:15
Director 23:18 48:21 354:21
directors 152:16 210:9
disadvantage 232:12 233:8
disagreed 237:20
disagreement 38:6 38:10,12
disappeared 247:11
disapprove 72:13
discharge 46:17 81:12 254:17 268:12
discharged 46:14 81:8
discharges 268:10
disclose 24:3
disclosures 23:13 23:22
disconcerting 189:10
discount 327:2
discover 7:12 328:21
discrete 94:13
discuss 5:19 29:22 33:10 101:15 123:18 145:11 250:13 251:10,13 269:11 301:15
discussant 109:18 247:8
discussed 22:14,16 30:7,13 32:15 33:13 63:17,21 65:10,13,20 67:7 84:14 128:21 135:8 250:4,13

252:3 291:15 299:11 347:16 348:17
discussing 11:19 28:8 108:19 128:19 245:18 265:5 291:13
discussion 3:23 4:13 9:3 10:8 22:22 33:2 40:7 40:12 46:1 50:8 50:21 56:9 64:13 80:8 88:1 89:20 90:17 92:4 106:13 109:2,9 122:9 123:9 132:18,22 133:2,4,10,14 134:2 136:8 137:14 145:3,10 148:16 169:22 173:11 186:9 208:15 210:5 226:12 228:4,17 235:13 236:16 238:5 239:18 242:2 243:16 244:6 247:17 249:4 257:12 262:1 282:7 293:14 296:6 298:18 300:14 301:6,14 310:8 311:8 316:14 325:16 348:3,8,13 355:17 368:1 373:17 374:17 375:9
discussions 86:1 106:20 134:5 157:21 190:10 213:22 325:19 326:4 330:12
disease 1:14,18 25:6 26:8 92:18 174:11 253:10
disengaged 107:18
disharmony 228:8 233:8
disparate 93:18 319:19
disparities 141:5 156:2 159:10,13 160:13 163:2 165:1,3 166:4 167:13,17,22 168:4,8,12,18 169:22 170:7,22 289:4 292:12 293:10,14 294:15 294:21 318:12 357:5
disparity 169:16 294:9
disrupt 228:19
dissipates 357:10
distinction 160:17 163:12 322:15 323:18
distinctive 18:2
districts 341:19
dive 11:19 332:19
diversity 160:9,9
division 159:12
divulge 111:6
DNSc 1:18
doctor 297:8
doctors 346:22
doctor's 324:5
document 69:14,16 200:5 224:12 288:8 289:9 292:8 315:21
documentation 65:6 114:7 257:9 266:6,17 268:18 308:10 315:12,16 316:11
documented 63:18
documents 64:5 220:20 360:15
doing 5:22 7:3 8:8 13:6 16:9 17:7,9 17:14 18:5 19:2 21:16 46:7 58:17 76:12 78:14 79:15 99:12 103:5,6 108:17 109:2 113:1 114:14 129:22 130:1 133:5,16,17 149:13 154:3,5,6 158:6,18 160:5,20 161:16 162:20 163:8 164:13 165:6,9,21,22 166:15 167:7,10 167:12,17,21 189:15 216:5 221:7 239:15 243:16 245:10 273:18 276:18 281:19 286:15 313:9 314:17 319:3,19,20 324:14 329:3 330:16 331:17,20 345:3,6,9 349:16 361:20 362:18,22 371:20 374:14
domain 160:8
dominator 32:2
Don 9:14
Donald 375:13
dong 323:10
door 235:16 243:18 280:14
double 95:16 98:22 115:8 266:19
double-check 81:16
doubt 65:5 139:10 147:22 220:7
dove 20:16
downplay 325:22
downside 35:1 295:16
downstream 323:5 323:13
downward 343:18
DPT 306:3
Dr 5:3 12:17 13:3 13:11,13,17 14:2 14:9 15:3,7 16:1 17:2,3,12,16 18:1 18:13 20:2 21:4,6 21:9,11 23:7,9,10 23:11,17 24:8,17 24:19 25:17,20,22 26:1,2 29:11,20 30:6 32:14 33:10 33:12 34:15 35:7 35:10 36:2,14,21 38:3,11,21 39:9 39:20 40:15 41:6 42:3,10 43:6,8,10 43:16,19,21 44:1 44:2,16 45:8,12 46:5,10 48:16,17 50:1,2,12,17,18 51:2 52:12 53:10 53:14 54:7,11,19 55:1,12,17,21 56:8,16 57:18 58:1,4,10 59:3,7 59:17 61:16 62:10 62:12,13 63:4 64:16,17 67:2,6 68:11,22 69:5,12 69:20,22 70:7,11 70:19 72:5,17 73:17 74:1,8,14 75:7 76:4,6,7,22 77:16 79:3,6,14 79:22 80:2,4,9,12 80:16,22 83:13,15 83:17 84:12,17 85:18,19 86:6,10 86:22 87:15,18 88:14,20,21 89:1 89:5,6,7,10,13 90:11,18 91:10,18 92:17 93:1,3,10 93:12,14 94:6,11 94:16,18 96:6,16 97:5,7,19 99:7,21 100:8 101:1 103:5 103:19 104:2,9,19 105:1,9,13,17 106:12,17 107:2,9 108:1,14 109:16 109:16 113:19 114:9 115:6,14,16 116:11,19 117:2,7 117:13,20 118:12 120:2,12,14,16,20 121:15,20 122:4 124:16 125:10 126:10 127:11 129:7 130:15 131:19 132:10 136:9 137:2,7,10 138:8,12 140:4,6 141:1,2,18 142:18 143:19 145:1,9,14 146:20 148:1,9,18 149:10 150:1 151:1,12,17 152:2 154:1,7,18 155:4 155:19,22 156:14 157:12,19 158:12 159:5,9 161:6 162:15 166:5 167:6,11,20 168:20 169:2,9,19 169:21 170:3 171:1,9,11,13,17 171:18 172:14,19 173:2,6,18 174:16 174:17 176:9,14 177:5,9,11,18 178:1,17 179:8,12 179:15,20 181:5 181:13,17,20 182:5,10,19 183:20 184:2,13 184:21 185:2,5,7 185:19,20 186:15 187:5,9,16 188:8 190:16 191:6,8,15 191:17 192:20 193:2 194:3 195:9 197:3,8 198:18 199:17 200:9,17 200:20,21,22 201:3,8 202:2,12

203:13 204:6
205:2,6,8 206:12
206:19,21 207:15
208:4,11,14,17,18
208:21 209:3,8,10
209:11,15 210:6,7
210:8,8 211:1,3,5
212:20 213:5,14
213:19 214:3,9,10
215:7,10,14 216:1
216:6,11,13,14
217:15,21 218:3,5
218:6,12,17,22
219:6,16 220:2,15
220:18,21 221:1
221:10,12,15,17
222:3,7 223:1,7
223:10,12,19,22
224:1,4,5,9,14
225:9,11,13,14,18
225:21,22 226:8
226:11 228:10,15
228:20 229:5,9
230:14 232:4,10
232:19 233:6,16
234:1,4,20 235:7
236:11,17 237:2
237:12 238:11
239:9 240:8,9,15
240:18 241:7,12
242:12 245:3
246:3 247:7,16,20
248:2,3,12 249:8
249:10,15,18
250:3,12 251:4,12
251:17,19,20
252:1,2,6,8,10,20
253:1,19,20,22
254:8,21 255:8,20
256:18 257:5,11
257:13 258:3,5,13
258:17,22 259:5
259:11,15 260:4
261:3,5,8 262:3,6
262:9,11,14,22
263:10,12,14
264:5,12,15 265:1
265:7,8,20 267:9
267:17 268:7,13
268:16,17,19
269:16,22 270:1,7
270:21 271:1,3,14
271:18,19 272:9
272:18 273:3,12
273:21 274:6,21
275:13 276:11,13
277:5,11,16
279:10,16 280:17
281:4,16,22
282:19 283:10,14
283:22 284:1,9,22
285:3,5,12 286:4
286:14 287:2
288:14 289:10,14
289:18,20 290:8
290:16,17,20
291:6,8,11 292:13
293:2,13,21 294:7
294:11 295:4,8,11
295:12 296:2,5,18
297:7,19 298:5,11
298:12,19 300:5,8
300:12,17 301:1
301:11,16 303:12
303:15 304:11,13
304:22 305:5,19
306:5,22 307:10
308:4,18 309:3
310:5,13 311:17
311:21 312:5,9,16
312:19,22 314:15
315:5,10,18 316:4
316:13 317:7
318:7 319:14
321:5,17,21 322:7
322:10,12 324:12
325:12 327:6
328:1 329:8 330:2
330:9 332:1 333:3
335:3,13 338:6,12
339:10 341:1,3
342:12 343:10
347:12 348:21
352:5,8 353:7
355:8,15 356:3,8
356:14,16,18
357:14 358:6,22
359:5 360:6,13,20
360:22 361:8,14
361:17 362:4,19
363:5,8,16 364:1
364:4 366:3,10,15
366:16 367:5,13
369:4,9,11 370:13
371:10 372:4,13
373:12 374:12,21
375:7 376:2
draft 18:20,21,22 121:4 169:17 345:16 371:9 372:15,22 373:3 374:6
drafts 19:5
drive 321:19
drop 59:11,15 276:21
dropping 196:13
drug 199:5
drugs 202:1
Dr.P.H 1:21
due 220:8 371:8 374:8
Duties 213:22
dysplasia 172:1 175:2,5 182:7
D.C 1:10

E

earlier 120:18 170:4 226:13 232:11 240:4 291:10 339:1,15
early 6:4 65:20 105:12 137:18 151:2 167:16 186:5 234:10,17 332:12 348:18 359:4
easier 270:5 312:13
easily 193:21 263:11 343:21
easy 133:20 188:12 254:11 286:20
echo 329:9 352:9
education 360:10 360:16
effective 29:4 162:14 189:13 193:15 194:22 195:1
effectiveness 160:12 165:7
effects 189:4 194:7 203:18 310:15,16 310:19
efficacious 256:6
efficacy 118:14 189:1,22
effort 6:22 8:2 276:4 354:12
efforts 33:14 66:17 109:8 246:4 295:15
EHR 114:16 144:19 175:15
EHRs 138:21 144:9 144:11 156:13 253:15
eight 79:2,3 211:16 333:21
either 22:5 25:10 28:22 29:10 67:16 68:8 69:14 71:16 71:20,22 100:5 119:20 154:14 175:1 200:11 201:22 228:14 249:16 255:14 274:8 302:17,18 308:9 340:10 346:7 347:9 349:5 370:19 371:1
electronic 19:10 175:14 252:17 253:14 311:1
element 221:18,22 222:2 223:9,14,15 240:20 274:8
elements 121:1 235:18 242:2 257:9 263:22 274:10 275:22
Elias 295:2
eligible 121:18
eliminated 44:18
Elisa 2:9 19:5 151:12 167:11 172:19 225:20 345:12 367:16 375:15
else's 370:15
email 19:4 349:20 374:5
emerged 10:8 365:17,18
emerging 190:1
emphasize 77:9 123:5
employed 111:4
employer 352:19
employers 347:1
enable 114:22
encounter 296:21 297:1,5
encounters 297:3 298:9 313:2
encourage 163:13 196:15 217:10 293:18
endorse 102:18 104:19 105:16 240:7 330:19,21
endorsed 26:22 63:9 104:11,18,21 105:15 174:1 197:12 202:9 206:1 233:10,12 302:1
endorsement 1:3 8:10 39:17 42:13 42:16 43:4 45:16 80:1 105:8 137:18 228:2 261:13,22 277:20 293:4
endorsements

273:18
endorsing 280:7 361:5
enema 115:8
energy 109:5 282:4 282:6 352:22 354:12
enforced 341:11
enforcement 341:9
engaged 367:22 368:16
enhance 137:21
enlighten 15:19
enriched 214:5,7
enrollment 142:11
ensure 27:7 60:18
entered 260:18
enterprise 334:5
entire 82:18 88:3 151:10 231:14 241:14 251:7 273:14
entirely 98:6
entities 97:16 297:14
entity 338:16 344:4 346:13
environment 7:5 97:3
environmental 9:15 14:11,20 18:3 345:4 355:19 356:2 361:19
envision 324:2 343:19
envisioning 17:17
episode 290:5 295:21 296:1,8,10 296:12,15,16 297:15,16
episodes 287:5,22 289:17,19 291:17 291:20 297:18 298:7 323:21
equally 139:17,20 280:10
equipment 107:19
errors 290:13
especially 127:20 159:3 237:4 259:22 266:20 330:3 351:20 364:18 367:10
ESRD 3:4 25:3 26:11,16 27:7 28:2,11,16 29:5 30:22 31:15 32:4 36:6 39:3 41:15 93:5 96:15 98:12
essentially 31:7 46:21 47:7,11 77:8 81:21 106:18 168:5 174:12 178:6,9 217:10 317:10 333:12
establish 40:8,13 333:13
established 22:11 27:21 30:9 34:8 37:17 297:4,9 315:19
establishment 321:20
estimate 161:10 315:4
estrogen 195:1
estrogens 189:15
et 19:19
etcetera 111:17 161:19 239:2 246:20 277:22 340:16
ethnicity 159:18 160:4,8,18,22 161:13 163:18 164:1,6,11,15 170:8
European 16:21
evaluate 291:1 328:6
evaluated 155:8 219:20 256:13 335:18
evaluating 10:14
79:18
evaluation 64:3 103:7 121:2,9 261:19 282:20 312:21 324:15,18 330:4 334:9,11,13 345:17 364:19 367:7
evaluations 29:14 63:2
event 201:17 255:11
events 195:4
everybody 5:3 6:11 19:20 23:1 34:12 40:8 43:2 47:5 62:10 80:22 82:5 90:19 99:14 131:1 224:12 243:18 252:10 265:16 269:21 272:13 280:13 363:6 368:1,15 370:15
everybody's 19:19
evidence 27:18 30:3 31:1 36:20 37:15 38:7 56:21 73:5 82:22 83:1 111:17 115:22 116:14 118:14 125:5,13 130:20 130:21 131:3 132:4 133:5 145:20 146:8,22 148:21 149:8 151:10 176:2,3,7 180:3 189:4 195:5 204:19 213:4 230:17 231:5,12 256:3,5,6,11,15 256:22,22 263:15 265:5 277:8 288:19,22 292:9 294:9 309:18 329:10 332:5,9,15 333:17 334:11,13 335:8,9,19,20
340:11 354:4,6 355:2 364:22
evident 212:15
evolution 182:12 334:1
exact 104:5 154:10 219:9 231:15 284:17
exactly 20:5 31:17 40:19 100:20 116:10 124:13 128:18 227:11 231:21 268:13 278:9 284:15 292:3 308:10 321:14 339:9 347:13
example 18:3 31:10 41:8 83:9 89:1 119:22 164:12 306:15 339:6 365:6
excellent 173:19 270:21 332:1
excepted 74:5
exception 64:7,8,19 66:10 67:15 230:19 361:11
exceptions 64:20 64:22 65:3 74:4 75:11 76:2 77:10
exchange 374:4
exciting 321:15
exclude 66:3,12 67:18 68:8,18 69:8 73:20 143:9 143:16 257:16 308:13
excluded 33:9 74:5 77:6 94:20 96:11 98:14,15 132:3,3 140:15 141:11 234:14 259:8 261:4 266:14 267:8
excludes 309:10
excluding 260:21
267:14
exclusion 64:7,19 66:21 75:20,21 78:8 86:9 140:9 140:10 157:16 204:16 231:16
exclusions 34:5 73:14 74:4,9 75:18 76:16 86:1 132:1 138:15 139:5,13 140:12 141:13,17 143:9 155:12 183:8 228:12,13 231:7 257:15 263:19 268:3
exclusively 70:20
Executive 354:21
exercise 45:19 82:4 194:21
exist 73:17 94:9 350:3
existing 16:6 78:5 116:6 121:22 243:3 328:6 346:11
exists 131:21 132:8
expand 47:6
expanded 47:10 51:21 278:22
expanding 52:6
expect 274:13 292:2
expectation 103:11
expected 319:11
expecting 208:7
expedient 154:1 179:7
expensive 144:13 196:8
experience 88:22 161:7 218:16 278:17
experiencing 7:19
expert 80:13 151:7 180:6 202:22
expertise 9:22

experts 85:5 153:6 226:14,15 232:13
expire 268:4
explain 69:5 79:9
explanation 70:16 79:8 88:7 234:18
explicit 131:14 141:13,17 268:8
explicitly 28:13 78:15 102:11 346:4
explore 159:10
expressed 227:12
extend 67:4
extension 84:19
extensive 30:15 257:8,8 336:9
extent 77:14 349:12
external 152:12 327:11 354:18
externalities 237:14
extra 163:6 273:1 276:3
extract 36:5,7,11 322:3
extraordinarily 194:7
extraordinary 89:4
extremely 134:20
eye 124:22 278:15

F

FAAN 1:19
FAB 349:21
face 60:13 85:2,2 156:8 161:13 351:4
faced 129:5
facilitate 299:12
facilities 26:15 39:5 41:17 45:1 90:5 92:10 96:8 104:7 294:19
facility 26:11 27:4 28:18 35:15 36:5 39:6 44:21 246:10 246:20 294:13
FACP 1:22
fact 13:8 28:15 39:4 52:20 73:10 87:10 112:20 125:11 134:6 184:3 194:20 218:20 219:8 223:16 234:9 238:17,21 240:18 249:6 256:5 264:18 271:21 272:1 280:10 294:12 336:6 347:4
factor 261:18 337:20 360:4
factors 21:22 176:19 178:7
failed 40:5
failure 253:9
fair 34:16 177:21 178:3 256:22 282:4 289:1
fairly 96:7 112:16 159:12 161:11 332:11 348:17
faith 149:17
fall 16:18 27:19 151:16 213:10 251:10 281:17 331:10 354:14,17
falling 213:9
falls 278:14
false 75:18,21 96:3 146:1
familiar 184:3 328:10 329:1
family 3:15 40:19 208:20 209:17,21 210:15,19 212:8 213:16,20 214:11 267:1
far 5:15 27:19 39:2 90:7 98:9 166:14 178:18 225:14 328:18 345:14 352:22 360:17 367:18
fashion 153:8 338:10
fast 169:5
fatal 221:3 276:1,6
faulty 264:2
favor 43:12 282:2 285:13,17
FDA 188:18
FDA's 195:8
feasibility 38:17 57:6 64:6 156:11 212:4,18 213:15
feasibility/usabili... 116:14
feasible 26:18 184:14 294:17
features 64:12
February 46:15 62:18 65:8 66:5,9 67:4,8,22 68:7 70:4 71:11 73:4 81:9 136:1 152:22 227:15 230:1,2 281:21 282:22 329:19
February/March 136:21
Federal 97:11
feed 116:17
feedback 18:20,21 19:6,19,22 151:9 257:17,19 372:20 374:2,5
feel 12:4 13:7 31:16 36:17 42:6 57:14 58:11,19 90:2,3 111:16 117:3 119:21 130:10 134:20 135:1 143:22 203:7,9 227:7 230:1 231:4 237:5 266:18 281:5,19 286:11 319:17 320:3 331:5 359:3
feeling 32:3 66:7 67:8,13 101:3 185:13 194:1 219:22
feels 13:14 32:8 229:22 285:8,22
felt 38:14 65:16 82:9 127:3 178:15 266:1 267:5 320:7 342:12
female 141:8 142:7 142:12,20,21 186:17 187:22
females 142:9
femur 189:8,9
field 14:6 26:14 161:4 162:20 163:9 164:9 212:1 313:21 331:16
fields 101:22 162:21
Fifteen 244:6
fifth 45:14 105:4
figure 18:7 19:11 202:9 205:9 308:10 309:7 336:2
figuring 7:20 9:8 11:3
fill 102:14 143:1 173:13 198:12
filled 101:22 142:10 161:12
fills 370:15
filter 19:22
final 36:1 39:9,17 106:9 136:4,22 151:5 153:12,15 241:12 245:10 298:12 300:22
Finally 28:9
financial 24:1,13
find 81:13 85:15 87:18 112:5 155:7 185:2,14 271:5 275:20 294:8 305:2 309:6 339:17 354:10
finding 17:10 345:10
fine 14:7 70:19 80:12 154:6 185:18 231:3 257:7
finger 188:7
finish 45:5,13 92:4 277:16
firm 227:17
firmly 172:13,17
first 8:17 11:21 14:17 21:2 40:4 42:16,20 56:17 60:10 64:15 109:18 110:2 135:22 163:17 168:6 173:1,22 174:7 183:17 191:18 207:8 224:22 246:12 251:15 275:18,22 279:17 285:6,14 301:19 304:4 317:14 322:19 333:4 355:13 361:1 371:6 372:11 374:6
fit 12:8 106:8 200:3 346:7
fits 38:16 261:16 347:9
fitting 13:12
five 5:17 89:17,18 114:2 175:4 189:6 250:8 262:9,20 263:2 279:8 304:6 367:6
fix 77:20 80:17
flaw 221:3 276:1,6
flexibility 336:17
flexible 110:19 274:2
flip 296:18
floating 13:8

flu 3:5 27:17 28:2 28:20 31:6 48:2 49:4,5,12 51:14 67:9 71:17 81:17 83:1 95:10 291:14 300:3,7 312:3 323:9 335:1,2
fluctuation 112:20
flue 52:16 97:8 265:11
fly 234:19 355:6
FMQ 81:16
FOBT 110:20
focus 49:10 60:17 66:17 68:6 70:20 108:22 109:3,5,7 113:9 159:13 247:17
focused 95:12 310:7 346:12
focusing 316:20 327:9
folded 33:7
folks 13:16 17:21 47:19 97:20 100:4 109:21 120:10 130:2 141:11,18 148:3 162:4 174:21 175:16 177:18 183:21 208:6 215:3 225:9 247:9 253:16 266:19 290:7 328:10,13 329:2,7 330:10 345:9 354:10 363:1,2,12 365:7 367:11
follow 38:13 105:22 118:7 125:4 144:7 145:1 145:14 184:10 194:4 264:22 265:3 274:22 330:2 353:2 370:2 370:7,19
followed 107:14 172:18 226:5 373:18
following 79:15 180:11 232:5 268:20 303:1 372:22
follow-up 118:11 177:14 178:12 179:13,14,18 289:3 290:21 369:17,18,19 371:13,14 372:3,6
food 355:20
force 91:5 110:15 110:22 115:19 116:9 122:7 126:11 147:13 149:5 155:15 176:6 332:5
Force's 125:4
forge 186:4,12
forget 13:5
forging 186:7
form 26:20 64:3 101:21,22 111:18 112:5 115:12,18 142:11 143:2 147:3 154:15 211:8 225:2 254:7 256:16,19 292:16 301:12
formal 125:18 349:21
formally 107:14 112:6 158:12 226:4 232:18 350:1
format 164:18,18 290:19 358:19,20
formative 245:20
formatted 314:5
formerly 111:4
forms 101:17,19 102:14 116:6
formulated 191:19
forth 235:10 238:15 350:18
Forty-one 251:21
Forty-six 200:22
Forty-three 252:1
Forum 1:1,17
forward 5:13 9:1 10:2 11:10,10 16:8 17:17 35:9 42:4,11 72:21 100:15 105:21 106:2,11 137:11 161:4 162:17,20 163:9 169:10 171:3 203:10 204:20 277:12 282:21 283:1 288:15 300:13,21 308:5 312:11,12 316:16 320:19 322:13 325:9 328:8 329:17 332:11 339:17 345:4,19 348:7,15 350:21 352:12 353:4,15 355:4 368:19
foster 133:10
found 200:6 213:9 219:12 248:8 314:1 318:5 345:11
Foundation 1:13 354:20
four 29:13 81:1 89:17 90:7 96:22 98:3 99:22 125:16 175:4 211:15 264:14 298:19 304:5
fraction 349:5,7,8
fracture 194:16 195:4 198:22 199:2,5,8,9 201:16,19,20
fractures 189:8 194:15,16 199:10 203:20
frame 8:1,7 9:5 10:19,22 11:18 12:1 22:15,19 25:8 65:4,5,10,13 65:14 66:5 67:3 68:1 70:2 78:7,7 90:12,16 133:13 183:14 184:5,7 185:3 226:19 227:5,8,11 230:7 230:19 231:15 347:18 348:10 353:16 356:9,13 356:19 357:2
framed 347:22
framer 7:1
frames 231:2
framework 9:17,20 10:10,16 11:13 13:14 323:3 352:11
framing 17:9 22:5 109:15 344:19 348:8 357:11
Frank 1:15 151:18
frankly 6:14 9:22 16:15 100:16 226:16 302:21
frax 203:4
free 319:17
frenzy 132:15
frequency 158:3 192:8
frequent 176:7
frequently 65:20 236:9
fresh 227:21
front 40:14 60:4 82:11 149:16 188:17 254:5 264:11 295:5 301:13 347:6
FSA 48:10,10 49:3
FSO 48:10,12 49:3
fulfilled 139:14
full 6:7 18:14 53:3 65:12 83:16 198:1 211:14 227:1,18 241:5
fully 6:8 347:15,17 364:8
function 194:15
functional 27:5
functionally 217:11
fundamental 12:16 99:11
fundamentally 346:9
funded 326:20
funny 290:17
furloughs 286:7
further 40:7 58:2 89:21,22 90:9 92:15 101:9 103:16 118:9 159:10 160:4 171:9 177:9 200:18 228:3 238:19 243:20 300:20 323:21 339:19 358:4
future 113:13 158:9 191:11 197:6 359:18

G

g 19:18
gall 222:16 223:16
gallstones 221:11
game 90:16
gap 82:10,14 281:11,15 284:2,6 284:8 286:18
gaps 366:7
gather 122:15
gathering 321:9
gaze 327:20
ge 276:9
gears 20:16
gender 292:18
genders 142:14
general 15:12 33:6 33:8 44:15 82:18 144:7,8 174:20 175:6,18,22 176:22 178:22

191:21 194:1 200:1 276:16 277:1 280:9,12 312:15 314:9 320:22 321:3 349:12
generally 33:21 38:1 284:5
generate 321:8
generic 29:22 182:17
gentlemen 116:16
geocoding 162:13 162:14
geographic 323:10 324:4 339:1 343:22
Georgetown 2:2
geriatric 359:13
germane 310:11
gestalt 14:8 195:5
getting 15:4,20 20:10 42:8 51:14 58:21 62:2 75:2 77:22 98:21 99:16 120:17 129:8 131:13 144:18 165:1 166:2 173:5 225:12 259:8 260:12,13,15,16 265:21 266:21 271:13 273:1 344:2 361:15 368:12
give 11:18 18:20 19:21 31:11 39:12 43:10 48:22 51:22 52:3 58:10 72:15 73:5 77:14 84:1 90:12,15 96:3 97:2 139:7 140:20 152:9 160:15 170:20 220:4,6,11 226:9 227:17 233:1 257:3 267:1 277:3 294:16,20 315:4 316:18 327:17,17,20 355:6 356:4 364:6 367:17 371:19 372:21
given 18:21 28:12 53:12,19 56:19 65:18 67:10 73:10 93:17 113:21 123:17 125:13 132:14 138:22 182:12 183:14 194:20 220:8 233:14 256:8 270:7 272:6 284:12 302:4 317:8 323:10 350:19
gives 142:5 143:21 342:5
giving 9:20 139:9 203:5 210:13 221:5 255:5
glad 173:6 312:6
global 21:17 89:21 91:5 97:18 122:10 314:18
globally 308:22
gloss 108:18 282:11
glossed 320:5
GMAP 190:11 193:9
go 5:13,18 13:18,19 21:19 23:3 38:1 42:10 43:2 44:7 45:19 47:16 48:18 60:10 62:4 63:22 64:14,16 68:14,20 72:14 74:21 75:5 77:1 79:4,20 80:1 81:3,17 91:11,15 91:20 92:4 99:9 104:14 105:21,22 106:19 109:6 119:17 133:8 135:22 136:3 143:3 145:16 146:16 151:9 152:19,21 153:8 154:19 155:6 161:20 163:20 171:3,11 178:21 182:4 202:8 208:22 214:12 217:13 219:4 222:4 225:15 227:1 229:2 231:7 232:16 233:10 235:14 236:6 237:21 238:4,15 238:22 239:18 243:9 247:22 252:20 260:22 268:19 270:5 275:14 276:8,10 278:4 280:3 284:1 286:20 300:13,21 301:1 306:17 308:4 316:7 324:14 325:9,17 328:8 331:19 332:13 333:21 335:16 338:21 343:10,17 347:10 348:14 354:11 361:6 362:4,17 365:9 369:14
goal 27:15 181:10 207:4
goals 3:2 7:18 27:21 320:17
goes 60:16 98:1,13 99:3 118:8 131:21 136:20 149:3 167:1 241:13 357:7
going 5:13 7:9,18 9:1,18 10:2,2,3 12:22 13:6 14:20 14:22 16:8 17:17 18:16,19 20:7,9 20:19 25:1 31:3,4 37:18 38:18 39:10 42:4 44:13 58:16 74:14 76:10,13 78:11 79:8,10 81:19 82:3 94:8 95:22,22 96:1,3 97:2 98:10,17 99:1 101:11 103:1 104:16 105:15 106:18,20 107:1 108:14,15 109:10 109:14,19 110:1 121:4,5,10 123:1 124:20 126:5 127:12 129:17 131:19 132:9,22 135:19 136:9,13 136:15 137:4 141:19 145:8 147:6,16 150:7,13 152:3,4 153:3 154:5,8,13,15,19 154:19 157:14 160:3 169:2,6,10 170:17 171:7 174:12 177:7 180:8 182:12 183:22 184:16,18 184:19 185:15 195:17 198:9 205:3 206:15,22 214:12 226:9 227:18 234:2 235:4 238:6 240:4 240:5,11,19,21 241:4 242:14 243:1 245:11,17 246:12 251:10 264:3 266:5,15,16 269:5 270:3 272:1 273:2 277:9 281:20 282:4,20 282:21 283:2 285:11 289:21,22 292:4 300:21 305:5 313:18 314:18 321:11 324:14 325:8 327:19 328:5,5,7 328:12 329:5,17 330:12,16 336:3 342:22 343:16 344:14 345:3,4 347:20 350:9 351:6 352:2,12,21 353:4 354:9 356:13 358:10 360:11 362:2,7 363:6 364:10 365:9 367:16 370:6,19,20 375:3 375:5,14
good 10:6 12:7 15:7 15:10,14 21:6,11 23:17 24:8 26:2 31:10,11 37:12,19 38:7 39:13 48:20 63:5 65:10 79:4 89:10 94:2 99:5 112:16 113:12 118:14 129:22 130:1 149:17 158:19 210:11 212:12 227:13,14 245:9 247:19 252:10 257:1,2 289:1 327:17 330:20 331:12,16 333:9 339:11 341:3,16 342:6,7 352:3 359:16 365:6 374:4
goodness 116:15
gotten 271:12 310:6 370:22
governing 124:11
government 346:18 352:18 357:19
Governments 363:18
Governors 350:14 363:10
grading 121:1 288:19
granted 326:17
grapple 352:2
grappled 325:18,18

grateful 367:21 368:20
great 6:12 13:4 16:22 23:16 26:2 47:20,21 116:22 144:21 173:2,6 187:6,11 197:7 208:14,18 209:15 225:21 245:8 329:3 332:3 339:2 352:11 355:5,17 357:2,6 367:6,9
greater 27:16 161:2 218:1 246:9
greatest 66:19
greatly 228:5
gross 159:12
ground 146:21
group 10:8,12,20 10:21 11:2,13,14 12:9 13:1,10,14 13:15 14:19 17:20 18:11,14 19:11,18 20:6 22:6 24:20 29:13 34:22 35:3 35:21 40:1 48:9 50:13 51:19 53:16 63:2 65:16 66:2 66:14 67:7,20 81:14,20 82:9 83:4,8 84:14 85:4 90:2 95:6,9 96:7 97:6 101:3 102:20 102:21 114:11 121:4 122:19 123:21 124:4 125:18 128:1 135:12,13 137:2 147:21 148:4 155:9 156:18 169:1 170:10,22 175:11 176:1 177:15 178:8 185:22 194:19 196:17,17,18 209:5 222:22 227:2,14,18 228:4 229:2,8,13,15,18 229:19,21 230:4,5 232:17 233:14,21 234:7 235:12 237:18,20 238:6 246:19 247:10 259:12 262:1,20 263:7 282:1,2 292:12,14 320:2,7 321:2,2 323:16 344:17,21 346:18 347:11 348:5,6 350:7,17,21,22 352:3,3 353:11 358:21 362:18 363:9 366:21 368:18 370:1 372:3 374:13,20 375:6
groups 10:7,16 11:12 13:19 17:18 18:5 19:9 20:2 49:9,11 60:17 92:20 94:14 110:20 123:20 124:5 131:8 140:10 146:2 161:15 193:10 207:4 241:3 293:7 321:1 333:19 344:3,14 345:8,20 346:8 347:10,18 348:4,18 371:16 371:19 375:11,12
Group's 240:22
growing 170:17 359:13
grown 368:4
guaranty 151:8
guess 50:14,18 51:5 53:17 58:8 59:17 60:2 73:1 78:15 85:16 91:21 92:3 92:11,17 93:14 106:15 111:13 138:2 146:20 157:18 177:22 186:12 196:15 206:14 212:4 224:16,20,21 245:4 249:12,18 251:4,8 252:21 254:5 274:12,17 280:4,22 292:20 301:22 311:9 319:14 339:14 341:9 342:18 351:8 362:17 365:8 375:11,18
guesstimate 193:4
guidance 169:4 217:5 289:5 292:11,14 294:17 294:20 295:9 355:6
guide 193:19
guideline 24:5 123:14 124:3 127:19 174:5 179:22 183:4 184:9 202:20 330:15
guidelines 27:11 32:9 33:20 123:12 123:17 124:6 131:7 134:12 141:9 144:7,8 181:18 182:4 183:11,22 184:4 192:1,7 230:17 314:9 330:13,13
gun 228:21
guys 17:21 62:14 100:20 127:12 161:8 209:16 240:19 292:20 329:6 361:6
Gynecology 174:4 177:2

H

HAI 365:5
half 21:4,10 211:16 211:17 327:5 374:16
half-hour 21:8 244:7
HAMMERSMIT... 2:8
hand 20:22 43:5,11 43:13 163:20,20 285:17 305:20
handed 202:5
handle 122:12 132:14 148:16 273:4 275:7,12 281:3 286:22 375:4
handled 141:6
handling 56:15 228:11
hands 78:20 79:1
hang 351:6
happen 98:11 150:13 151:9 168:18 234:15 236:22 343:15 350:12
happened 72:12 201:17 206:10 337:20
happening 168:6 266:4,16
happens 55:18 91:15,15 140:5 243:17
happily 367:12
happy 14:18 49:21 239:4 264:21
hard 20:10 40:17 116:7 135:3 154:14 169:5 217:22 231:11 239:22 286:15 291:5 294:20 315:18 320:1 338:20 339:5 342:3 368:11,16
harder 102:2
harmonization 3:23 30:14 32:1 32:11 33:14,15,17 41:18 56:11,12 57:11 89:22 92:11 93:16 97:20 101:10 102:3 103:16 105:6 106:7,21 226:18 229:17 231:1 246:4 251:14 258:18,20 261:9 261:11,12,16 265:22 290:4 297:20 298:2,17 299:13,18 308:17 308:20 356:20
harmonization/c... 242:18 243:11 245:14
harmonize 41:19 72:15 92:15 94:1 98:1 227:10 233:9 233:13 291:2 357:22
harmonized 28:5 41:21 42:9 78:5 78:21 92:12 94:7 94:10 98:6,8 99:3 357:13,15
harmonizes 356:22
harmonizing 53:12 72:9,10 92:22 231:14
hate 102:13
hats 245:8,9
head 20:21 24:4 91:20,20 228:21
heads 293:16
health 1:3,13,14,16 1:20,21 2:3,15,19 2:22 3:15,20,22 4:14 6:14 8:4,6 9:10,13 10:9,10 10:14 12:12,18 15:12,12 16:22 17:6 18:4 24:10 26:5 29:1,2,7 51:11 89:15 90:4

93:5 95:6,7,10
96:9 97:17 113:11
113:14,16 114:12
114:19 115:3
117:17,22 118:3
118:10 119:15
125:3 136:12
139:9,16,19,20
140:20 144:13
152:20 153:19,21
155:10,20 157:5
158:16,17 159:17
160:16 163:11
165:4,8 172:8,9
172:11,15,20,22
187:17,18,20
188:20 190:19
191:10 192:13
193:10 194:13
196:2,3 198:15
200:4,7,15 204:14
204:15 205:22
208:7,8,10 210:3
210:10 214:2
224:20 225:10
245:21 251:3
253:3,16 260:15
260:19 264:16
278:11 287:4,16
287:22 291:19
293:6,8 294:4
295:6,21 296:8,9
296:12 297:13,15
297:16,16,17
298:7,21 299:10
301:9 318:17,18
318:19 319:4,10
319:13 322:4,22
323:1,4,22 324:3
324:6,16 325:2,21
326:7,16,19
334:10 338:14,17
341:21 342:10
344:7,9,21 346:20
346:21 347:22
348:1 349:8,22
350:16 351:19,20
352:13 353:12,22
356:11,12 357:7
358:8 360:9,11,12
363:11,20 365:15
365:17 366:9,9,19
healthy 27:15
357:1,1,17 366:20
374:3
Health's 211:22
Health/WellPoint
2:14,20
hear 25:18 106:3
173:3,17 177:19
178:1 182:20
208:15 210:6
211:4 223:11
225:10 236:6
253:19 277:5
312:6
heard 6:20 7:14 9:4
9:11 12:3 21:7
28:7 38:12 79:7
84:13 149:14
154:8 167:8
172:19 183:7
193:5,11,16 241:7
270:1 339:16
367:17
hearing 191:3
231:3 247:21
316:3 330:11
hears 235:13
heart 1:17 253:9
353:18
hearts 355:2
HEDIS 49:15,20
51:21 52:3,15,22
53:6 110:11
111:12 114:19
115:2 117:17
122:1 124:11,19
136:2 139:6 144:6
144:14 151:11
152:16,18,19
153:16,20 154:22
156:7 157:8
159:17 164:16
187:13 206:8
311:6,6,11 314:8
314:12 318:4
319:6
heel 188:7
HEIDI 2:6
Helen 2:6 13:2,12
14:3 18:22 19:20
35:8 39:10 43:16
86:11 98:7 106:18
118:2 176:20
183:21 270:2
273:3 275:6
279:14 284:3
315:15 361:1
366:3 372:19
375:15
Hello 283:9,9,10
help 5:15 7:4 8:7,7
9:6,16,18 43:17
74:22 90:13
111:14 133:9
134:2 182:22
193:19 275:14
299:12 321:19
328:12,21 329:6
336:10 353:3
361:12 366:6
367:10 372:8
373:2 374:19
helped 325:17
333:13
helpful 15:6,15,18
22:12,15 34:16
36:3 51:14 59:4
90:14 109:9
115:17 117:4
158:13 159:8
182:11 185:8,11
204:17 231:9
285:13 295:1,14
300:15 318:12
320:10 322:12
324:12 327:19
330:8 353:16
helping 11:2 195:2
375:20
helps 20:12
hemodialysis 25:7
hesitant 227:16
233:14 326:1
hey 104:14 190:2
HHS 127:5 340:15
357:12 359:16
hi 23:8 167:18
173:17 253:19
291:8,11
HIB 306:4,13,15,15
306:18 307:20
hideous 313:17
hierarchy 357:9
high 3:12 27:16
33:7 37:22 39:12
58:6 66:18 82:10
118:12,13 120:1
125:12,17 126:2
145:20 171:15,21
173:9,22 174:12
174:22 176:12,19
177:4 178:7,14
182:4 194:17
196:8 206:17
213:2 234:7
246:10 253:4,7
254:2 260:1
262:10,19 275:1
276:14 277:9
278:1,7 279:18
280:5,11 285:18
285:18 293:15
318:6
higher 133:18
162:11 175:10
176:1 199:9
279:21 319:11
highest 146:3
343:17
highlights 128:14
hints 316:18
hip 188:7 194:15
history 3:15 60:7
114:1 208:20
209:18,20,21
210:15,18,19
212:8,8 213:16,20
214:12 215:5
267:1 333:12
375:20
hit 75:13 272:12
369:7
hits 162:5
Hittle 2:18 293:21
293:21 295:4,11
HIV 174:6 179:16
180:9,16 181:2
182:8
HIVAIDS 172:3
175:3 183:14
hoc 125:21
hog 131:19 132:9
hold 150:9 285:18
holding 20:21
228:21
home 3:22 29:2
54:13,16 90:4
93:4 96:9 266:21
287:4,16,21
291:19 293:6,7
294:4 295:6,20
296:8,9,12 297:13
297:15,15,16,17
298:7 299:10
324:5
homes 93:9 324:6
honest 59:2
honestly 181:20
343:9
hook 126:5
hope 70:21 160:10
171:2 220:2
316:13
hoped 83:18
hopefully 8:14
70:11 116:12
119:5 124:8
154:11 208:6
238:21 243:12
301:19
hoping 374:7
HOS 196:12,17,17
197:4 250:1,18,19

hospital 1:20 3:5 3:21 46:12,20 47:3 82:2,6,18 84:10 93:4 97:13 255:10,10 266:5 270:9 272:21 273:15 285:1 339:6
hospitalization 248:10 269:1,4 297:2,10,22 299:15
hospitalized 47:7 47:12 81:4 265:10 284:13 297:8
hospitals 90:4 98:19 104:6 266:18 271:11 297:22 324:5 346:22
host 206:4
Hotel 1:9
hour 21:4,9 44:11 228:18 372:11
hours 6:4 44:12,14
how-to 10:13 11:5 11:13 16:3 19:18
HPV 52:21 157:13 180:10,16,22
HRSA 353:3 354:17
huge 100:15 119:16 334:21 359:9
Huh 332:14
Human 8:4 125:3
hundreds 366:1
hurt 34:21
hysterectomy 155:13

I

ICD 268:4
idea 55:17 90:20 191:10,20 194:14 195:16 269:12 322:13 332:6 339:20 344:1 348:2,7,14,19
ideal 90:21
ideas 17:19,22 18:12 320:18,20 345:3 351:9
identification 212:2,6
identified 117:10 118:18 233:22
identifies 171:22
identify 118:18 119:14,19 134:16 162:4 189:2 294:12 375:10
identifying 100:21 120:10 168:11
imaginable 41:3
imagine 29:21 30:4 217:22
imaging 146:3 217:18 220:19 221:16
immediate 158:10 369:19
immediately 20:15
immunization 3:3 3:4,5,18,21 4:9,10 24:21 25:2 26:10 27:13 28:6,10 30:1 32:18 41:5 45:6 47:11 49:13 52:15,16,19,21 60:15 62:2,19,20 63:8 65:6,7,11 69:15,18,19 71:19 81:2,4,18 82:1 83:2,8 89:12 95:19 96:5 97:9 101:7 226:20 227:6 242:15 255:14 263:6 265:9 289:22 296:14,22 297:4,9 297:11 298:13 299:9 302:2 303:22 307:17 309:13 313:9 320:14 321:11 322:9
immunizations 46:6 67:10 94:1 245:16 246:6 249:1 301:3 307:13,15 316:2 323:8 334:22
immunize 27:16 289:16 291:20,21
immunized 267:11 267:11,13,19
immunocompro... 175:10
immunosuppress... 180:9,15 181:1
impact 37:2,5 38:19 58:13,14 82:10 111:17 118:13 120:1 134:15 141:15 143:5 145:20 211:12 212:16,21 213:1,2 214:19 340:3 356:12
imperative 28:12 30:20
imperfect 161:22
implement 52:1 54:5 153:19
implementation 88:19 113:21 353:1
implemented 38:20 39:2 53:18 91:3,4 114:13 153:16 299:6
implementing 157:9
implications 145:5 168:9
implied 131:14 138:11 325:11
implies 271:22 288:2
imply 257:2
implying 124:22
importance 21:19 30:2 36:18 38:6 62:7 63:19,20,21 111:17 116:13 118:13 204:19 211:19,20 239:1 281:8 332:7
important 6:16,18 12:7,22 16:3 22:18 32:15 41:5 52:14 53:6 55:22 57:14 60:15 109:1 115:20 120:21 127:21 134:21 136:16 158:22 159:4 170:11 205:5 214:11 222:5,8 256:21 266:11 272:7 277:22 282:8,14 290:7 293:15 305:13 314:16 323:15 324:10 329:18,22 330:4 332:11 336:14 346:5,9 347:9 348:19 353:8 363:3 364:18 371:12
impossible 310:1
impressed 6:11 20:15
impressive 315:7
improve 113:17
improved 159:2 197:6
improvement 36:19 37:9 56:19 87:22 88:13 160:6 161:3 165:13,22 167:1 195:6 273:10 283:7 284:12 322:5 346:20
improving 195:6
inactivated 28:14
inadequate 222:21 224:8,16
inappropriate 367:1
incentive 104:11,17 196:6
incentivized 197:1
include 63:13 71:20 140:21 142:14 178:8,14 183:5 224:11 232:2,7 262:18 267:10 281:1 306:18 363:17 375:18
included 26:19 27:1 58:17 73:19 89:3 94:15 115:9 115:10 140:19 142:12 166:21 170:15 177:15 190:14 204:3 223:4 229:18 262:7 268:21 346:4 369:22
includes 168:15 254:13 306:11
including 129:16 176:18 177:11 191:1 253:12 255:6 262:17 375:8
inclusion 86:9
inclusive 250:10
inconsistency 126:9
inconsistent 217:4
incorporate 95:1
increased 158:3 176:17
increases 126:12 175:4
increasing 31:3
incredible 162:7 313:12
incredibly 188:12 196:7 203:19 232:1

indefinite 181:15
indefinitely 180:15 180:21 181:11
independent 182:9 310:3
independently 39:22 195:18
indeterminant 142:7,13,14
indicate 71:17 145:21 309:12
indicated 46:17 71:21 81:12 111:18 142:11 183:12,13 249:21 254:18 268:12 271:17
indicates 27:19 71:18
indicating 257:17 257:20
indication 39:1
indicators 24:16 341:21 355:19 356:1 358:3,8 365:11,18
indirect 158:20
individual 7:6 53:17,19 56:17 97:16 114:11 122:9 123:2 163:7 165:18 294:18,19 296:1,17 316:1 318:17 319:12 327:8,22 339:6
individually 242:17
individuals 27:17 173:22
indulge 5:17
indulgence 226:22
industry 51:22 52:3 341:22 342:1
infected 174:5
influenza 3:4,5 24:21 25:2,9,13 26:10 27:10 28:6 28:10 30:1,21 31:7 32:19 33:17 37:16 41:4 46:16 48:5 60:15 62:19 62:20 63:7 65:7 66:20 69:15,18 81:10 89:12 106:13 227:6 257:15 270:8 287:15 338:4,7
info 281:18
inform 243:5 288:16 301:8 345:19
informally 158:13
information 26:10 26:13 36:8,9,12 36:12 44:8,9 55:20 56:2 58:18 58:21 59:1 61:13 61:17,19 65:1 78:4,17,21 80:17 80:20 85:5 105:16 143:14 159:19 160:4 161:13 163:19 164:4 165:6 166:1 168:15 169:18 185:1,3,9 196:8 212:12 213:20 215:18 225:16 231:11 235:20 236:22 260:13,18 268:6 271:5 275:16,21 276:9 283:6 286:13 300:1,18
informed 122:8 132:22 276:7 345:20
informs 33:1 243:15
inherently 104:6
initial 21:19 183:17 213:6 310:8 367:22
initially 19:12 57:10
inkling 118:22
inpatient 46:12 93:4 254:12,13 268:10 322:2
inpatients 46:13 81:7
input 153:5,5,13
inroads 360:15
insert 60:9
insight 61:2 190:15 291:18
insights 330:8
instance 40:5 235:20 274:9 366:19
instances 326:8
Institute 1:21 24:10 163:21
institutional 321:22
instrumental 5:21 8:13,16 11:17,20 21:20
instrumentally 9:9 324:13
intact 195:7
integrated 246:20 253:13
intended 28:22 66:17
intensity 349:13
intent 65:17 66:20 68:2,4 69:13 74:3 75:16,17 76:1,5 77:15 199:11
intention 193:3 283:20
interact 344:17
interaction 158:16
interdigitated 374:14
interest 23:13 24:1 24:7,14 159:13 293:11 334:14,16 372:9
interested 156:1 157:4,5 223:15 296:14,17 343:3 359:1 367:3
interesting 14:12 83:19 84:3 360:19 366:10,14
interests 207:14
interface 13:15
intermediate 147:8
internal 111:22 134:7 237:17 327:9,21
internally 134:4 142:4 166:9 293:10
International 24:5
internationally 16:14
interoperable 314:4
interpret 37:14 144:8 269:18 291:5
interpretation 122:22 123:2 271:10
interpreted 132:16 147:5 268:15
Interpreting 269:19
interrupted 356:6
interval 178:22 192:8
intervention 82:21 118:15
interventions 161:21 349:14
interweaving 13:5
intolerance 257:18
intro 25:15 49:1 110:8
introduce 109:14 193:16 209:16 210:4 301:14
introduced 23:12 173:7 174:1
introduction 109:3
introductory 63:3
invasive 175:5
investing 327:15
invite 23:8
involve 11:11
involved 32:7 203:10 229:16 351:7
involving 296:13
IOM 24:5 164:8 358:7 359:18
irrelevant 344:5
isolated 20:4
isolation 13:19
issue 45:3,7 56:12 57:11 61:14,15,20 72:6 74:15 78:7 80:20 85:17 86:16 87:3 91:16 92:7,8 94:7 95:16 97:20 101:9 104:1 116:12 118:17 119:16 120:1 122:4 124:12 126:7 127:20 130:17 135:9 141:10 148:17,20 159:10 162:15 164:10 165:17 167:9 170:17 175:17 189:17 200:18 202:18 204:7,21 205:5 216:15,19 218:13 222:8 228:11 229:7 230:15,21 231:16,17,21 232:8,14 234:5,21 234:21 235:3,3 237:9,15 242:1,18 250:4,12,19 251:5 251:10 257:14 258:13 261:9,14 262:15 267:4 273:11 276:5 278:18 279:1 280:18 286:6,6,8 286:19 289:15,17

289:18 299:18 303:3 305:8,12 306:21 307:9,9 308:15,17 313:9 338:13 339:9,12 341:9 343:2 354:7
issues 30:7 39:17 40:18 50:5 78:22 83:14 91:1,1 94:15 99:16 100:20 107:6 112:3 113:1 114:14 123:11 133:9 147:10,19 154:10 156:1 158:2 167:21 168:8 188:10 196:21 206:15 212:4,5,18 213:15 221:8 233:18,22 234:2 237:7,13 238:18 242:20 245:14 248:4 249:16 251:13 252:4 264:9 265:21 266:22 275:20 279:17 285:11 288:7 289:7 291:14 298:15 314:14,16 318:7 332:19 338:15 343:7 354:1 355:1 356:12 365:10 370:3 371:14
item 97:8 136:8 371:11 372:7
iterating 15:3
iteration 13:21

J

jabbed 325:13
Jackie 33:3 43:14 83:6 94:17 101:15 103:12 138:8 145:2 194:4 195:12 247:10 254:8 262:12 276:12 277:10 287:18 292:5 296:3 312:9 316:10,14,22 346:1 348:20 353:21
Jackie's 291:2
Jacqueline 1:18 37:2
January 46:15 81:9 124:9 135:21 136:20 151:2 152:5,21 153:2 297:15
Jarris 5:10
Jason 1:23 47:14 81:3,15,17 84:7 84:12 85:20 88:14 247:12 262:12 289:10 355:9 360:21 367:10
jaw 189:11
jazzed 6:11 20:14
JD 2:8
jiving 146:19
job 15:2 22:17 77:19 84:11 129:22 130:1 202:13,13 353:2
Joe 168:21
join 173:7
joining 5:12 291:12
judgment 58:5,9 61:18,21 62:3 284:14
Judy 187:3,8,14 190:2 196:9 198:11,14,16 199:14
juggle 109:20
July 153:17
jumped 155:16
justify 232:15

K

Kaiser 1:25 162:9 165:5
Karen 2:5,10 87:5
KCQA 3:4 26:14 29:6 30:20
keep 16:8 20:19 35:4 79:1 107:7 119:15 122:13 137:17 146:5 159:4 169:3 178:16 186:7 215:3 251:12 266:12 286:16 353:17 372:7,8 374:11,17
keeping 35:19 375:13
Keith 1:17 104:9 151:17 152:2
Kevin 2:14 173:13 173:14
key 87:3 104:4 105:5 107:14 169:9 172:13,18 226:5 233:17,18
Keziah 2:16 287:10 291:8 294:1
Kidney 2:21 25:4 26:3,7
kids 302:4,6 313:4
kind 5:7 10:13 13:7 14:17 17:14 40:3 88:7 103:6 111:20 113:1 120:8 122:10 131:18 155:6 157:7,22 161:19 163:14 178:19 192:2 195:10 197:22 198:3 199:4 205:4 278:15 288:13 292:21 295:14 298:3,15 305:16 310:1 311:3 320:16 322:5 326:14 327:6,21 337:22 343:4 344:2,5,19 350:16 351:4 357:9 368:17
kinds 14:4 270:19 332:19 337:6 359:22 364:19
KINSINGER 1:14 14:2 50:2,17 51:2 58:4 59:7 67:2 68:11 69:5,20 79:6 115:6 126:10 141:2,18 142:18 177:11 179:15 216:14 218:3,6,17 219:16 221:10,15 224:4 234:4 248:3 248:12 257:13 284:1,22 363:8
knew 287:11
know 6:2 21:16 22:12 24:3 30:9 31:9,18 34:22 35:5 38:22 39:15 50:7 51:16 54:4 54:15,16 55:10 56:3,11 57:7 59:16 60:3 61:1 63:17 65:9 87:7 90:16 92:14 98:5 107:7 110:7 116:5 119:10 124:18 126:6 128:16 129:16,17 131:11 135:2 140:2 141:10 142:2 143:2,18,18 144:9 144:16,17 145:15 145:18 148:5 150:10,13,19 151:18 156:18 159:16 160:19 161:10,18 162:9 172:11 177:7 179:18 181:17,20 181:21 183:7,22 184:7,14 190:12 192:7 193:8 194:22 195:22 196:7,18 197:3 198:16,20 204:4 207:8 209:9 211:15,21 216:10 216:16 219:11,20 228:17 231:10 233:1 240:1 241:19 245:6 248:19 249:13 259:2,22 263:3 265:15 267:13 279:2,9 280:6,6,8 281:10 283:12 284:18 295:22 297:13 302:21 303:3 305:22 309:15 313:8 316:7 317:6 321:14 322:2 328:14,18,20 331:9,9 336:2,22 337:19 339:21 341:4 342:7 343:9 349:4 352:21 354:20 356:14 358:13 359:15 360:2 361:4 362:11,12,13,14 364:1,2 366:8 368:5 371:4 375:17
knowing 281:7 362:5 367:11,19
known 281:14
knows 344:15
know,is 126:12
KP 135:6 202:20
KP's 179:22 180:5 183:3
Kristin 2:7 14:10 42:10 43:7,9,10 171:11 375:15
Kristin's 43:1
Kurt 1:10,13 5:9 13:4 37:16 132:10 156:18 169:10 186:22 234:20

285:5 376:2

L

LA 9:13 13:6,16 14:19 17:6,14,21 18:1 347:10 351:12 358:20 360:3 373:21 374:14
lack 261:11
Lackner 2:19 208:13
Ladies 116:16
laid 253:7
language 20:10 69:17 102:4,5,12 102:15 104:3,5 112:11 115:7 144:20 160:9 163:19 164:1 283:19 291:3,5 336:13 364:16
languages 166:20
large 59:10 196:19 211:21 282:7 284:5,6,10 317:12 318:4
larger 6:15 7:2,9 8:20 16:10 33:1 59:18 72:5 88:11 147:4 167:10 191:3 243:20 245:20 246:1 281:22 286:21 288:15 301:8 325:1 353:10
lat 165:12
late 234:11 368:16
latest 184:9
launch 349:21
launched 163:10 206:5 350:1
laws 341:20 350:19
lay 233:18
laying 121:13
lead 31:3 109:17 174:17 180:7 203:1 362:6
leaders 66:13
leading 146:2 358:3,7
learn 243:14
learned 108:16 245:18 301:6 320:13 364:17
learning 7:10 325:6
learnings 324:10
leave 94:3 123:16 126:16,19 127:9 148:7 235:15
Leavens 2:20 173:1 173:4,12
leaves 57:13
leaving 126:19
led 10:9,13,21 11:2 214:4
left 254:19 263:16 299:4 367:14
leftover 279:11
leg 135:22
Legacy 354:20 355:2 362:12
legislation 350:19
Legislatures 363:19
length 357:5
lengthen 175:19
lengthy 113:5
LEONE 1:15 151:21
lessen 353:6
letter 233:19
let's 43:10 46:7 47:22 62:4,9 66:7 77:1 79:22 128:10 196:19 221:1 233:21 243:22 245:3 251:12 252:20 348:10,10
level 26:11 29:3,3 35:15,16 36:6 39:6 41:9 44:21 46:20 51:12 53:15 53:22 63:10 64:21 64:21 65:2 66:9 66:21 68:3 69:13 93:19 97:14 114:13 118:6 166:7,7 171:4 176:3 205:14,17 205:21,22 223:21 246:19 251:3 274:8 277:10 279:18 280:4 285:14 288:8 294:5,6,13 316:21 319:2,13 321:8,22 322:1,16 338:16 339:4 340:9 342:17 343:17,21 344:7,11 349:2 350:14 352:19,19 357:8 365:21
levels 175:12 205:18 253:12 281:7
liberating 348:5
life 132:11 195:3 337:8 340:4 357:5
liked 84:5
limit 138:5 154:13 183:18
limitation 215:5
limitations 130:11
limited 66:16 273:18 288:20 293:4
Linda 1:14 50:1 58:3 62:21 70:16 73:2 124:17 134:3 140:7 141:1 170:11 177:10 216:13 221:1,2,7 222:7 224:2,6,14 229:11 234:3 247:10 257:12 262:12 283:22 352:5,7 363:7,16
Lindee 2:15 209:13 253:18
LINDE-FEUCHT 1:16 352:8 357:14 358:6 360:13 370:13
line 5:5 25:15 47:20 69:3 81:16 99:20 107:13 116:17 172:9,11,15,17 173:16 208:7,9,13 209:14 247:1 253:17 265:13 270:10 287:9 291:10 298:4 319:9 330:14 369:3,5,8
lined 155:14 246:8 283:13
lines 107:10 245:5
linguistically 163:15 167:5
link 353:3
Lisa 2:21 25:14,16 26:3 29:11
list 14:19 194:17 362:16 375:2
listed 85:10,12 114:10
listening 107:11
lists 224:11
literature 278:12 281:13
little 5:20 15:19 25:20 26:13 32:3 32:10 35:22 42:21 49:1 51:22 55:10 98:9 100:17 103:14 109:20 118:8 120:21 123:13 127:14 135:22 162:19 176:4 178:2 180:1 183:2 186:8 187:7 187:15 189:16 199:11 202:20 215:2,5 226:13 235:5 238:5 243:17 262:15 266:4 271:4 278:11,13 290:4 311:12 319:10 339:21 340:1 345:12 347:20 349:11 360:2 367:17 368:13
lives 213:8
local 350:15
located 220:17,18
location 93:11
locations 93:13
locked 18:15
logic 142:8
logical 73:5
logistical 91:1 99:15
logistics 42:8 337:17 374:20
long 114:7 151:18 156:22 160:21 188:22 189:4,21 205:17 229:10 246:9 331:9 337:7 344:16
longer 16:16 51:7 175:20 177:13 197:1 230:7 273:18
longstanding 27:20 49:15 50:3 56:3 110:12 117:17 122:1 319:5
look 14:6 15:14 16:13 22:20 24:15 35:12 37:4 39:5 39:21 43:11 44:4 46:11 47:22 51:7 52:6 56:1 57:8,11 58:20 82:9 86:12 86:13 95:8,21 97:13 100:9 102:20,22 118:21 121:7 123:20 124:2,3,7 126:22 127:3,10 128:4,16 135:14 146:12 147:10 154:19

159:1 160:8,12 165:17 166:17 169:7 183:16 185:11 203:21 206:22 207:4 209:4 215:7 217:15 219:4,7,8 221:2 224:15 227:21,22 241:16 242:18 246:6,13 264:11 287:17 290:1 292:16 295:9 302:3,6 304:7,22 305:1 306:1,2,3,3,18 307:20 316:7 323:3,9,14 324:3 324:13 330:4,5 338:19,21 343:8 344:18 351:17 352:12 356:10,16 359:2,20 361:6 373:7,8
looked 83:4,10,12 89:16 103:2,3 120:4 146:22 156:19 170:14 188:9 248:3,5 249:16 258:15,19 268:2 305:1 310:9 311:22 322:20 338:4
looking 8:6 9:19 14:4 15:9 16:19 35:22 36:6 37:8 39:11 40:1 42:7 87:20 88:4 95:9 96:22 99:12,21 100:17 103:21 125:5 127:14 142:9 147:12 156:22 163:2 168:2,7 170:5 176:21 178:11 185:20 188:19 194:11 205:13 216:2 222:10,20 235:1 243:3 250:7 250:7 254:1,6 255:3,4,9,11 261:10 262:19 263:13 274:20 281:11 283:16 294:18 295:14 300:16 303:20 305:9 317:17,18 318:13,15 319:12 321:10 322:21 323:5,13 333:16 333:17 338:22 340:15 344:13,22 351:12,15 360:5 362:1 363:15 373:10
looks 9:8 11:4,5 12:6 13:4 100:12 110:16 111:1 119:1 120:16 163:18 189:13 228:13 257:22 368:15
look-back 112:21 113:5,22
look-backs 113:1
lose 81:15 267:15 348:19
losing 61:4
lost 116:17 298:15 302:14 322:11 364:21
lot 11:15,17 16:16 21:2 61:4 66:3 67:15 73:14 85:7 98:22 103:14 113:15 125:7 134:5 150:3,11 159:16 178:21 197:4,6 205:16 207:11 216:15 247:18 257:10 271:16 275:3 281:19 285:10 291:13 301:17 308:1 315:3,20 333:6 334:12 337:16 341:18 346:14 347:3 354:14 360:10 364:12 366:5,8 369:16
loud 339:16
louder 178:2 187:8
love 129:1 338:2 357:3,18 359:3
low 58:9 64:7,18 67:11 187:7 189:14 234:6 259:22 332:15
lower 112:17 131:12 147:21 351:1
lowest 349:2
lt's 186:12
lumped 133:15
lunch 186:6 207:18 228:18 243:22 244:4,7,8
lunches 244:1 245:7
Lung 1:15

M

machine 341:20
Madeline 1:19 15:6 16:12 38:10 85:18 170:2 359:4
mail 108:2
main 85:16,17 122:4 201:4 266:1 282:2 303:5
mainstream 365:2
maintain 195:2
maintenance 1:4 8:10 198:2
major 27:14 58:13 189:1 230:9 252:5 252:7 371:7
majority 241:21 285:8,15,20,21 371:2
making 9:7 56:14 69:9 99:19 120:9 127:21 128:2,6,20 129:4,14 130:8 139:3 140:3 190:21 202:21 203:3 220:1 226:16 277:17 287:20 289:5 291:22 364:14
male 3:15 141:8 142:7,11,19 208:19 209:17 210:15
mammogram 121:19 128:7,11
mammograms 127:16
mammography 145:21 158:14
man 375:16
management 2:15 2:19,22 164:5 177:14 198:21 214:1 264:16
managing 199:7 201:18
mandate 104:5 200:15
manner 28:17
March 25:10 31:13 46:15 66:6 67:5 73:3,15 81:10 152:22 227:5 230:7 234:8,13
Mark 2:13 62:14 62:22 63:2 70:5 74:8 226:9 228:10 229:12 231:5 232:4 234:5 241:3
marked 53:22
Marriott 1:9
Mary 1:21 2:13 23:10,14 24:9 61:1 116:2,3 124:14,16 127:5 176:10,19 194:3 202:5,13 352:6 353:18 355:8,14 356:7
Mary's 203:15
MASON 1:17 44:5 104:10,21 116:21 117:6 152:3 207:22 240:3
mastectomies 140:14
mastectomy 132:4 132:5 140:16,18 143:16
match 10:17 85:19 227:4,8,11 228:14 264:18
matched 8:20
matches 85:20 116:1
materials 15:18 20:9 161:19 196:12
Matt 1:25 10:9,20 12:5 33:3 58:1 94:16 134:2 143:18 179:20 182:13 185:9 194:5 240:10 278:16 322:13 339:13 343:11 345:22 353:19 355:9,14 356:18
matter 108:12 143:10 144:2 244:11 280:12 376:5
Matt's 44:6,10 97:6 182:20 241:7 243:1 343:1 356:5
maturity 334:5
max 112:18
maximal 332:22
ma'am 247:22
MBA 2:6
McELVEEN 2:8 167:18 168:3
McGONIGAL 2:21 25:14,17,22

26:2,3 38:21
43:19 44:1 94:18
MCH 313:7
MD 1:13,14,15,16
1:22,23 2:6,10
201:22
mean 16:21 34:21
37:17 41:2 58:13
59:18 76:18 78:3
79:7 86:19 94:12
98:18 102:6
128:12 133:21
141:9,15 142:22
161:9 201:5
202:14 207:20
218:7 219:4 223:4
229:1,18 235:22
257:22 270:19
274:1 275:11
312:6 313:16
316:5 317:6 327:2
329:12 342:2
358:7 362:10,20
368:14
meaning 87:1
137:8 278:3
334:17
meaningful 114:17
115:4 138:21
139:21,22 140:3
156:13 342:19
means 70:15 102:9
111:3 123:2 229:5
229:7 236:20
264:2 271:17
272:4 309:8,15
333:4
meant 287:20
measure 9:9 19:1
21:2 22:3,7 25:1,2
26:12,13,14,20,22
27:7 28:5,7,10
29:9,14 30:19,21
31:2,9,11,14,17
32:13,15 34:6,17
34:22 35:15 36:15
36:17 37:9,17
39:1,6,7,14,22
41:15,21 42:5
44:3 45:7 46:2,10
46:12,18,19,20,21
46:21 47:2,22
48:1,3,8,14,19
49:1,4 50:3,15,16
51:10,10,18 52:9
52:20,21 53:20
56:4,7,21 57:3,10
57:13,20 60:11
61:14 62:15,15
63:1,6,8,8,10,12
63:19,20 64:2,3,6
64:12,18,19 65:4
65:17 66:4,12
67:19 68:3,12
69:10,13,17 70:1
70:3,21 71:8,8,22
75:4,4 76:14,20
77:3,7,15 81:3,3,5
81:7,21,22 82:8
83:4,9,10,15
84:10,13,19,20,22
86:2,19 88:17
89:21 90:6,20
91:6,11,13 93:3,4
93:5,6 94:8,10
95:2,10 96:12
101:6 103:2,7
108:21 109:3
110:2,6,11,12
111:5,9,12,15
112:1,7,12,16,22
113:7,8,10,12,14
113:18,20,21
114:5,10,15,19
116:1,8 117:7,8
117:17,21 118:5
118:10 119:11
121:2,15,16 122:1
123:16,19 124:21
125:11 126:6,16
126:22 127:7
128:1,4 129:6,19
130:5,6,12,18,20
131:1,5,9,11,18
131:21 132:7
134:20 135:11,18
138:20 139:6,9,12
140:15 141:16,20
142:1,8 143:12
145:16 146:6,10
146:15 148:6
149:12,20,21
150:3,9,15 154:18
154:20 155:1,4,7
155:10 156:3,13
156:19 157:1,7,9
157:11,20 158:11
159:1,21 164:16
164:20 165:18
167:9 169:13,16
169:16 170:5
171:17,18,19,22
172:7 173:8,11,20
173:20,22 174:17
175:12 177:10,16
177:17 178:11,16
178:19 179:4,6
181:8 183:19
184:11 185:16
186:15,21 187:13
187:16 188:11
190:3,9,12,13,18
190:19 191:4,16
192:3,9 193:4,13
193:17 194:2,10
195:19 196:5,13
197:2,9,11,12,13
198:10,14,16,19
198:22 199:1,6,11
199:15 200:4,10
200:19 201:5,9,9
201:12,15,21
202:3,4,16 204:4
204:8,18 205:11
205:14,19 206:20
208:4,5,16,19
209:16 210:2,5,13
210:14 211:7,14
212:16,17 213:13
214:7 215:16,19
217:8 219:1 220:6
221:4 224:7
226:13 227:4,6,8
227:21 228:1,7
233:11 235:1,8,13
236:4,7,9 237:7
237:14,16 238:1,4
238:7,9,16,21
239:13,20,22
240:13 243:8
246:12,13,18
247:4,8,12,14
248:16 249:9
250:2 251:15
253:1,11,21,22
254:10,20 257:15
258:4 261:19
264:8,13 265:2,8
265:11,14,17
266:1 267:18,22
268:1 270:5
272:17 274:8,14
276:3,6,20 277:6
277:15 278:22
279:5 280:7 281:6
281:8,11,14,14
282:11,20 284:20
284:21 286:19
287:1,3,3,9,13,14
287:17 288:17
289:2 290:10
291:13,15 293:3,3
293:5,12 294:19
296:21 297:11
298:13,16 299:3,4
299:5,10,14,15
300:3 301:14,21
302:1,20 303:5,20
304:8,14,18 305:8
305:18 306:1
307:2,8,11,13
308:3,18,20
311:19 313:21
314:1,17 316:17
319:5,6 329:9,20
331:2,2,3,21,22
334:14 335:5,10
336:17 340:6,9,19
341:8,12 342:20
343:8 344:22
350:18,18,20
353:9 354:10,13
355:11 361:7
365:3 370:3 372:6
372:12 375:22
measured 6:21
21:21 73:7 190:5
220:5 275:10
280:20 343:20
measurement 11:5
17:1 32:8 44:21
48:6,22 49:17
53:22 117:12
123:10 124:10
127:16 128:15
132:19 134:13
152:11 153:4
168:9 172:4,6
187:14 197:16
205:19 302:8
324:15 334:5
350:3 353:12
measures 4:14 5:6
5:22 8:5,10,12 9:6
9:7 11:1,3,4 14:5
14:12 16:6,20
18:4 20:16 22:10
22:14 24:21 26:8
27:3 28:20 30:9
30:15 31:10 32:18
33:16 35:12 40:2
40:19 41:9 42:19
44:13 45:6,14,15
45:20 46:4 49:2
49:10,15,19,22
50:9,19 51:12
54:17 56:15 57:15
60:8 62:1 65:11
67:5 71:3 74:3,13
78:6 79:21 85:7
85:10,13 89:12,14
90:1,9 91:4 92:20
93:9 94:6 95:7,12
95:17,20,21 97:22
98:3,7,10 99:12

99:18,22 101:7 103:11,22 105:6 105:20 106:8,10 106:13 108:10 109:18,22 114:20 116:22 118:4 124:11,19 127:14 131:15,16 136:2 139:16 151:11 152:16,20 153:8 153:22 156:7,9,15 156:16 157:2 158:1,6,22 159:17 160:2,8,11,12 161:18 162:16 163:2,7,19 165:8 165:19 168:11,18 170:13 186:1 190:4 191:1,18 196:3 198:13 199:22 201:4,7,12 203:8,9 205:10,16 205:20 206:5,7,8 207:4 209:4,7 210:20 214:6 225:6 226:2,20 230:18 231:1,15 231:20 233:4,8,10 233:12 235:11 236:13 242:15 243:4,6 245:10,19 245:21 258:5,15 258:21 260:5 265:22 266:8 272:16 277:4,13 277:21 281:20 286:17 298:20,20 299:22 300:16,19 301:8,9 304:15,16 305:3,17 306:2 308:7,22 312:12 314:12 315:19,20 316:15,22 317:21 318:4 319:4 320:14 321:7,14 322:4,16,17 323:8 324:16 326:4,10 326:12,14 328:5,6 328:9 329:16 330:1,18,19,21 331:4,15,18 332:3 332:13 333:8,20 334:9,10,12,21 335:2,7,16,18 336:5,7,18,18,20 337:1,2,4,6,8 339:18 342:16,17 343:20 344:2 346:11 347:8 348:22 349:18 350:7 351:14,15 352:13 354:16,22 357:8 360:8 361:5 362:17 364:6,20 365:5,15,16 366:2 366:13 367:9 371:13 373:13,16 374:2

measure's 160:15
measuring 6:13 10:10,14 30:3 47:11 99:4 129:20 198:3 258:11 296:21 334:15 344:20
mechanism 42:4 212:7
MEd 1:20
Medicaid 27:2 155:21 156:4 159:3,11
medical 25:12 27:9 28:16 50:20 54:12 54:16 64:21 65:18 118:9 119:12,17 119:20 120:7 128:17 130:12 144:12 197:21 210:9 212:11 213:18 259:20 260:12 311:20 313:22 356:9 360:9
Medicare 27:2 49:8 54:10 187:17,19 190:4,8 195:22 196:1 250:20 251:5,7 299:7
medications 194:8
medicine 163:22 276:17
Medows 109:16 155:5,22 156:14 171:18 174:17
meet 42:12,15 43:3 50:9 56:17 72:21 79:17 83:15 99:13 102:15 138:5 139:11 152:17 211:20 263:17 339:18 340:13,17 354:5 374:17
meeting 23:21 24:12 58:22 84:15 90:3 100:5 124:9 139:8 141:19 207:9 270:16 281:21 289:14 329:19 370:18
meets 36:17 39:22 40:9,13,16 42:6 43:12 50:6 86:5 103:18 111:16 204:19 255:12 269:15
member 5:12 142:10 161:14,20 203:3,6 211:6 241:15 372:16
members 23:8 29:13 48:11 55:2 83:4 110:3,16 120:9 121:11 143:17 152:5 155:9 156:18 187:22 212:2 267:2 373:6
membership 35:4 160:9,10 318:1
Member/Public 3:7,17 4:16
men 209:19,20 210:15,17,18 211:16 215:1,11 215:12 216:20
mental 345:7
mention 61:6 84:18 111:8 167:12 176:15 213:5 310:15 321:2
mentioned 30:20 38:13 85:11 97:7 310:5 315:15 359:6 372:19
mentioning 86:3
MERRILL 1:18 33:4 34:18 43:15 61:6 68:16 73:12 73:18 83:7 95:15 96:11,18,21 101:16 138:9 145:4,13 150:21 195:13 200:14 203:7 204:1 207:3 220:13,16,20 229:15 230:11 247:18 248:6 249:2,14 250:6 251:9 252:12 254:9,22 255:17 256:1,20 257:6 259:6 260:20 261:6,20 262:5,8 262:13,16 263:5 263:20 265:4 269:10,17 270:11 279:4 287:19 288:18 290:12 292:10 295:19 296:4,9 297:6 313:6 314:3 317:1 317:13,18 349:20 363:21
mess 186:6
message 108:2
messed 5:7
messy 314:18,22 315:3
met 1:9 21:18 45:16 77:8,15 103:9 105:2,4 106:5 183:6 228:1 238:21 316:22 371:17
methodological 168:8 336:8
methodologies 91:2
methodology 77:2 77:4 156:8
metric 134:7
metrics 356:2
MGH 168:21
MHA 1:22
mic 131:20 132:9
Michael 2:2 276:11 301:11 341:1 342:4
microphone 83:5 247:13 361:16
middle 123:13
migrant 318:19
Mike 274:22 290:16 316:14 343:11 346:1 348:20 366:15
mile 163:6
million 120:9 161:12 213:8 260:5
mind 137:17 146:6 169:3 266:12 286:17 348:11 352:10 374:11
mine 203:16 212:19 234:20 262:13
mineral 192:2 199:4
minimal 119:5
minimum 112:17
minorities 170:10
minority 170:9 285:22
minute 10:1 43:11 64:10 133:3

162:18
minutes 5:17 8:17 133:3 173:10 229:1,10 244:6,9 325:19 367:6
miracle 243:16
missed 95:3 120:2 218:13 268:5 296:6 301:18 303:10 355:16
missing 61:7,8 62:1 100:7 146:14 245:6
mix 311:3
model 13:14 18:9 38:3 322:20,21 343:1 344:20
moderate 37:22 38:1 39:13 58:6 125:16 332:14
modification 137:11,16
modifications 138:10 239:14 240:1,2
modify 227:8 229:19 235:14 237:22 358:11
mom 157:12
moment 6:9 116:18 173:15 193:2 299:1
money 354:13
monitor 202:1
monitored 338:10
monkey 370:21
month 73:15 168:19 231:8 233:2 283:2 374:16,16
months 25:7 27:8 46:13 51:5 62:17 63:14 71:9 81:8 180:11,12,17 182:2 197:19
morbidity 323:14 337:13 340:5
morning 6:2,4 15:7 23:17 24:8 26:3 37:16 48:20 63:5 79:16,21 80:15 126:3 186:1 210:12 235:2 265:12 266:2,7 281:17 301:17 320:13
mortality 145:22 214:14,19 323:14 335:2 337:11,12 340:5
motion 285:6,10
mouth 137:13
move 32:1 80:10 105:21 106:2,11 135:13 137:15 170:1 204:20 228:6 259:1,11 278:20 332:22 345:19 353:15
moved 278:2 332:6 333:19
movement 6:15
moving 7:6 34:10 92:15 162:8 171:14 203:9 208:19 239:16 282:21 283:1 328:15 333:14 336:19
MPA 1:25
MPH 1:14,18,23,23 2:6,7,8,9,10
MPP 1:13
MSN 2:6
muddy 335:17
multi 334:6 344:2 346:15
multiple 253:12 275:18 297:3,14 297:22 298:9 304:15 313:11,14
multi-cultural 160:16 163:11 165:8
multi-stakeholder 151:7 152:12 347:2 348:4
MUNTHALI 2:9 151:14 369:13 370:17 372:2,10 372:15 373:14 375:3
mutable 87:8
Mute 107:17 182:21
myriad 166:15

N

n 294:13 295:5 317:3,13,14,20
NAEGLE 1:19 15:7 38:11 93:14 94:11 170:3 171:1 359:5
name 321:2,3 355:12 375:17
names 49:4 188:19
narrow 47:13 265:15 358:5
national 1:1,14,17 2:2 85:4 180:7 203:1 284:4,19 321:8 330:15 350:14 351:13 352:10,16 354:22 358:15,16 363:10 363:18 365:17,20 366:19
nationally 16:14 321:9,13
nature 31:15
navigating 125:1
nay 182:11
NCQA 2:13,14 3:5 3:9,10,10,11 4:10 47:19 48:1,19,22 56:5,6 60:9 93:6 110:6,11 111:5,12 111:19 117:9 119:11 121:17,21 125:20 134:8 135:19 136:10 147:9 149:13 150:16 153:5 154:22 157:22 158:5 160:7 161:16 163:10 173:21 186:17 187:4 196:16 197:12 200:18 202:4 204:18 206:19 246:15 247:1 301:15,22 302:22 315:13 317:20 323:22
NCQA's 126:6 137:12 139:3
NCSL 363:18 364:2
near 68:9 355:1
nearing 67:16
necessarily 45:3 194:9 227:10 260:11
necessary 40:11 66:3 230:8 292:2 347:8
need 11:16 14:17 15:5 18:6,17 21:14 22:1,21 28:12 30:10,21 35:21 40:3,6,7 58:18 72:12 76:9 80:10,10 83:5 91:20 100:9 102:5 102:7 106:15 107:6,8 109:1,4 125:10 133:19 146:5 148:10 154:4 161:20 166:3 170:8 177:13 186:2,11 202:14 205:12 212:17 215:2 223:20 224:10 229:1 232:4 233:16 237:21 238:4 239:19 242:9 250:3 251:13 258:10 264:5,10 267:8 268:18 271:20 272:13 279:3 280:5,6,15 282:10 285:9 288:3 298:18 300:17,19 310:11 323:12 328:9 331:14 335:7 339:12,17 341:14 345:8,9 347:15,16 348:14 350:13 356:16 366:17 372:7
needed 21:15 67:18 68:8 102:10 158:2 173:14 203:11 214:8 342:13
needs 30:10 76:11 97:21 102:11 130:19 143:12 146:16 216:9 236:22 267:5 284:6 286:21 308:19 309:16 333:7 345:19 375:10
negative 214:18 215:4
negotiation 235:10
neither 80:14
network 24:6 166:18
never 111:5 219:12 232:22
new 1:19 5:12 7:3 7:15 8:2,2 22:12 22:18 23:8 46:21 47:9 52:4,9,22 105:18 114:2 116:3 117:21 123:13 188:16 202:13 238:9 278:21 282:7 303:22 329:13 360:15 367:1

newly 7:15
nexus 321:17
Ng 187:3,5,9,16 190:16 191:8,17 193:2 197:3 198:18 199:17 201:8
NGA 364:2
nice 14:11,21 15:2 22:17 178:19,20 225:7 288:5 335:19 367:13
Nicole 2:8 167:15 375:15
nine 224:10 264:14 303:2,10 305:3 340:14
NISHIMI 2:9 169:2,19 294:11 295:8 329:8
nodding 293:16
Noes 79:3 120:15
noise 148:14
nonprofit 329:3
nonspecific 223:17
non-financial 24:2 24:6
non-high 174:14
non-pneumonia 274:19
non-randomly 59:15
non-recommend... 228:6
non-speaking 291:9
norm 21:12
normal 218:18
note 52:14 53:6 66:15
noted 63:11,13 64:9,22 65:5 124:13 151:6 300:2
notified 34:9
notion 291:20
notwithstanding 195:7
November 46:14 81:9 372:17 374:8
NQF 2:4 3:7,17 6:17 7:3,10,13 8:3 8:6,9,21 9:6,12 11:3 16:6 17:5 19:2 26:21,22 29:8 34:8 47:1 63:9 68:1 72:18 79:17 98:1 137:18 148:11 149:1,3,7 167:7,14 168:12 169:5 197:11 202:5 205:22 224:22 226:19 227:4 228:8 229:16 233:10 235:4 273:17 274:7 277:11 312:11 324:15,17 328:11 330:10,10 330:19 331:12 334:20 338:15 345:13,16 353:15 360:7 361:2 375:14,18
NQF's 6:19,22 7:4 16:11 28:6 33:14 35:5 333:11 337:1 353:8
nuance 180:4,5 334:18
nuanced 180:2 181:3
number 24:14 38:19 54:20 55:2 59:10 60:16,18 138:14 141:3,20 170:13 186:14 227:3 284:12 288:21 301:2,10 302:9 303:3 304:5 308:12 309:17 316:15 317:17,21 318:5 326:7 334:21 340:2 343:3 351:14
numbers 5:11 37:11,14 170:15 212:22 213:2 263:3 276:22 279:2 302:19 336:11 338:20 359:8,21
numerator 32:2 33:22 34:2 40:20 54:19 55:10 59:12 74:16,21 75:5,13 76:3,9,11,21 77:5 77:13 78:10 83:20 83:21 86:1 87:11 89:8 98:2,14 99:10 101:8 102:22 106:22 127:15 131:22 139:14 140:19 170:16 213:11 214:22 217:16 220:21 224:7 232:2 246:7 255:7 258:2,15,16 259:2 259:4,7,9,13 260:22 263:19 264:20 268:7,19 268:21 269:8 270:9 271:4,22 272:2,5,5 275:10 280:19 283:17 308:16
numerous 153:5,13 299:16
nurse 255:15
nurses 213:22 255:21 359:21
nursing 1:19 93:9 266:21 324:6 359:19
nut 365:14
nutrition 362:13
N.W 1:10

O

o 319:8
Obama 271:15
obesity 341:18,22 342:1 351:22 352:14 362:9,14
objection 154:3 185:5
objectives 357:16 357:17
obligation 241:15
observation 322:19
observations 61:7 61:8 317:14
Obstetrics 174:4 177:2
obviously 17:13 20:20 111:3 136:11 154:15 190:6 216:16 330:7 347:3 359:12
OB/Gyns 313:3,5
occurred 129:4 183:18
occurs 278:10
October 25:9 46:14 62:18 65:8 66:8 67:21 68:6 70:3 71:10 72:2,4 81:9 227:5 297:17 371:6 372:17
odd 311:3
Oddly 142:3
ODPH 358:2
offered 25:11 74:18 87:2,6 269:3
Office 164:5
offices 324:5
offline 206:9 298:3
oh 21:6,11,12 43:21 47:16,20 49:7 82:14 84:20 116:15 151:21 186:22 187:10 244:1 252:2,13 254:8,21 289:2 300:6 303:10 325:12 337:13 352:6
okay 13:16 17:2 19:14 21:12 23:11 25:19 42:22 43:4 43:13,21 47:16 48:17 53:1,9 62:14 64:17 69:12 72:8 78:19 81:1 84:20 87:16 88:20 95:18 111:1 112:14 117:6 120:13 128:8 131:12 145:13 151:22 152:2 155:19 156:14 167:13 169:21 171:10 181:7 185:6,19 186:12 186:22 187:11 197:3 201:2 208:14,18 209:8 222:9 224:1 240:17 244:7 251:20 252:9 254:9 255:17 256:1 257:5 262:14 263:16 265:1,7 267:17,20 267:21 273:16,22 279:12 282:17 283:14,14 287:1,2 287:18 288:18 298:5 300:6,10 308:8 310:13 344:9 348:9 363:6 367:4
Oklahoma 274:17 279:3 283:6 286:7
old 43:5 122:13 126:3 236:10 277:15
older 3:5,14,19 25:7 27:8 46:13 48:3,4,13 49:5,8 54:10 62:17 63:14 71:9 81:8 112:11 123:21 135:13

158:2 170:11,15 186:13,16,18 188:1 192:2,11 197:14 200:3 201:14 209:21 210:19 211:16,17 246:14,16 249:20 250:21 253:5 254:3 263:1 280:12 284:13,20 288:10
OMB 164:12
once 45:21 104:10 104:17 142:5 169:7 189:1 214:17 215:4,8 216:10 221:6 250:13
onerous 101:17
ones 31:8 32:19 44:19 91:19,22,22 93:2 120:19 169:15 242:19 245:12 302:21 311:22 358:1
one-question 164:18
one-star 331:21
one-time 214:15
ongoing 132:18 138:19 197:10
open 5:19 12:2 106:15 107:9 173:16 226:1 235:9,16 245:4 251:21 257:11 282:7 292:15 301:3 367:15
open-ended 299:21
operating 351:5
operationalized 270:13
OPERATOR 107:12 116:16 172:12,16,21 173:15 208:10,12 209:13 226:3 247:22 253:18 369:7,10
opinion 214:17 241:18 282:18
opinions 125:8
opportunities 10:18
opportunity 6:13 7:2,12 8:19,20 9:4 11:9 12:1 14:1 20:13 22:2 36:18 37:8 56:18 63:6 82:20 123:6 139:8 140:21 210:13 224:13 226:12 236:5 273:9 283:7 284:11 298:1 321:7,16
opposed 35:15 43:14 179:10 344:3
opposing 43:14,15
optimal 144:1
option 13:10 78:2 133:12 138:18 149:19 150:2 264:7 277:12 314:21
optional 138:15,17 139:5 143:8,9,20 144:3 155:12 157:16,17
options 92:5 184:15
order 8:5 152:21 153:21 161:18 223:5 245:12 314:13
ordered 197:16 220:11
organization 167:4 172:17 196:20 309:9,10 363:14
organizations 153:13 339:17 362:11,13,14,15
organization's 355:12
orientation 370:1
oriented 109:21 359:9
original 304:2
originally 49:11 126:17 127:8 256:19
osteonecrosis 189:11
osteoporosis 3:14 186:13,16,20 187:13 188:4 191:20 197:13 198:21 200:2 203:20 208:1,15 209:1,5 225:1
ought 95:9 357:11
outcome 43:20 94:3 156:16 248:11 334:14,16 335:7,9,18,21 336:5,7,20 337:1 337:3,6,18 343:5 360:8
outcomes 187:18 190:19 191:11 193:11 196:2,3 323:6 335:4 336:1 351:20 359:9
outline 18:22 164:3 174:3 314:10
outpatient 254:12 254:13
outreach 361:13
outside 160:14 200:7
outstanding 92:1
outward 343:16
overall 60:21 62:9 121:1 122:18 167:21 179:6 212:16 242:17 261:13,19 284:10 286:16 304:14,17 310:12 332:7,12
overlapping 18:8,9 50:8
overly 274:3
overlying 35:20
overuse 158:1,6 272:6 273:2,11
overview 30:8
overwhelm 335:5
overwhelming 316:2
over-call 218:16

P

PACE 2:10
package 207:1
packs 343:4
page 3:1 4:7 59:6 188:17 256:2 263:3,4 292:16 317:18
paid 6:21
panel 151:7 152:12 153:5
panels 153:6 188:18
PAP 155:2 175:1
paper 9:15 18:20 18:21 83:11 168:1 168:7,14,20 169:8 252:18 295:1 311:2 345:6,10 347:17 348:16 371:22 374:7,15
paragraph 284:17
parallel 13:18 137:5 287:14 325:6
parallels 353:8
parameters 342:14
parent 351:22
park 1:9,9 32:17
Parkland 1:20
parsed 309:14
part 6:14 12:22 14:19 19:21 49:13 54:7 57:16,20,22 59:18 65:3 82:1 90:6 99:11 101:16 115:2 121:10 124:20 126:18,20 127:4 128:3 130:10 131:9,11 135:4 138:3,11 139:6 144:13 148:5 152:18 159:6 161:1 170:21 180:21 191:2 200:15 204:1 211:13 223:19 236:20 241:14 246:4 290:21 294:7 320:8 323:6 334:19 336:14 338:12 345:7 346:5 347:21 356:15 361:18 364:4 368:18 371:22 372:11 375:7
PARTICIPANT 283:9,12
participants 172:22
participate 286:9 286:10 373:22
participating 370:8
particular 35:3 57:10,13,20 84:15 135:9 166:10 174:22 187:21 193:13 196:13 213:12 215:16 220:5 223:15 236:1 255:9 321:6 333:9 357:22
particularly 5:5 21:18 83:3 94:20 109:5 155:22 175:1 218:9 221:18 312:8
parties 367:3
partners 2:21 26:7 350:17 355:10
partnership 1:23

355:11
party 245:8,9
pass 86:15,15,15,15 87:13 142:16 154:16 275:18 281:9 314:13 333:20 334:3,3
passed 45:20,21 67:9 332:15
pass/no 333:20
pat 319:17,18
path 137:5 165:9 365:9
pathway 163:14
patient 26:5 28:11 54:12,15 62:19 64:21 66:12 67:18 69:16,16,18 71:18 71:20 72:4 75:19 95:7,11 96:14 112:2 114:1,2 119:19 128:5 130:7 133:6 202:15 213:21 257:16,19 258:9 260:17 266:7,9,12 267:6 271:7,11 296:13,15,17,22 297:2,7,13,18 311:15 322:16 323:7
patients 3:12 25:6 26:17 27:7 28:2 28:16 29:2,5 36:13 47:3,5,7,12 54:20 62:16 63:14 66:4 67:16 68:8 68:18 69:9,20 70:1 71:3,9,11,15 73:20 74:2,5 75:9 75:9,10,11,14,16 76:17 77:4,6,7 81:4 82:1,5 88:17 93:6 94:19 98:19 99:1 155:13 171:21 173:9 174:15 175:3,3,8 175:19 177:4 186:18 197:15 200:11 231:18 246:16 253:4 254:1,14 255:1 262:17,18,19 263:1 265:10,14 266:22 267:10,12 267:16,18 268:4 268:20,21 269:1,2 269:4 272:21,22 273:14 274:19 279:19 284:13 287:5,16,22 293:6 293:8 298:9 299:6 299:8 323:19 324:6,7 327:8
patient's 296:1
patterns 359:21
Paul 5:10 7:14
pause 243:13
pay 22:21 121:6 242:10 310:11
paying 276:18,19
payment 190:6
payoff 120:17
PCMH 54:5
PCPI 2:13 3:4 31:11 62:15,22 63:8 74:3 230:5 233:7,20 237:17 237:20 239:18 264:7
PCPI's 226:14
Pediatrics 27:14
Penn 1:15
Pennsylvania 1:15
people 5:4 17:5 19:3,11,12 20:15 20:17 22:16 27:15 34:20 38:19 44:8 49:18 51:14 55:9 55:13 58:11 59:9 59:10,15 61:5 62:2 92:2 96:2 98:21 109:2,11 115:15,21 123:3 123:20 134:1 135:12 139:7,13 140:12,13,16,21 141:3,5 146:22 161:12 162:6,22 163:1 164:11 169:7,13 170:12 186:2 194:1 195:2 200:5 204:4,12 213:9,10 216:4 217:10 220:4 221:8 223:21 230:1 232:21 234:7 244:1,2,4 256:8 259:6,8 260:8,21 261:1 276:16 278:3 289:16 291:21 295:17 307:7 310:16 312:1 323:19,21 324:1 327:22 332:13 333:1 336:1 337:9 338:1 345:5 357:1 357:1,17,18 360:3 361:6 366:4,17,20 367:20,22 371:21 375:8,10,14
people's 372:9
percent 27:16 28:2 59:8 82:15 144:15 144:17 155:21,22 160:22 175:16 211:16,17,17 213:12 256:8 259:18 260:6,10 273:8 284:4,15 295:6
percentage 25:5 48:4,11 62:16 110:3 117:9 121:17 155:1 186:17 209:19 246:15 253:3 254:1,14 287:4,21 341:19
perfect 90:19 192:20 228:20 326:1,2
perfectionist 359:2
perfectly 40:12 239:4
perform 190:7
performance 26:7 27:3 32:8 48:22 49:17 82:10 97:14 97:16,22 123:10 124:10 130:22 152:11 155:20 175:15 190:5 220:5 232:1 272:12 273:7 278:2,8,14 279:18 280:9 281:7,15 284:2,6,8 286:18 319:9 330:18 331:15,18 342:19
performed 197:17
period 48:6 101:20 112:21 113:5,22 121:19 137:22 140:17 147:9
periodic 278:8
periodically 278:4
periods 113:5
peritoneal 25:8
Permanente 1:25
permission 327:20 359:3
persistence 89:11
persistent 174:10
person 22:6 44:11 142:19 188:9 192:13,18 193:12 290:6
personal 214:2 260:19 282:17
personally 20:11 222:12
personnel 89:16
persons 289:19 310:9
person's 188:7
perspective 16:16 95:14 130:7
perspectives 242:5
petition 229:19 230:12
petitioning 230:15
pharmacologic 197:18
phase 27:2 150:8 151:15 168:16 368:9 372:3 373:14,16 374:3,9 374:10
phases 168:5 372:14
PhD 1:13,19,22 2:2 2:5,9,10
phenomenal 185:21
philosophical 99:16 276:14 277:2
phone 20:22 80:6 83:8 88:1 107:13 185:12 186:7 187:3,5 208:1,3 245:5 283:11
phones 126:4 244:5
physical 352:14 362:15
physician 29:3 38:14 41:9 53:19 65:6 71:1 96:13 114:21 118:6 128:19 130:9 205:17,21 206:2 297:1 318:18 319:6,13
physicians 1:22 23:20 31:5 67:12 67:15 68:14 69:8 69:14 71:2 76:16 114:21,22 129:21 144:16,19 206:6 220:4 230:10 258:8 319:11
physician's 71:13
pick 24:18 35:13

217:9 222:18 301:19
picked 96:8
PICKENS 1:20 321:5,21 322:10
picture 11:16 15:4 16:10 42:18 77:14 95:18 96:3 186:10 277:1 290:3 319:22 324:13 327:18
pie 157:13
piece 12:7,8 14:22 57:13 113:7 118:8 119:9
pilot 274:18
ping 18:12
pinging 107:7
Pittman 1:21 24:8 24:9 355:15 356:8 356:16
place 84:5 90:21 328:16 350:4 360:16
placed 6:17
places 51:15 279:9
plan 8:22 11:9 49:7 51:12 112:22 113:6,10 114:12 114:19 115:3 117:17 118:10 119:16 124:8 144:13 150:17,18 156:15 192:13,15 196:1,1,22 198:16 201:18 204:14 205:22 227:1 246:20 253:13 260:15 305:16 306:10 317:21 318:17 319:2,13 323:22 338:17
planning 5:16 149:18
plans 112:22 113:9 119:16 136:12 139:3,10,17,19,20 140:20 143:17 149:14 152:20 153:19,21 155:10 155:20,21 156:4 158:10 159:9,11 159:17 160:3,20 160:20 163:13 164:3 165:5 187:20 192:4,6,14 192:15 193:6 195:6,18,21 199:7 200:5 201:6 303:19 305:13,22 318:2 319:10 324:3 344:9 346:21
plan's 190:5
plate 52:6 158:4
platform 353:15
play 119:9 136:18 207:14 363:4
please 72:14,14 79:2 107:10,14,17 108:3 109:4 110:9 116:18 169:8 172:13,17 173:15 226:4 239:5 241:19 245:5 247:22 285:18 330:5 361:6
pleased 26:9 162:6
plowed 146:21
plus 307:20,20
pneumococcal 3:19 3:21,22 98:18 242:19 245:12 246:6,17 247:5 249:12 250:5,14 253:2,6 254:4 257:18,21 258:21 265:9 266:20 287:6,14 300:5,9
pneumonia 3:19 47:3,4 82:1,5,13 82:17 88:16 246:13 248:14 265:14 273:14 279:20 284:20 285:4 334:22 335:2 338:5,8
PN7 87:22
point 16:3 28:4 29:12 43:1 44:6,6 44:10 45:18,22 50:12,21 55:22 67:11 70:6 76:19 80:18,20 89:14 106:1,22 121:3 124:6 133:11 136:8 176:16 178:18 197:7 198:9 205:6 212:20 214:11 218:7 221:3 227:13 230:4,6,11 237:11 238:13 239:10 240:3 250:16 264:10 270:22 272:8 273:6 274:21 275:1 277:18 278:21 288:15 291:2 292:15 299:21 300:15 305:20 309:5 310:2,21 312:15 312:16,22 320:4 321:4 329:21 330:3 332:2 334:2 342:22 343:14 347:19 348:17 353:8 368:21
pointed 44:17 77:2 127:6 148:2 166:13 176:20
pointing 100:22 103:12
points 247:19 271:1 292:6
policy 23:19 51:21 144:6 169:5 295:15 327:13 343:9 349:6 355:1
political 132:15 147:17 148:10 363:14
politically 150:22 236:14
politics 42:8
population 1:3 3:4 4:14 6:14 8:5 9:6 9:10 10:9,10,14 11:1 12:10,11,13 12:18,20 16:7,16 16:22 18:4 25:3 26:11 28:12,15,21 29:7 30:22 31:2,3 31:16 32:4 33:5 34:3,19 35:14 36:4,7,10,13,19 37:3,4,7 39:3 41:4 58:15 72:9 74:11 82:14,18,19 88:3 88:8,11,19 94:21 95:6,10,13,19 96:4,20 98:12 111:10 113:11,14 118:14 119:19 120:1 131:10 141:16 159:3 170:18 171:4 174:20,21 175:6 175:18,22 176:22 178:6,10,22 181:4 182:18 183:5 199:21 200:1,7 206:17 211:13,14 211:22 212:6 213:7 216:17 243:6,8 245:21 249:4,19 250:7,20 251:3,6,7 258:11 259:12 260:2,6 273:13,15 274:1 274:11,15 278:22 280:4,9,13 283:8 284:10 290:8 294:6 301:9 321:13 322:17,22 323:4,8 324:4,16 324:19 325:2,4 326:12,16 327:18 334:10 338:14 341:21 342:9 344:5,21 346:20 347:8 352:13 353:12 356:12 357:6 359:9,13 366:9
populations 7:7 29:1 33:7 53:5 66:19,19 101:4 141:14 170:6,21 171:15 174:13 178:15 183:15 246:9 249:20 250:8 318:22 324:8
portfolio 168:13 337:2
portion 212:13
pose 17:22
posed 354:8
position 6:16,20,22 8:21 35:5 149:1 331:13,17
positive 146:1 180:10,13,16,19 181:2 219:3 340:4
possibility 72:3 94:13 191:13
possible 22:8 34:4 58:19 93:16 97:22 100:3 148:1 174:18 195:10 235:10 274:2 299:2 330:20 331:8
possibly 82:19 90:8 190:16,21 191:4,5 193:5,7 198:20 272:10 371:5
post-fracture 202:3
potential 95:5 123:18 135:18 150:12 156:2 228:1 318:21 367:2

potentially 8:2 92:1 136:14 137:11 139:1 157:22 194:14 233:12 236:6 274:18 298:17 327:16 339:2
power 224:3
PPV 248:8 288:9
PQRI 70:6,9,12,13 70:17,21,22
PQRS 70:21,22 71:14 77:1,4 206:1
practical 183:19 351:3
practice 53:16,19 65:18 219:12 230:9
practices 27:13 49:13 272:20 319:6
practicing 230:9
precedent 44:15
precision 288:8
preclude 160:3
predict 162:2
predictive 161:17
prefer 64:14
preliminarily 22:13
preliminary 14:4 29:14
prep 282:6
preparation 289:8 315:21
prepared 184:11 247:16
preparing 21:1
prescribed 197:18
prescriptive 274:3
present 1:12 2:12 63:6 123:22 135:21 136:20 236:7 354:13
presentation 325:20
presented 37:10 49:16 56:20 83:20 146:8,17 152:21 199:15 228:12 231:20,22,22 236:4 239:13 242:3,11 264:6 315:6 335:1 340:7
presenting 84:4 108:22 145:19 146:11
PRESENT(Cont'... 2:1
President 24:9
presiding 1:10
press 107:14 172:13,17 226:4
pretty 10:17 12:14 12:16 22:10 23:3 30:8 50:4 86:7,8 87:7 137:18 189:10 196:19 248:5 263:11 284:7 311:11 317:3 323:3 332:10,14 352:13 370:15
prevalence 96:17
prevent 195:3
preventing 194:14
prevention 1:3,14 1:18,24 29:7 179:5 180:7 351:13 352:11,16 356:21 357:16 358:16
preventive 110:15 110:21 116:9 122:7 134:11 155:15 226:15 243:3 276:15,16 277:4 301:7 320:15 323:2 373:13,15
previous 33:14 62:20 69:19 81:22 84:19,20 85:22 173:20 246:4 259:3
previously 47:1,2 88:16 197:11 261:10,12 297:8
primarily 115:3 175:13 264:16,17
primary 29:17 109:2 171:19 247:8 307:2 313:3
prime 109:8
principles 9:16
printed 117:2
prior 46:17 72:2 81:11 172:3 254:17 268:12 319:3
priority 66:18 159:13 194:17 293:16 336:19
priors 59:19
private 329:2
proactive 340:16
probably 20:6 21:7 30:7 63:11,13 64:22 101:12 103:19 106:3 126:12 128:14 132:14 135:20,20 137:4 151:3 160:21 161:11 165:17 168:1 169:14 171:8 182:1 200:3 206:18 207:1 222:14 252:3,5,9 254:6 264:1 276:4 277:8,18 279:21 280:5,20 290:9 292:2 295:5 307:3 308:4 315:14 317:4 320:22 325:8,16 346:17 355:4 366:17,21 370:20 371:15
problem 52:11 84:8 97:10 149:5 157:9 181:9 189:12 267:22 268:14 271:9 272:19 304:12 310:17 311:10 313:12,17,19 314:7 325:1 327:12,12,16 357:7
problematic 133:18
problems 128:9 189:7 269:20 270:20 326:6
procedure 221:16
procedures 165:20 337:14
proceed 11:14
process 4:13 5:15 7:11 8:11 19:10 20:4,17 21:3 23:6 69:6 75:3,4 76:14 76:19 100:16 105:11 106:18 108:16,17 120:18 128:3 137:12,19 138:4 140:2,4 151:10 152:10,18 153:1,11,20 156:15 169:11 177:6,8 198:4 234:21 235:9 237:9 239:1 243:2 243:21 247:2 286:22 320:2,9 332:12,22 334:1 335:16 336:18 350:1 354:11 358:9 365:13 375:20
professional 157:15 360:16
professionals 26:5 360:12
profile 126:2
profiling 161:17
program 71:14 88:8 160:17 163:12,20 165:19 166:11 190:9 206:5 214:1 349:15
programs 91:3 299:7
project 118:1,4 167:15 168:6,17 214:4 225:20 336:21
projects 165:14
promise 52:13 127:11
promote 164:22 167:4
Promotion 1:14
prompt 225:19
proper 342:14
proportion 87:2 231:18
proposals 248:16
pros 50:22
prospective 294:22
prospectively 169:12
protect 194:12
protected 256:9
proved 15:17
provide 26:12 143:11 150:16 212:12 223:8,13 304:18 317:11
provided 29:5 65:4 66:10 69:15 71:17 279:19 281:12 308:2
provider 72:1,2 93:20 97:13 166:18 257:17,19 298:10 338:17
providers 26:6 166:19 313:3 359:22 360:1
provides 68:13 164:16
providing 329:10

374:1
provision 323:2
provisions 351:2
prudent 150:22
public 1:13,21 24:10 87:20 88:9 106:15 113:15 136:1,2,3,21 151:6 152:22 153:8,10 168:15 190:8 200:15 226:1 301:3 325:21 326:7,16 326:19 348:1 349:22 353:22 366:8 367:16 369:2,3 372:17 373:7
publication 152:19 153:20
publicly 170:1 293:5,12 294:2,3
pull 34:12 56:2 92:6 144:10 214:7 224:3 263:11 336:9
pulled 219:21
pulling 315:2
pump 109:8
purchasers 26:6
purely 179:5 212:22
purpose 99:8 189:16 314:5
purposes 202:1 222:15 307:5 326:17 333:9
purview 176:21 200:16
push 91:8 154:4 161:4 162:17,20 163:8 282:12 371:5
pushed 320:7 334:4
pushing 159:14 320:3
put 10:20 44:9 52:3 55:15 72:20 89:15 101:18,21 102:12 136:21 137:11,19 151:15,19 152:4 178:10 179:3 192:7 217:2 219:8 257:10 259:7,9 264:11 270:14 277:12 290:1,22 295:15 310:13 332:2,3 339:17 340:14 350:18,21 351:3 352:22 355:4 358:18 362:16
puts 167:2
putting 36:16 76:15 137:13 162:3 190:8 239:10 331:5
pyramid 357:4,6
P-R-O-C-E-E-D-... 5:1
p.m 244:11,12 245:2 376:5

Q

Qaseem 1:22 23:17 23:18 30:6 34:15 36:2,21 39:9 54:19 55:1,21 58:10 74:14 76:4 76:7 79:14 80:2 97:19 99:21 106:17 127:11 129:7 130:15 131:19 145:14 148:1,18 177:5 181:20 183:20 184:13 214:10 232:4 234:20 236:11 237:2 251:17,20 252:2,8 263:10 265:20 267:17 268:13,17 271:3,18 272:18 281:16 285:5 330:9
quadrant 223:3
quality 1:1 25:5 26:4 71:1 82:2,22 87:21 88:12 118:3 128:15 160:6 161:3 165:13,21 166:22 178:19 179:4,6 181:7 196:3 206:2,7 219:1 256:15 305:1 332:8 335:8 337:8 340:15 357:5 358:16
quantitative 341:8 341:12
quantity 256:14 332:8 335:8
quatro 163:15
question 17:13 19:7 21:17 32:19 34:16 35:7,13,20 36:16 37:1 38:18 39:9 40:2,10 41:20 42:14 47:4 50:14 51:5,7 54:21 55:3,7,13 56:17 59:8,9,11 59:15,18,20 60:6 60:19,20 61:3 67:2 73:8 79:16 79:19 86:21 87:15 88:6 89:13,19 91:7,21 92:11 104:10 107:2,13 107:20 113:20 136:10 138:3 140:7 141:2,4 142:4 143:8 149:11 150:4 152:1 156:14 157:20 164:18 167:19 171:2 172:13 177:19 179:8 182:20 183:2 187:21 188:2,4,11 189:17 191:12 194:12 197:8,10 205:3 208:21 224:21 226:4 240:12 241:9 243:4 249:18 258:17,18 259:16 271:15 273:8,17 274:12 274:17 276:14 277:2 280:17 284:2 293:11 294:8 295:12 297:20 303:10 314:19 315:1 318:11,13 330:10 333:5 334:20 339:19 340:18 341:4,17 342:18 346:9 348:22 350:10,11 354:8 361:1 363:9
questions 12:11 14:16 29:9 42:1 49:22 57:4 67:1 107:21 117:16 120:13 122:3 188:22 209:6 226:6 275:14,17 286:5 299:17,19 299:22 365:8 366:7 370:9
queue 52:7
quibble 238:12
quick 12:15 140:7 152:10 171:1 183:20 186:3 226:17 227:20 234:4 318:10 363:9
quickly 23:4 59:1 186:5 243:12 296:19 325:17 368:12 370:16
quiet 368:8,13,14 368:22
quit 320:22
quite 18:2 63:22 82:19 101:5 142:6 162:13 201:11 226:15 228:8 234:19 257:10 309:7 310:18 315:7 336:8 348:5 369:1,15,16 370:4
quoting 269:13

R

race 159:18 160:4,8 160:18,22 163:18 163:22 164:6,11 164:14 292:17
racing 243:18
radar 329:4
radiation 112:3
radiologist 217:6 217:22 218:14 219:8,13,16 222:18
radiology 219:17
raise 43:13 55:22 72:5 79:1 122:5 133:9 189:18 237:11 285:17,18 327:20
raised 39:17 61:20 77:17,18 78:13 80:19 170:11 188:21 242:20 289:15 316:15 333:5
raises 38:17 112:2
raising 147:20 222:9 272:15 275:19 312:10
ran 260:4
random 187:19
randomized 288:21
range 51:6 58:14 126:20 147:12 182:3,6
ranges 52:6
rapidly 363:6
rare 189:11,12 194:7 203:19

rate 20:19 37:12 64:7,8,19 122:18 146:3 259:22 260:22 279:21 284:4,19 302:20 307:21 342:2,6
rated 111:2
rates 31:4 131:11 133:16,17 146:1 159:2 162:10 189:14 275:1,2 276:14 280:8 302:18 303:10,13 303:20 304:10 306:19 308:1 337:12,12,13 338:7 339:7 340:4
rating 112:9 145:17 331:1 332:7,21
ratings 121:8 125:12 196:14
ratio 147:20
rationale 27:6 190:15 261:21 289:13
ratios 317:9
reach 107:18
reaching 197:4 361:3
read 146:17 180:8 183:3 216:22 217:2,6 219:20 237:7 267:21 268:1 292:3 301:13 342:13
readily 291:3
reading 32:5 145:18 146:10 188:16 211:15 219:9 271:3 284:17 352:10
readmission 337:11
reads 145:20 146:8 214:22 268:14
ready 40:15 43:2 62:10,14 80:22 89:5 101:5 116:15 145:6 148:22 150:4,6 198:8 244:1 251:15 252:22 261:22 264:13 295:17 319:14
real 7:19,20 32:14 91:1 93:15 94:15 126:7 286:13 322:4 365:8
realistic 97:2,3
realistically 10:3 134:11
realize 47:17 93:8 252:15 301:18 307:22,22
really 6:8,11 7:1,8 7:10,17 8:6 10:22 11:2 12:22 13:18 14:6,10 15:1,6 16:3,21 20:3 21:3 22:21 30:22 31:11 31:18 33:8 34:8 34:20 35:5 37:13 37:20 41:20 46:2 49:18 50:5 53:6 54:1 58:16 61:18 61:19 62:8 77:20 80:9 86:16 90:11 94:7 97:15 98:7 98:20 99:11 100:9 100:11 102:14 108:22 109:12 113:12 118:18 119:13,21 121:6,9 121:11 129:9 133:18 136:16 139:9 142:6,16 143:1,20 144:10 146:5,10,22 147:10 148:15 149:21 152:10 154:2,7 156:9 157:8,10 158:13 158:18 159:14 160:21 162:7 163:14 165:9,16 165:18 167:2 176:20 177:14 179:1,9,16 187:6 189:4 190:13 195:13 196:6,11 199:6 201:15,18 203:15,17 204:10 212:14 214:11,13 214:20 218:5,13 223:20 228:13 229:3 231:8,19 232:8 233:17 234:19 237:9 238:8 239:15 241:16 242:10,11 245:8 252:4 254:16 256:8 257:9 259:21 264:10 265:10 266:11 269:19 272:7 274:7 275:1 275:2,4,21 276:5 276:7 277:22 278:1,1,17 279:17 280:7 281:6 282:4 282:6 286:18 290:6 291:1 294:11 299:6 305:12 306:9,20 310:3,10 311:8,13 311:16 315:16,18 315:21 316:7,12 319:19 320:2 321:15 327:8,10 327:13,14 328:11 328:20 329:5,21 329:22 330:8 331:3,12 332:13 333:16 334:2,6 336:8,16,19 337:9 338:13,21 339:11 341:13 342:3,20 343:2 346:9 348:19 351:16,18 353:7 354:2,3,11 362:2,20 363:3 364:21 367:21
reapplication 265:6
reason 7:21 51:10 60:5 61:3 64:21 65:2,15,15 66:10 67:17 124:5 127:8 133:20 195:19 217:2,8 227:7,13 227:14 229:19 234:5 237:2 272:18 276:17 286:2 334:6 338:8 347:22 361:17
reasonable 19:13 78:18 178:18 213:3 236:15 274:16 285:6 371:15
reasonably 37:12
reasons 132:8 140:11 216:21 333:6 354:8
reassess 278:7
recall 83:14 311:15
recap 3:2 24:20 296:7
receipt 62:20 69:19
receive 27:9 28:16 39:4 62:18 75:12 75:19 77:12 112:9 225:15 255:15 260:9 268:22 269:1 288:3 297:13 373:2
received 3:22 25:10 26:20 28:2 48:5 65:7 69:17 71:19 71:21 72:1 74:17 75:15 77:11 102:10 110:17 113:20 121:18 155:2 246:16 253:6 254:3,17 255:13,22 268:11 272:3 287:6 288:1 288:4 293:4 299:8
receiving 25:7 186:19 190:6
recognize 65:12
recognized 67:21
recognizes 233:7
recommend 101:6 105:10,20 129:10 131:7 153:2,3 203:2 329:14
recommendation 47:6 51:3,4,20 63:16 66:15 102:18 106:10 110:22 122:8 125:19 126:4,18 127:6 137:3 153:12 176:5 181:10 182:16 184:12 204:22 211:13 226:18 238:16 239:6 261:7 295:20 296:7
recommendations 27:21 46:22 49:14 68:20 115:20 134:10,17 147:14 152:15 158:8 176:12 177:3 228:9 238:15 263:9 300:21 307:16 370:4
recommended 90:7 106:1 111:21 146:18 164:7 165:21 175:19,21 180:11,19 181:1 226:19 227:4 249:3 250:9 262:20 302:4 309:19
recommending 130:3
recommends 164:5 164:13 176:2 288:9

reconciliation 204:21
reconsider 264:21
reconstruct 264:8
record 50:20 51:15 108:2,12 118:9 119:12,20 120:7 128:17 130:12 144:12 212:12 214:2 244:11 259:20 260:19 311:20 313:14,22 376:5
recorded 74:7 75:20
records 119:18 197:21 213:18 260:12 311:2,14
recurrent 174:10
redefining 296:8
redo 238:7
reduce 188:13 248:9
redundancy 207:13
redundant 207:5
reevaluate 116:8
reevaluated 53:8 110:13 112:7
reevaluating 112:11
refer 64:3 339:12
references 185:10
referred 66:14
referring 118:3 198:20
refers 373:12
reflect 5:15 11:8 12:3 28:15 32:22 121:8,13 241:14 241:17 242:11 277:1 320:12
reflected 6:9 33:19 126:14 132:2
reflection 322:15
reflections 243:20 321:3
reflects 242:4
reformat 264:8
reframe 348:13
refuse 239:14
refused 238:10
regard 51:19 323:4
regarding 113:2 298:16 342:4
regardless 272:13
registries 321:18 321:21 322:9
registry 311:2 323:13
regular 8:9 97:9 257:11
reined 32:10
reinvent 9:19 15:5
reinventing 353:17
relate 12:21 16:7 29:22 42:19 245:19 355:19 360:9,11
related 45:14 63:19 65:3 85:11,13 103:22 157:19 168:8 233:11 264:17 271:2 322:14 323:14,17 334:14 356:1 363:20
relates 30:14 167:21
relation 359:8
relationship 17:15 365:7
relative 251:8 340:19
relatively 194:17 236:8
relax 20:12
relaxed 325:12
released 27:11 153:17 358:7
releases 184:10
relevance 7:5
relevant 199:22
reliability 37:19 56:22 60:22 64:5 113:2 146:12 156:7 257:7 274:14 312:18 315:7,15 316:12 317:2,4,8 318:3,5 319:2,8 326:10 330:6 333:18 334:11,16 336:4,6 340:12 364:21
reliability/validity 57:5
reliable 26:18 60:1 277:22
reliably 213:17
reluctance 333:6
rely 54:1 311:14 357:11 361:12 362:3
relying 51:12 183:11
remain 174:10
remainder 67:12
remains 33:5 278:7 280:10
remaking 149:21
remarkably 246:7
remember 32:9 105:9 176:11 273:12 287:19 319:7
reminder 176:10 229:6 246:3,11
remnant 145:2
removal 191:14
remove 193:3,13 194:10
removed 191:4,7 193:18 194:2 195:17 196:5
removing 190:9,15 196:10
renal 25:6 26:8 28:1 92:17 253:10
rendered 309:13
rep 30:20
repeat 93:2 214:15 214:17
repeating 129:7
report 71:3,14 82:12 101:12 115:1 122:14,18 123:6 133:22 135:12 142:20 163:5,22 164:8,20 202:16 206:7 239:3,6,11 241:13 242:10 266:13 281:8 294:14 302:13 305:15 310:2 312:14 314:21 332:6 359:18 360:14 371:9 372:16,22
reported 34:2 48:8 62:19 69:19,21 86:17 88:11 112:22 133:7 175:15 186:18 204:15 222:14 293:6,19 294:2,3 305:11 314:13 317:22
reporting 71:2 82:2 87:20 88:5,10 122:17 132:16,17 133:2,12 147:11 148:13 162:21 166:6 168:15 188:14 204:11 206:3 286:16 293:12 294:10 295:13,16 305:11 306:7,9,21 307:5 307:9 318:14
reports 303:1 309:20 311:15 313:19
Repository 27:5
represent 175:10 290:6
representative 46:19 81:6 134:22 230:8
representatives 152:13
represented 363:13
represents 48:3 77:11 88:15
request 224:20 227:19 289:4 292:11 362:20
requesting 289:3
require 306:14
required 322:1
requirement 139:15 273:22 274:2
requirements 125:14 330:6
requires 118:7
research 152:13 210:10 278:12 326:18,18,19,21 326:22 327:7,22
reserve 277:19,20 278:3,20 280:16
resolution 2:14,20 154:12 172:8,9,11 172:15,20,22 290:18
resolved 32:16
resource 366:6
resources 1:16 9:11 44:6 161:19 257:3 327:15
respecified 115:4 139:22 140:1
respect 80:10
respected 48:6
respects 287:13
respond 41:6 59:9 69:1 177:19 182:20 235:14 236:6 237:13 275:16 303:7 353:21 360:22
responded 54:21 55:3 188:1
responding 69:7 369:12
responds 68:13

response 149:10 233:20
responses 373:3,8
responsibility 102:20,21 121:12
responsible 350:22
responsive 126:9
rest 62:8 79:20 105:10 157:14 247:9 254:4
restate 279:14
restating 327:7
result 76:18 99:17 151:5 180:13,20 237:10 241:13 333:22
results 26:19 64:9 81:20 122:14 124:1 157:7,8 212:1 225:3 259:17,18,21 260:3 264:3 273:7 273:19 293:19 315:6 333:18
resumed 108:13 180:15 244:12
retooled 114:16 138:21 156:13
return 78:16 151:3
returned 84:8
reused 314:5,6
Reva 2:10 14:9 20:21 21:7 23:5 24:17 35:8 43:16 44:17 55:22 63:4 64:13 84:18 86:2 87:4 89:7 93:1 102:18 109:14 132:10 138:8 143:7 150:2 214:4 229:6 231:22 238:12 240:3 246:2 247:3 277:17 298:14 329:9 361:2,14 365:14 375:15
revamping 190:20
Reva's 278:21
review 45:13 67:1 83:11 111:15,22 119:12 125:21 151:8 153:4 169:13 171:19 176:3 198:2 212:14 270:6 283:5 301:19 310:4 324:11 358:8 372:12,21
reviewed 182:15 247:9 331:4
reviewer 29:18 47:15 146:15 186:21 211:2
reviewers 64:14 252:13
reviewing 154:9 190:12 210:12 251:17
revise 227:3 238:4
revised 236:7,9 239:20,22 265:17 299:2
revising 177:6 238:9
revision 81:21
revisions 238:20
revisit 11:16 242:14
revote 79:20 239:19
re-discussion 236:10
re-present 235:15
RHI 3:12 175:16 177:18 185:13
right 13:15 20:2,5 24:19 41:7 42:22 55:4 67:6 76:5 81:2 82:11 85:15 87:12 98:15 104:22 110:10 114:18 123:8 128:8 135:10 140:17,22 143:20 146:19 147:19 148:21 149:16 152:6 158:5,11,21 181:22 187:12 195:15 205:13 208:3 209:11 213:19 214:16,22 218:12 219:6 223:7 224:9 234:1 235:22 239:11 247:2 251:18 256:1 259:5,18 261:1,3 262:5,6,8 262:21,22 263:6 266:10 268:14,16 269:16,22 271:10 282:10 287:12 292:21 294:14 295:5,8 296:18 298:11 301:12 302:1 303:14 312:3,19 313:10 313:20 315:10,13 318:1 320:10 322:9 335:10,13 337:3 347:5 358:19 359:12 360:13,14,20 367:11
rigid 347:21
rigor 289:8
rigorous 326:11,22 326:22 336:9 354:11
ringing 126:4
risk 3:12 27:16 33:7 66:20 168:9 171:15,21 173:9 173:22 174:10,13 174:15,22 175:4 175:11 176:1,12 176:19 177:4 178:7,14 182:4 199:9 201:20 203:5 206:17 218:1 234:7 246:10 248:9 250:8 253:4,7 254:2 260:1 262:10,19 336:6 337:20
risky 201:17
risk-benefit 147:20
Rita 39:10
RN 1:18 2:10
road 1:10 38:9 99:1
Robyn 2:9 167:11 375:15
role 16:11 73:2 105:19 116:3 121:10 129:18,18 353:8,10 363:3 375:19
roll 349:3
rolling 48:11 323:9
rollup 350:11,12
Ron 1:13 10:11,21 12:5 318:9 325:14 328:4 352:6 353:18 355:10 359:5 362:7
Ron's 330:3 348:21
room 48:2 108:4 182:22 226:8 369:12
roster 107:21 226:6
rotovirus 307:20
routine 28:16 180:14
routinely 124:19 361:11
Rufus 107:9 108:1 172:10 208:8 225:22 245:4 247:20 283:14 369:4,5,6
rule 56:13 127:5 215:22 270:2 371:2
rules 215:15 257:8
ruling 223:16
run 23:21 68:17 111:9 149:4 165:2 165:13 213:7 216:19 318:3 319:8 339:13 367:12
rundown 152:10
running 67:11 129:20 165:7
ruptured 213:3

S

s 188:8
sa 17:1
safe 355:20
safety 112:3 188:22 189:5,22
sake 264:15
sample 96:17 187:19
sampling 59:21
Sampsel 1:23 19:17 52:13 53:1,9 60:7 70:5,8,14 87:12 87:16 111:1 112:14 119:8 120:6 134:4 142:3 142:22 144:5 156:21 161:9 190:2,3 195:21 211:6,7 216:7 224:19 250:16 259:16 273:5,16 277:14 305:7 317:20 341:16 351:10 358:13
Sarah 1:16,23 2:19 10:13 11:2 17:2 52:12 70:12 95:5 109:13 120:2 132:11 134:2 140:8 141:1 148:2 156:18,19 161:6 190:1,3 208:12 211:1,6 214:10 250:15 259:15 273:4 278:16 279:11 305:5 306:9 320:21 325:11 339:10

341:2 346:1 348:20 352:6,7,9 358:2,19 370:12
Sarah's 16:19 97:6 171:7 275:1 321:3
satisfied 151:22 152:1
satisfies 106:7
Saturday 188:16
save 186:8
saved 368:2
saw 7:16,18 53:2 253:8 265:11 272:22
saying 9:4 22:18 68:14,17 72:8 75:7 76:8 127:22 128:7 148:19,22 149:6,7 189:3 232:21 234:13 236:3,16 254:16 257:1 269:12 277:2 288:20 316:10 324:22 325:11 330:21,22 336:12 341:6 350:6 361:3 362:6
says 73:3 95:18 127:15 129:4 131:1 165:12 176:6 181:14 188:4 215:1 216:8 239:6,18 252:17 252:18 262:9 263:15 267:7 268:20 271:6 284:3,22 302:18
scalability 343:14 344:12
scalable 343:21,21
scan 9:15 14:11,20 18:3 97:3 217:17 218:2 219:1 221:5 222:13 345:4,7 361:19
scanning 195:10
scarce 257:3
scare 365:2,3
scared 365:1
scary 142:6
schedule 17:20 185:21 242:14 303:22 370:14
scheduled 369:20
schedules 307:17
scheduling 373:19
scheme 37:5
school 341:19 349:5 352:1
schools 344:8 346:22 349:7 359:22
science 93:22
scientific 57:21 103:20 212:4 261:16
scope 10:12,16 12:9 13:14 15:9 16:13 31:19 344:19
score 203:4 274:9
scores 232:1 315:7
scratch 345:2
screen 29:15 81:14 128:1 129:10 131:1 155:3 172:5 195:14 329:5
screened 46:15 81:10 102:10 114:4 174:11 204:4 209:22 210:21 254:17 268:11 288:3
screening 3:9,9,10 3:10,11,12,14,15 108:10 109:22 110:3,5,17,18 113:17 114:8 117:8,18 118:5,15 121:16 145:21 154:20 155:9 159:22 160:2 170:2 171:15,20 173:8,21 174:7,14 174:20 175:18,21 176:2,7,18,21 177:3,13,16 178:6 179:9,13,16 180:14,20 183:6 183:12 189:2,13 192:9,18 194:10 197:13 200:2,11 201:14 203:2 207:19 209:19 210:17 214:15,16 214:17 215:1,3,8 215:12,13,15 216:3 217:3,11 219:3 221:4 222:14 225:2
screening/somet... 179:18
scrutinize 332:14
scrutinized 332:16
se 180:12,18 213:4 281:14
searches 17:9
searching 207:11 328:17,18
season 65:21,21 67:9,16,17 68:9 68:10 234:11,11 234:16,17,18
seats 109:12
second 151:15 168:16 199:9 201:20 204:4 229:7 302:6,7,11 308:9 334:19
seconds 25:18
section 146:13 188:17 220:22
sector 329:2,3
see 8:17 11:8,22 13:11 14:1 15:1 29:16 36:9 42:14 45:6 53:18 56:2 58:8,22 66:22 68:19,22 72:14 85:20 86:2,14 87:2,6,10,14 92:5 96:13 99:12 100:20,21 103:16 106:6 107:5 110:16 124:14 159:1 161:1 166:18 170:14 175:8 183:13,17 185:3 192:11 200:18 207:5 215:17 219:4 220:14 224:13 225:7 231:17 232:21 239:21 242:10 247:11,18 252:12 254:4,6 256:12 259:19 262:16 263:18 264:1 273:19 281:12 283:16 291:1,3 292:17 293:17 295:16 298:3 300:1,20 302:8 306:19 309:19 311:12 316:10 318:12 319:10 326:3 329:16 332:4 338:8 341:18 351:4 358:10
seeing 32:12 74:12 98:4,16 99:17 100:1 151:19 215:4 222:11 268:5,17 271:6 272:21 282:22 350:16,22
seen 41:8 62:17 71:9 102:9,9 255:1 272:15,20 278:13 333:12
sees 219:14
segue 367:13 369:1
select 168:11
selected 288:11,12
selecting 168:17
self 266:12
self-report 61:20 162:12 188:11 191:16 204:13 266:7,9 267:6 312:1
self-reporting 271:7
semantics 179:19 305:8
Senate 125:2
send 100:3 121:5 185:8 225:16,17 225:18 240:4 295:3 361:6 364:7 364:11 373:4
sense 6:12,15,19 7:17 54:6 61:16 95:22 139:18 140:14 143:21 178:21 184:18 192:5,21 206:21 217:21 228:21 229:1 234:14 256:12,13 284:5 298:6
sensitive 168:12 169:16 236:14
sensitivity 269:6
sent 225:20 374:15
sentence 285:2 309:6 320:21
sentences 110:8 210:4 253:21
separate 28:9 39:12 40:18 92:18 94:8 123:21 145:17 167:14 179:4 198:13 259:12 279:17 290:10 293:7 325:3 361:5
separately 34:2 74:6 77:10 86:17 94:4 124:7 135:14
separating 39:2
Sepheen 2:14 48:21 62:13 110:7 111:14 117:14 124:22 143:5

154:21 155:15 162:19 186:22 198:5 246:21 301:15
Sepheen's 161:10
September 1:6 49:18 66:1,5,6 369:21 372:6
series 166:13 248:16 365:11,16
serious 351:17
serve 24:14
served 130:5 318:22
service 27:2 39:4 116:9 122:7 131:16 143:13 243:4 301:7 347:1 373:15
services 1:17 8:4 110:15,22 125:3 133:5 134:12 155:15 163:16 167:5 276:15 278:12 320:15 323:2 326:19 373:13
set 33:19 55:8 56:5 72:19 73:1 83:16 88:8 115:3 139:6 145:10 163:13 169:12 187:14 194:22 222:4 231:14 304:9 325:8 352:17 356:1 370:14
sets 215:17 225:15
setting 28:17 44:15 68:5 96:1 345:22
settings 104:2 231:3 318:21 360:1
severity 213:1
sexual 170:10
sexually 117:11 118:19 119:19
sharable 358:18
share 14:18 169:1,8 280:11 358:20 359:3
shared 6:19 18:22 19:20 20:5 127:21 128:2,5,19 129:4 129:13 130:7 139:2 202:21 203:2 339:8
shoal 125:1
shocked 20:17
shoot 107:4
shooting 280:13
short 27:20 73:13 181:15 189:20 337:16
shortage 306:14
shortages 234:10 234:15
shorten 353:6
shorter 244:3
shot 49:4,5 71:17 249:1 300:3 312:4
shots 3:5 48:2 49:12 51:14
shoulder 368:8
show 134:19 139:8 142:15,17 218:19
showing 124:1 256:7 273:7,10
shown 59:22 78:19 214:18
shows 31:1 163:14 213:11 343:15
side 107:4,4 113:10 113:11,11 119:16 149:1 194:7 203:18 290:1,1,22 290:22 327:1 351:21 356:10 364:13
sides 149:8
sift 270:17
sigmoidoscopy 110:19
sign 247:19
signal 107:18
signaled 369:10
signal-to-noise 317:9
significance 359:11
significant 12:14 112:21 134:19 138:19 170:15 189:5 231:13 284:11
significantly 159:2 248:8
silent 176:13
similar 31:15 32:3 156:8 173:20 246:7 265:11 272:16 370:21 371:2
similarly 57:5 156:6
simple 310:18 330:22 340:19
simplify 144:11
simply 41:6 73:4 143:21 159:21 227:3 228:6,8 238:15
single 104:6 193:12 240:6,12,13,20 241:1 307:19 317:4 332:7
sink 344:6
sit 117:15 129:9,12
sites 355:21
sitting 319:16
situ 172:3
situation 72:18 136:11 220:3 297:21 314:20
six 25:6 27:8 31:12 46:13 51:4 62:16 63:14 71:9 81:8 89:14 95:20,21 97:1 180:11,17 218:1 279:8
size 143:11 217:19 219:9,10
skew 59:13
slated 27:3
slice 265:15
slicing 89:2
slide 42:11 45:4 116:22 372:2
slides 369:22
slight 285:20
slightly 111:10 335:6 358:11 364:16
sloppy 102:12
small 34:19 37:3,6 38:19 44:13 58:14 82:15 88:2 100:14 141:3,14,16,20 143:6 213:2 284:7 295:6 317:3 322:21 323:4 325:1 371:16
smaller 290:22 338:20 343:22
smear 175:1
smears 155:3
smokers 3:15 208:19 209:17 210:15
smoking 212:7 340:4 350:19 362:9
social 15:16 347:1
societies 129:10 149:6
Society 125:7 181:22
sociodemographic 159:19
soft 25:21 325:13
sold 343:4
solely 51:12
solicit 362:17
solid 36:20 176:8
solution 123:19 135:18
solve 78:12
somebody 142:5 252:18 287:8 366:4
someone's 260:14
someplace 302:17 311:7
somewhat 44:20 64:11 67:22 72:17 125:1 157:19 315:3
son 367:20
soon 184:16 240:10
sorry 23:20 24:11 43:19 44:1 61:11 69:4 70:7 87:18 102:13 110:19 116:20 124:15 142:15 155:16 167:18 183:1 211:3 220:15 223:10 228:15 230:5,5 251:21 254:8,21 259:1 262:3 263:12 271:4 273:4 283:13 296:5 300:6,11 303:9 307:12 317:16 352:6,7 355:16 363:7 369:7
sort 14:21 17:18,18 18:12 31:16 33:18 42:16 93:21 102:15 137:4 139:9 143:22 158:8 164:4 166:20 198:2 199:1 207:12 217:18 225:16 242:7 258:11 272:14 289:8 291:4 294:19 323:12,18 331:1 332:20 333:4 340:10 343:2,15 356:22 357:8 363:12 374:13
sorts 51:15 159:19
sound 13:16 149:18 287:12

sounds 38:4,6 42:3 49:17 53:10 69:7 91:22 116:13 137:14 152:4 154:3 185:18 202:18 204:17 225:5 286:2 300:12 311:14 355:16 360:6
source 41:16 45:3 92:8,16 93:13 138:22 250:18 289:6 290:9 310:22 317:5 359:16
sources 50:20 62:3 91:2 93:18 101:5 129:2 130:14 131:17 252:17,18 260:14 310:22 313:11,14 314:2,3 314:11 315:3 316:9 325:20 326:15 327:3 358:17 361:21 362:2
space 125:9 328:15 368:14,22
SPANGLER 1:23 48:16 84:17 86:6 87:18 88:20 93:1 93:10 249:15 289:18 360:22 362:4 363:16 364:1 366:3
speak 38:21 97:3 166:19 178:2 187:7 191:8 232:13 233:14 333:16 364:19
speakerphone 107:16
speaking 291:12 356:20 364:16 366:3
special 6:4 33:5 34:21,22
specific 28:22 31:2 36:4 37:4 44:19 49:21 59:4 61:14 174:2 176:1 190:17,19 192:8 209:2 221:20 229:11 245:19 246:9 284:14 294:20 298:6 301:7 304:7 323:8 373:4
specifically 28:11 32:4 178:12 188:21 219:18 221:13 272:2 289:12
specification 57:9 142:13 249:11 261:15,15 269:14 269:18,20 270:13 270:14,17
specifications 28:7 28:13,19 33:19,21 40:20 41:19 54:3 57:19 71:6 72:20 73:1 83:16 85:21 87:4 92:13 99:8 103:1,9,21 111:11 113:3,3 138:14 223:20 230:16,22 246:5 249:17 253:9 258:20 263:18 264:19 267:10 269:15 283:18 289:15 292:1
specifics 178:5
specified 57:1 114:20 118:5 155:11 175:7 227:9 253:11 349:1
specifies 221:18,19
specs 83:19,22 86:5 144:22 156:12 298:22
spend 108:18
354:12 360:2
spending 17:8
spent 229:14
spinal 194:16
spirit 104:4,8
split 372:14
spoke 232:11 290:17
spoken 237:19 308:11 331:13
sponsor 350:8 367:2
sponsors 354:10
spot 47:21
spring 136:3 336:22
squarely 200:7
staff 2:4 9:13 17:5 17:21 100:10 107:4 135:19 136:10 235:5 246:22 247:1 312:11 316:16 330:10 345:13 370:6 373:2 375:18
staffing 359:21
stage 25:6 26:8 253:10 368:16
stages 105:12
stakeholder 334:7 344:3 346:16
stakeholders 333:7 346:18
stand 111:11 217:1 321:14
standard 28:6 33:18 41:19 65:10 72:19 83:16 85:21 86:5 87:4 92:12 99:8 102:15 103:10,18 163:17 165:12 226:19 230:15,22 246:5 249:11,17 253:8 258:19 261:14 263:17 264:18
267:9 289:15 296:11 298:22 327:21 361:18
standardization 144:1 164:10
standardize 104:15
standardized 65:14 72:20 164:3 166:1 166:2
standardizing 99:14
standards 3:3,8,13 3:18 4:8 163:13 165:9,20 166:13 229:17,20 295:21 350:2,3 353:22 354:2 356:2
standing 189:9
standpoint 219:11
stands 146:7
Stange 1:10,13 5:3 5:9 12:17 13:11 13:17 15:3 16:1 17:3 18:13 20:2 21:6,11 23:9,11 24:17 29:20 32:14 33:10 35:7 38:3 40:15 42:3 43:6 43:10,16 45:8 46:5 52:12 53:10 58:1 61:16 62:12 72:5 77:16 79:22 80:9,16 84:12 85:18 89:5,10 90:11 91:10 92:17 94:16 97:5 101:1 104:9 105:13 106:9,12 107:9 108:1,14 115:14 116:11 117:13 118:12 120:12,16 121:20 122:4 124:16 132:10 137:7 138:8 140:6 141:1 145:1,9 146:20 148:9 151:17 152:2
154:1 157:12 158:12 159:5 162:15 166:5 167:6 169:21 171:9,13 177:9 178:17 179:12,20 181:5 182:10,19 185:5,20 188:8 191:6,15 192:20 194:3 195:9 201:3 202:12 203:13 204:6 205:6 206:12,21 207:15 210:7 213:14 215:10 216:1,13 217:21 218:5,12 218:22 221:1 222:7 224:1,5,14 225:22 226:8 228:20 232:19 234:1 240:9 241:7 242:12 245:3 247:16 249:8 250:3,12 251:12 251:19 252:1,6,10 252:20 257:11 258:3,13 259:15 261:5 264:12 270:1 271:1 273:3 274:21 276:11 277:5 279:10 280:17 281:22 283:22 285:12 286:14 288:14 289:10 290:8,16 295:12 296:2 298:12 300:12 301:1 304:13 305:5 306:5 310:5 311:17 312:9,19 314:15 315:18 316:13 318:7 319:14 321:17 322:7,12 324:12 325:12 327:6 339:10 341:1 343:10 347:12

352:5 353:7 355:8 356:3,14,18 358:22 360:6,20 361:14 363:5 366:15 367:13 371:10 372:4 375:7
star 107:14 190:9 331:1,2 332:21
stars 190:4,14 196:14,18 197:5
start 10:6 16:4 22:22 23:14 25:1 32:3,5 99:6 108:9 108:14 110:1 134:10,13 139:1 153:19 173:13 252:21 320:20,21 324:18,21 330:16 331:14 338:22 343:17 348:10 352:4 357:2
started 8:11 16:5 24:20 245:3 320:6 347:18
starting 16:10 121:3 134:13 324:17 343:16 344:11 345:1,2 347:19 348:16 375:12
starts 165:11 325:4 325:4
state 14:14 59:4 93:22 96:4 116:4 270:16 321:10 340:7 342:20 343:4,20 346:10 346:17,19 350:19 363:18,19 365:21
stated 102:11 218:18 254:2 311:16
statement 32:3 36:11 54:20 73:19 73:22 74:21 98:2 126:11,18 127:7 127:15 177:21 178:4 214:22 256:4 268:8 277:17 279:7 313:2
statements 32:6
states 26:16 28:1 322:8 340:20
statewide 322:8
statistical 336:10
Statistics 366:20
status 28:11 46:16 47:11 81:11 187:18 190:13 246:14 267:14 268:11 277:19 278:3,20 280:16 296:22 297:4,9 302:2
staying 148:15 150:8 356:9
stays 374:13
steering 1:4,9 8:21 29:7 105:19 121:11 129:19 168:4 211:9 238:14 239:12 242:6 294:16,22 328:2 362:21
step 19:8,14 42:16 43:17 58:2 100:15 103:15 174:18 188:8 243:14 285:16 301:5 323:15 332:11 344:15,18
steps 4:18 5:16,20 18:18 19:7,15 20:11 186:9 243:20 320:16 345:22 367:18 369:15
steroid 206:16,17 208:16 209:1 225:1
Steve 9:14
stick 154:21
STIEFEL 1:25 12:6 16:18 17:12 40:17 56:10 57:12 95:4 96:19 102:17 103:17 135:5,15 136:5 162:10 179:22 181:9 182:14 183:3 202:19 240:11,17 322:14 325:10 334:8 335:11 338:3 346:2 356:19 374:19 375:1
stimulate 344:1
stop 66:22 89:2 276:19
STOTO 2:2 276:13 290:17 291:6 301:16 303:12,15 304:11,22 305:19 306:22 307:10 308:4 309:3 310:13 311:21 312:5,16,22 315:10 316:4 341:3 348:21 366:16 373:12
straightforward 50:4 122:2 248:5 286:5
strata 87:11 89:9 125:22 231:19
strategies 357:21
strategy 351:13 352:11,17 356:21 357:16 358:16,17
stratification 48:9 86:4,12,13 87:1 122:17 125:19 132:13 134:22 136:15 137:9 154:12 167:22 168:10 181:4 182:16 183:9 292:12,22
stratified 48:7 83:20 84:2 93:7 123:7 137:4 147:11 156:3 169:17 250:11 292:17 293:5,12 293:19 294:5
stratifies 183:4
stratify 97:12 122:20 133:19 135:11 159:18 293:3
stratifying 123:19 124:13 131:5,8 289:3
streamlined 8:14
stress 28:13
strict 374:10
strike 213:16
striking 320:10
Stroke 1:18
strong 38:7,22 112:1 157:10 180:3 219:22 227:7 230:4,6
strongest 134:17
strongly 102:17 135:2 229:22 231:4
structural 342:16 342:16 351:14
struggle 37:1 39:14
struggling 30:18 31:8 99:5 266:3
stuck 138:1 368:1 375:21
studies 216:17 223:14 248:18 256:7 340:2
study 217:7 219:7 219:15 220:11,12 220:19 223:16 248:7,7 313:9
stuff 5:18 6:6 19:1 117:1 329:4 341:20 362:22 364:22 366:9 368:10
sub 304:14
subcommittee 224:15
subconscious 6:5
subgroup 83:8 146:16
subgroups 325:5
submission 26:20 65:1 82:13 176:16 198:1 199:19 292:16
submit 198:8
submits 361:11
submitted 26:9 101:20 118:4 202:11 205:16 215:17 254:7 256:19 329:11
subpopulation 274:5
subsequent 40:10 248:9
subsequently 137:17
subset 41:3 47:13 82:13,16 88:2 98:12 273:22
subsets 44:13 84:2 183:5
substance 315:11
substantial 285:22
substitute 84:9
subsumed 94:9
subtle 116:7 236:1
subtracted 74:10
succinct 22:8
Sue 1:20 321:4
sufficient 56:21 145:22
suggest 22:4 265:4 278:9 340:3 366:16
suggesting 135:11 280:22 294:4
suggestion 123:5 243:2
suggestions 342:5

370:4
sum 324:7
summarization 101:2
summarize 9:2 135:7 240:14 310:1
summary 42:12 50:13 63:1 81:14 82:9 121:5 304:15 317:19 346:4 367:17
summer 140:5 153:17
summing 324:2
supply 66:16 67:13 73:14
support 9:12 10:4 176:17 212:15 258:7 259:14
supporting 180:4 195:5 345:14
supports 275:4
suppose 242:21
supposed 31:20 38:1 39:16 58:16 76:12 130:20 258:1
sure 5:8 8:19 13:7 17:4 19:18 23:1 30:6,13,15 31:18 36:21 40:4 56:14 59:1,6,19 60:4 73:4 79:7,8 80:16 80:19 85:2 88:4 98:20 101:17 107:17 110:14 114:22 115:11,12 115:22 120:9 121:7,12 129:21 140:2 144:3 147:1 150:18 158:10 168:3 173:12 178:3 187:16 206:10 214:20 216:6 217:6 222:5 223:22 233:19 236:21 241:16,22 242:21 253:20,22 254:5 263:8,8 270:9 272:11 280:1,5 283:18 286:1 295:3 296:20 307:7 313:18 329:14 341:13 347:15 352:14 357:12 364:14,18 370:15 372:18 373:20 374:4,13
surmountable 91:5
surname 162:2
surprise 154:10
surprising 125:13
surprisingly 14:13
surveillance 177:14 178:12,13 278:5,8 338:10
survey 49:6 50:15 51:9,10,17 53:20 54:2,8 55:8 56:5,6 56:7 57:3 59:19 61:12 90:5,6 93:6 130:6 187:17,18 187:19,22 188:2 190:20,21 191:11 191:12,20 192:16 193:7,11,14 194:2 195:17 196:2,4,6 197:9,22 198:14 199:13 201:12 205:11,12 246:18 247:4,12 249:22 251:1 299:5 311:19 365:18,20 370:21
surveys 48:7 54:5 196:7 197:11
suspect 18:11 106:2 354:4,19
suspects 14:15
sustained 6:21
sways 241:21
swirling 127:2 238:3
switch 47:18
switched 20:15
switching 134:6
synthesizes 353:14
system 15:22 28:1 64:21 65:2 66:9 66:10,21 71:2 82:2 97:17 143:15 162:1 206:3 246:20 253:13 288:19 323:1 344:7
systematically 85:3
systems 1:21 97:11 322:5 326:19 348:1,1
S-E-S-S-I-O-N 245:1

T

T 265:9 304:17
table 40:6 79:16 148:7,13,15,19 149:12 154:2 184:22 185:15 202:14 224:17 238:10 242:5 244:8 281:18 285:7,8,15 286:2 293:17 299:1 344:3
tabled 185:6 225:6 229:3 235:6 299:16
tabling 235:2 236:15,20 285:13 285:17
tabs 35:4
take 8:16 15:14 17:10 25:18 35:8 43:5 44:7 45:15 55:9 64:10 80:5 89:9 97:12,18 100:9 106:14,16 108:8,16 109:11 116:12 121:12 126:21 138:11,17 145:17 149:1 153:14 159:17 162:18 173:9 178:9 185:11 186:5 194:18 227:21 229:7,12 233:3 243:14,22 265:1 278:15 282:4 288:15 295:10 298:2 301:4 304:19 312:15 316:9,16 320:11 330:4,5 332:18 334:17 348:6,9 351:16 353:18 374:21
taken 34:5 78:22
takes 21:2 336:7 353:13
talk 10:1 31:20 34:13 39:16 58:3 62:22 64:11 85:1 90:8,14 91:11 98:18 120:20 127:12 144:6 173:10 200:18 206:9 255:15 308:19 313:2 337:9 338:1 345:12 349:13 357:18 359:7 366:21
talked 60:14 128:9 134:22 154:5 169:15 226:2 255:20 257:16 259:2 265:21 320:17 335:15 339:9,21,22 343:13 344:10 345:16 346:14 351:12 355:18
talking 11:15 14:18 15:16 16:12 32:6 37:6,16 39:19 53:2,7 57:19 58:12 69:7 92:21 94:7 108:9 144:19 178:4 196:11 200:10 201:13 202:2 211:5 258:22 261:8 300:7,8 309:22 335:9 339:1 345:9 345:21 346:3 351:21 354:6 356:20 362:22
talks 74:16 115:7 160:18 188:17 352:17
target 94:14 118:13 122:19 352:15
targets 49:11 201:13,15 272:12
task 8:4 16:8 110:15,22 115:19 116:9 122:7 125:4 126:11 147:13 149:5 155:15 176:6 240:11 245:20 282:2,13 282:14,15 323:7 332:5
tasks 13:17 282:3 319:20
tax 340:3,8 341:7 342:6
taxation 340:1
taxes 341:6
taxing 341:9
team 87:9 161:15 162:7 168:21 171:7 193:11 197:4,5 210:11 294:1
tease 100:11
technical 153:6 193:9 277:17 364:13
technically 278:21 305:9,17
tediousness 242:8
telephone 107:15

tell 22:19 162:19 163:7 165:3 180:4 223:2 269:10 302:14 319:8 357:15,18
telling 129:22
Ten 256:8 303:15
tend 50:20 175:3 337:15 338:20
tends 327:8 337:10 346:11
tentatively 369:20
ten-year 203:5
term 142:16 179:9 181:16 188:22 189:4,22 246:10 337:7,16
terminology 177:22 178:5 291:17,19
terms 31:5 32:10 37:2,15 48:9,10 57:4,8 58:6,11,15 69:6 92:15 96:4 97:20 105:17 106:21 113:19 129:12 132:2 138:16 139:21 145:19 146:7 149:20 169:10 177:21 178:4,5 191:4 208:22 213:2 256:11 263:18 265:22 281:15 283:20 309:17 326:9 328:3 330:12,18 331:6 336:4 340:16 347:22 355:10
territory 340:8
test 117:11 186:19 188:3,5,6 192:3 192:12 199:4 201:22 213:6 217:3,11 219:3 273:22 274:4 317:4 319:4 339:20
tested 26:15 64:2 82:17 119:11 313:21 329:10 354:3
testing 3:14 26:19 60:11,16 85:1 156:6 180:10,16 180:22 186:16 225:3 239:2 257:7 259:17 264:1,3 273:6,13,19,21 274:2,7 315:6 317:3 326:8 333:17
tests 180:17
Texas 321:10 322:3 322:10
text 133:8
thank 5:3,4,5 29:6 29:11 42:22 62:12 62:13 64:17 89:10 110:20 173:18 185:19 195:9,12 209:8,11 210:12 225:13,21 226:11 228:15 229:6 240:8,17 241:6,8 241:8,9,10,11 242:13,13,13 248:2 295:11 296:2 355:15 360:20 363:5 369:9,12,13 375:13 376:1
thanks 50:2 63:4,5 152:2 173:6 209:15 291:11,12 298:11 376:2
that,if 350:9
therapy 189:3 197:14,18 200:13
thing 16:9 17:3,14 18:19 21:13 23:15 24:18 30:12 32:21 33:6 41:1 53:14 62:6 75:8 78:14 78:18 83:18 85:15 86:11 97:9 100:8 102:13 104:4 131:20 132:3 133:1 138:6,20 140:22 142:1,5 144:3 154:2 157:13 158:9 166:20 169:3 186:7,10 188:15 212:7 214:13 232:22 233:2,17 236:10,18 242:22 244:3 248:12 250:22 256:21 272:14 282:11 283:4 292:10 296:16 321:6 322:6 328:2 336:8 349:11 351:16 356:4 367:7,20
things 8:1 12:4 14:14 19:3 21:21 29:22 35:6,10,11 37:6 39:19 72:8 75:4 84:18 100:13 100:14,17,18 103:6,13,14 108:19,22 111:13 123:3 138:12,16 149:17 154:4 158:7 162:17 164:7 166:15,17 167:3 169:5 194:22 199:21,22 211:9 218:16 235:21 254:19 269:12 270:15 271:21 274:4 280:19 282:12 286:7 288:16 301:18 304:2 310:7,8,10 311:3 312:20 315:8,15 316:20 320:4 321:1,20 325:17 328:7 329:13 330:17 334:22 335:3 336:12 337:10,14 338:1 341:10 342:8,10 343:12 344:16 346:2 348:22 360:10 365:12 367:14 369:19
think 6:18,20 7:21 10:2 11:16 12:6,7 12:15,19,20 13:4 13:13 14:16 15:10 15:19 16:1,20 17:16 18:6,8,10 18:17 20:4 21:14 21:15 22:1,11 23:2 25:14 29:15 30:16,19 32:16 33:4 34:15 35:11 35:19 36:2,4,21 36:22 37:3,22 38:16 41:7,14,18 41:22 44:5 45:2,3 45:4,6,8,16 46:2 47:14,17 50:4,5,9 50:19,20 52:10,14 53:21 54:13 56:16 57:3,7,18,21 58:4 58:7,18 59:3,20 60:5 61:1 62:5,6,7 62:21 63:10,12,21 64:11 65:19 66:22 67:7 70:15 72:22 73:7,9 74:15 75:7 75:21 76:8 77:16 77:19 78:11,12 79:4,7,18 80:2 82:8 84:4 86:10 88:1,14 89:4 90:18,19 92:7 94:18 95:7,9,12 96:6 98:10 99:4 99:17 100:8 104:3 106:5 107:3,5 109:7 115:16,22 117:13 119:6 121:20 124:18,20 125:10,15,17,20 126:1 127:1,13,19 127:22 128:13 129:11 130:12,13 130:16 131:4,17 132:6 133:19 136:15,16 137:10 137:21 142:20 143:1,17 144:21 146:5,19 147:21 148:10,10,22 149:4 150:1 151:2 154:13,14 157:15 158:22 159:4,12 160:3 165:16 167:3 169:3 170:6 170:7,16 177:20 178:17,19 181:21 184:21 185:13,15 190:16 191:9 192:9 193:3 194:6 194:11,20 195:4 197:5 198:19 199:20 200:17 202:14 203:12,15 203:17,21 204:6 204:18 205:4,10 209:3 211:8 212:3 212:11,15 213:1 214:10,13 215:2 216:1,7 218:14 221:2 222:13,21 223:1 224:16 225:2,6 228:11 229:2,13 231:5,16 232:10 233:16,17 235:7,18 236:1,12 236:17,19 237:3,6 237:8,13,15,16,21 238:3 239:10,17 239:19 240:15 242:19 243:1 245:12 252:2,8 257:4 261:10 263:10,16 264:5 264:10,12 265:18

265:20 266:4,11 268:8 271:14,16 271:19,21 272:4,6 272:7,9,14 274:9 274:16 275:4 276:16,17 277:1,7 279:1,3,16 280:6 280:14,18 281:4 281:17 282:3,8,8 282:10 283:13 285:10,12 286:4 288:14,17,22 289:20 290:5 291:16 292:13 293:13 294:7,11 296:5 297:19 298:1 299:21 300:17 303:2 304:11 305:7 309:3 310:8,10,17 310:18 311:9 312:5,7,9,14 313:6 315:12 316:3,5,19,21 317:9 319:16 320:2,5,7,15 321:15 323:6,18 324:9,10,18 326:8 329:1 330:7 331:12,15 332:10 334:17 337:8 338:12,14 339:2 339:12 340:11,13 340:17 341:3,16 342:5,8,12,14,15 342:20 343:3,5,6 343:14 344:20 346:5 347:6,9,12 347:13,16 348:2,6 348:16 349:12 351:9,10,16,18 352:3,10 353:4 354:9,14 355:5,10 356:4,10 357:10 358:22 359:5,7,10 359:14 360:4 368:11,17 369:21 371:11,17 372:5,6 372:8 373:9

thinkers 17:19

thinking 9:20 10:11 12:5 15:8 15:20 16:6,15 93:14,19 141:4 190:20 200:4 211:19 212:16 271:11 286:14 318:20 320:13 321:6,19 325:2 326:13 327:5 331:15 334:8 337:7 341:14 342:10 343:13 344:12 346:10 347:7 351:19 352:20 354:18 359:12 360:3,18 361:4 363:12 368:17

third 180:21

Thirteen 120:14 319:15

thought 10:6 13:4 14:21 15:1 22:17 53:2 54:6 79:13 85:14 86:6,7 87:17 92:2 103:3 158:6 170:3,21 172:9 188:5 201:1 216:14 248:5 323:17 352:7

thoughts 13:2 83:5 138:16 139:3 169:7 368:9

thousand 44:11

thousands 34:20 44:14

threat 91:13

threats 113:4

three 9:11 10:7,15 11:12 20:20 33:16 34:7 44:17 52:2 72:7,16 73:10 77:18 80:19 82:3 83:22 104:12,13 104:16 110:13 125:16 152:17 180:12,14,18 184:17 186:1,4 203:8 218:4,5,6,9 218:11 224:10 226:2 295:18 299:22 302:12 304:4 308:6 309:17 363:22 373:20

three-star 331:3

three-year 183:5 278:6

threshold 284:15 333:8,14,14

thresholds 278:1

tie 156:16 375:16

tied 359:17

tighter 294:3

tightrope 134:8 135:7

tightrope-like 125:1

time 6:5,16 7:19,20 17:9 20:10 21:2,5 25:8 46:3 49:18 51:22 52:4 65:3,5 65:10,13,14 66:5 67:3,3 68:1 70:2 72:18 73:11 78:6 78:7 89:20 91:6 91:14 93:17 102:5 107:22 108:18 113:6 123:15 126:15 127:1,9 132:11 133:11 140:17 145:18 154:9 160:21 183:13 184:5,7 185:3 186:8 189:21 198:9 199:19 202:11 205:9,17 207:8 212:13 215:13,20 216:9 226:7,19 227:4,8,11,15 228:16 229:3,13 230:7,19 231:2,15 233:17 234:22 238:7 243:17 245:22 256:17 273:18 286:19 293:4 303:21 307:14 312:13 333:4 339:15 348:9 354:12 360:2 367:15 368:2 370:6,11,14 371:18 372:21 375:12

timeline 85:20 151:1

times 152:17 175:4 188:16 235:22 242:8 275:18 309:15 336:1 370:22

timing 136:13 151:13 181:18 185:14

tiny 278:12

tired 368:15

title 202:5

tobacco 209:20 210:18 339:22 340:1,3 352:14 354:7,22 362:12

today 5:8,14 8:12 8:14 11:17 28:20 94:8 100:1 109:17 117:1 154:16 155:5 185:16 201:13 236:5 325:19 373:18 375:9 376:3

today's 46:9 325:16

token 241:22

told 20:21 125:2 208:2 255:21 258:8 260:17

tomorrow 370:20 375:4

ton 54:15

tonight 370:20

tools 161:4 166:3

top 24:4 174:13 324:9 357:4,6 360:14

topic 63:20 118:13 192:5

total 26:16 213:7 308:2

totally 86:11 97:4 147:19 222:15 238:9 300:10 333:22

Touchtone 107:15

tough 136:11 365:14 368:6

toxic 355:20

track 118:11 157:6 157:7 251:12 267:15 293:10 298:15 302:15 304:8 336:2

tracked 305:4

tracking 197:1

tracks 199:2

tradeoffs 61:22

traditional 168:17 197:21

traditionally 338:15

transcends 162:16

transcribing 375:17

transfer 144:10

transformation 88:15

transformative 8:2 8:18 20:13

transgender 141:5 141:9 142:18

transgendered 141:13

transitioned 142:19

transitioning 16:2

translate 28:21

113:14 135:3
transparency 264:19 333:1
transplant 175:9 182:8
trauma 189:9
treat 194:8 195:14 199:5 201:21 258:16
treated 174:9 200:5 204:5
treatment 175:2 180:11,18 189:1 200:13
trend 303:20 304:1 305:15 306:11 307:5,18
trending 304:19 305:12 307:9
trials 145:21 288:22
tribe 340:8
tried 14:7 278:19 322:8
triple 266:19
trouble 173:5 183:2 373:10
true 59:16 77:14 95:22 147:19 218:14 277:18 311:17 312:6
truly 77:11 121:7 143:12 150:4 242:4 297:21 341:21
trumps 286:3
trust 80:21 315:13 316:6
truth 302:14
try 5:15 13:8 22:7 43:6,8 46:7 86:18 91:12 95:1 108:15 115:17 155:6 161:8 163:8 169:11 174:17 186:3 207:4,5,17 227:9,19 233:12 235:9 274:1 332:21 333:1 335:4 352:4 357:20,21 361:18
trying 7:22 8:1 34:11 35:4 77:9 84:9 113:17 119:9 144:10 161:4 162:2,17 164:2,22 178:7,10,13 192:3 232:15 239:16 254:11 305:21 327:13 340:14 342:1,2 343:6 351:3
tune 14:7
turn 182:21 307:14 341:11
turned 55:5
Twelve 171:13
Twenty-ninth 371:3
Twenty-three 249:2
twice 174:7
two 7:17 11:12 12:10 18:10 19:9 22:13,16 23:8 24:22 40:18 49:2 78:22 84:21 93:9 103:6 109:18 110:8,14 120:5 138:12 147:10 162:18 164:13,14 164:17 168:5 172:21 173:10 175:20 180:12,17 180:18 188:10,18 198:13 201:4,7,10 210:4 238:18 253:21 279:17 283:3 297:18 302:5,11,17 303:16,19 305:21 307:14 308:7,12 319:19,20 320:15 324:10 333:19 334:3 344:14 345:20 346:8 348:22 357:22 367:14,19 370:16 372:10,20 373:20
two-star 331:2
two-year 121:19
type 113:17 135:6 259:20 296:20 298:10 336:16 351:15
types 109:21 221:21 303:7 309:1 329:15
typical 51:21 174:14
typically 39:20 52:2 234:10,16 249:22 250:21 317:21 337:12
typo 279:4,9

U

UK 360:17
ultimately 84:4 323:9 337:20
ultrasound 217:3 217:13,18 221:10 221:13,21 222:16
ultrasounds 223:4
unbalanced 195:11
uncertain 150:19
uncertainty 189:19 192:21 204:7
unclear 271:17
uncomfortable 203:8,9 219:19 226:16
underbelly 325:13
undergone 175:9
underlying 27:6,9
underneath 357:9
underreporting 222:11
understand 7:11 51:11 68:12 69:10 94:5 101:19 104:8 127:18 128:9 131:13 205:12 228:7 232:20 239:5 254:10,11 270:18 292:3 305:19 307:7 313:4 336:11 339:19 364:14
understanding 59:7 70:15 72:6 77:17 182:1 183:2 232:8 296:20 299:12 317:2
understands 19:20
understood 37:10 220:2
undertreated 191:21
under-discussed 191:22
under-managed 191:22
under-50 122:20
undo 91:16
unfortunately 27:18 80:13 119:18 128:22 134:18 144:15
unintended 148:11 158:19 216:2 272:10,16
Union 16:21
unique 6:19 8:20 28:17 30:5 44:20 64:11 72:18 96:7 282:15 290:9 353:14
uniquely 6:17 70:12
unit 346:6,15 347:2 347:2,5,7
United 26:16 28:1
universal 51:4
universe 361:10
University 1:15,19 2:2,18 293:22
unnecessary 35:2 207:7
unusual 235:11 275:13 291:5 328:2
unwillingness 286:8
update 20:16 126:5 181:18 184:7,9,11 185:14 191:10 193:7,14
updated 63:16 115:12 124:19 140:4 191:5
updates 5:22
updating 8:9 22:10 116:6 124:21 177:8 184:4
upper 126:13,19 138:5 147:12 154:12
up-front 103:10
USA 14:14
usability 38:16 57:6 87:20 204:20 261:17
use 27:3 45:1 50:20 66:21 67:12,15 77:3 83:5 88:8,9 102:4,5 108:17 113:8,9 114:17 115:5 121:3 138:21 139:21,22 140:3 143:20 155:11 156:13 157:1 162:11 165:13 166:8 197:10 206:16,17 208:16 209:20 210:18 215:18 225:1 243:2 247:13 257:1,2 326:1,16 327:2 366:6 375:11
useful 86:18 180:5 303:5 306:17 325:9 357:11
users 152:13

348:11
uses 48:10 353:14
USPSTF 111:22 112:10 117:19 123:14 124:3 126:3,17 131:10 138:5 158:8 176:11 192:1,7 211:12
usual 14:14 327:21 328:16,22 361:21 362:1,22 363:1,2
usually 304:3 314:7
utility 251:8
utilization 93:22
U.S 27:19 110:15 110:21 116:9 122:7 155:14

V

VA 216:15 278:13
vaccinate 98:21 272:12
vaccinated 33:22 46:16 72:4 81:11 98:21,22 234:8 266:13 267:3,7 271:8,9,13 280:1 280:2
vaccinating 266:19
vaccination 3:19 3:19 27:10 30:21 31:4,6,12 66:17 66:18 74:17,18 75:2 98:18 246:14 250:10 253:2 258:21 265:11 266:6,20 267:13 268:22 269:2 275:4 277:9 279:22 287:7,15 291:15 307:19 308:21
vaccinations 52:4 273:1 305:10
vaccine 3:22 25:9 25:13 28:3 46:16 48:5 65:19 66:11 66:16 67:11,13 68:17 73:13,21 74:19 75:14,20 76:11,18 77:11,12 81:11 87:3 95:11 97:9 234:6,10,12 234:15 246:17 247:5 249:6,12,21 253:6 254:4 255:2 255:22 256:9 257:3,18,21 258:10 259:9 260:9,17 268:12 269:7 303:7 306:12,14,15 308:22 312:2
vaccines 52:1 157:13 248:14,19 250:5,14 272:7 276:15 302:3,10 302:16 303:16,17 303:21 304:1,7,21 308:6,7,14 309:22 313:17
vaccines,by 302:10
vagaries 232:20
valence 248:13,17 248:18,22 249:2,5
valid 26:18 59:22 60:11 277:22
validate 119:12 260:11
validation 120:7 257:8 259:20
validity 37:20 56:22 58:6 60:10 60:13,22 64:6 85:1,2,3 113:3 146:13,13 156:8 257:7 312:17 316:11 318:16 326:9 327:9,11,21 330:6 333:18 334:12,17 336:5,6 340:12 364:22
valuable 73:15
value 30:19 34:17 46:3 73:12 327:15
variable 333:10
variables 159:20 165:13
variation 98:16 112:17 134:19 277:14
various 24:2 57:8 105:22 223:14 260:14 337:14 340:13
vast 318:2
vehicle 60:3 61:14 249:22
vending 341:20
verify 143:3
versed 61:11
version 183:4 333:15 357:3
versus 58:6 61:14 146:18 156:4 164:18 318:17,18 318:18 319:13 334:9 342:6
vested 346:19
vets 347:2
view 203:16 205:7 221:3 227:13 230:4,7 330:3 343:14 347:19
vigilance 340:16
Vir 2:22 208:17,21 209:8,11 210:6,8 210:8 211:3 213:5 213:19 214:9 215:7,14 216:6,11 217:15 219:6 220:2,15,18,21 221:12,17 223:7 223:12,22 225:11 225:14,21
virtual 111:19 112:8
virus 28:14
vis 112:3,3
visit 62:17 70:2 71:10,12 72:2 96:14 133:4 297:1
visual 245:9
visually 245:7
voice 30:12 108:2
voiced 90:19 266:2
volume 114:21 153:16 365:22
volunteering 362:6
volunteers 9:22 17:8
vote 21:13,15 22:2 40:16,22 42:21 43:2,5,12,20 53:13 58:3 61:17 62:4,5,8,9,11 78:1 78:3,14,14,15,17 78:18,22 79:12,22 80:2,5 81:1 89:5 115:21 116:15 120:13 137:8 138:10 145:5,7,11 146:6 147:6,6,8 147:16,16 149:15 150:17 154:17 171:10 182:11 221:9 222:19 224:3,6,6 235:12 237:5 239:22 240:20 241:1 250:15 251:15 252:11,22 261:19 264:6,13,14,17 271:2 275:8,15 279:10,13 283:5 283:15 285:9 288:16 290:11 295:17,18 319:15
voted 89:17 234:22 235:8 249:7
voting 42:11 170:1 171:12 222:9 224:2 239:1 242:8 252:21 286:1,19 318:8
vulnerability 170:9
vulnerable 94:21 170:6,21 174:13

W

wait 52:2 104:13 247:15 273:19
waiting 370:18
walk 245:11 280:14
Wal-Mart 51:17
want 9:2 12:20 13:6 16:4,5 19:4 19:11 23:5,7,14 24:3,17 29:12 30:12 38:13 39:21 40:13 43:4,8 44:3 45:19 48:19 50:22 57:7 58:2,3 63:2 84:16 86:4 87:5,9 90:8 91:22 104:14 107:7 111:3 115:15 116:2 120:3 121:6,21 126:7 127:3 128:11 135:2 138:7 139:7 140:20 144:4 145:14,16 148:5 149:16 154:16 155:16 159:14 167:12,13,16 173:9 179:4 184:22 186:3 187:2,14 192:10 193:12,14,20 194:1 198:5 206:22 209:3 210:3 213:5 221:8 228:18 231:1 235:15 236:4 241:12,20,22 244:2,3 245:6 247:17 249:13 250:10 251:16 257:4 264:21 267:2 269:11 270:4 276:2,7 280:1,21 282:9 285:15 288:17

289:5 290:22
291:6 293:18
303:6,7 304:7
306:11 307:18,20
312:12 313:1,10
318:9 320:18
325:14 326:14
336:1 344:1
351:16 352:8
355:12 356:15
358:14 359:7,14
360:2 363:5 364:8
364:10,12 365:3,9
365:22 366:2
369:5 371:17,21
375:13
wanted 11:18 19:17
34:12 110:7 111:8
124:2 125:18
138:13 143:7
176:16 209:2
210:11 229:11
237:11 250:22
264:8 284:1 300:4
309:5 316:8 328:3
329:8 356:7
369:14 374:11
wanting 143:10
337:9
wants 137:15
191:10 361:14
Wardman 1:9
Washington 1:10
wasn't 37:20 47:17
75:12 102:18
126:14 146:15
200:9 214:13
325:15
wasted 234:12
watch 125:8
water 355:20
waters 335:17
wave 151:20
way 8:14 11:14
20:22 31:4 33:17
43:5 45:12 55:7
55:16 56:4,15,22
59:13 60:8 75:3
83:19 84:3 86:21
87:8 90:14 91:4
92:10 93:15 112:6
122:12,16 123:7
126:20 127:9
128:3 129:20
130:16 131:5,20
132:7,14 142:8
143:2 146:11
147:11 149:2
154:14 156:2
159:7 161:22
162:22 163:3,4
164:3 165:1,17
166:1,2 169:6
179:1,7 198:3
201:22 204:2,9
206:14 214:22
215:6,15 217:12
228:12 231:19
235:15 237:6
242:7 262:2 268:3
268:14,15 269:13
270:14 271:10
289:21 291:22
293:16 294:9
302:18 304:8
308:9 313:15
320:9 325:7,9
327:7 330:22
331:9 340:4,15
349:9 352:16
353:14 364:7,17
375:10
ways 41:15 75:8
133:20 164:13,14
164:21 302:13,15
307:4 312:14
314:6 342:15
343:1 361:9
364:15
web 27:4 295:2
WEBBER 2:2
webinar 367:2,12
website 285:1
294:14 372:16
WEDNESDAY 1:6
week 202:13 371:6
weekend 156:22
weeks 358:4 370:16
372:20 373:20
weight 277:3
weird 189:8
welcome 3:2 18:11
23:8,16 29:9 69:3
202:12 296:4
355:13
WellPoint 1:23
111:9,10 119:10
120:4 134:5,12
141:22 148:3
157:3 161:7 165:5
305:14
WellPoint's 111:22
well,l 309:19
went 66:4 87:5
108:12 117:22
192:10 244:11
302:22 355:17
365:13,15 376:5
weren't 84:15
198:6,8
we've 79:10 103:13
290:3
wheel 9:19 15:5
353:18
white 329:12
whoa 224:7
widely 39:1
wider 319:13
willing 222:12,19
227:21 233:15
238:19 355:3
willingness 227:3
wind 71:12
window 278:6
WINKLER 2:10
17:16 23:10 24:19
25:20 26:1 29:11
33:12 35:10 36:14
39:20 42:10 43:8
43:21 44:2 46:10
48:17 50:1,12,18
53:14 55:12,17
56:8,16 57:18
62:10,13 64:16
73:17 74:8 80:22
83:13,17 86:10
88:14,21 89:6,13
90:18 93:3,12
99:7 100:8 103:5
103:19 105:9
109:16 113:19
114:9 117:2,7
120:2,14,20
121:15 143:19
149:10 154:18
155:19 159:9
161:6 171:11,17
172:14,19 173:2,6
173:18 174:16
176:14 177:18
178:1 179:8
181:13 182:5
184:2 185:2
186:15 197:8
200:9,17,21 202:2
208:4,11,14,18
209:3,10,15 211:1
211:5 222:3
223:19 224:9
225:9,13,18
228:10 235:7
236:17 240:15
241:12 246:3
247:7,20 248:2
249:18 251:4
253:1,20 254:8
258:17 259:5
261:8 262:11,14
264:5 265:8 267:9
268:7,16,19
269:16,22 270:21
272:9 273:12,21
274:6 275:13
282:19 283:10,14
287:2 289:14,20
290:20 291:11
292:13 293:13
297:19 298:11,19
300:5,8,17 301:11
308:18 328:1
333:3 335:3,13
338:6 361:17
362:19 366:10
369:4,9,11
winter 151:2
wisdom 9:22
wish 69:4 108:4
230:12 308:21
wishes 107:11
withdrawn 150:15
woman 129:13
192:1
women 3:14 117:9
121:18 122:6,13
122:19 155:1
158:3 171:22
174:5,8 177:11
179:15,17 180:10
180:16 181:1
186:13,16 189:8
194:13,18 197:14
198:22 199:2,7
200:2 201:13,16
201:19 211:18
women's 157:5
158:16,17 188:20
won 161:15
wonder 130:4
138:15 146:21
147:17 187:7
205:15 226:22
314:15 371:21
wondering 93:16
93:21 226:21
263:17 289:12
355:18 359:6
Woodley 1:9
word 12:18 143:20
207:12 241:6
269:5
wording 105:18
292:7 299:12
words 75:13,19
95:16 137:13
229:21 232:5

296:11 310:6 328:4
work 5:22 7:3 8:9 8:13,16 10:11,12 11:17,20 13:1,6,9 13:19,21 14:11 15:1,10,17 16:22 17:7,11,15,17,22 18:2,5,7,9 20:1,20 29:13 42:7 44:12 44:14 46:7,8 47:1 50:13 54:4,17 63:1 65:16 66:2 66:14 67:20 68:19 69:10 81:14,20 82:9 83:3 101:8 101:10,11,12 102:1 120:17 121:4 135:22 150:9 151:13 155:8 156:17 161:2 162:8 168:1 185:22 195:5 196:16 227:1,14 227:18 228:4 229:12,15,18 230:4,5,16 232:17 233:14 235:12 237:17,20 238:6 239:16 240:21 241:3 243:5 244:4 247:9 257:10 265:2 276:3 282:16 301:9 316:19 318:15 319:3 323:16 325:3 328:11 330:7 345:7,14,18 345:20 347:6,10 348:5 352:21 353:5,6,6 363:21 364:3,5 365:4 366:5,8 368:11,17 369:15,16 370:1 372:3 374:12,13 374:20 375:5,6 376:3
workable 314:1
worked 21:3 44:18 111:5 311:10 320:3
workers 29:1
workforce 354:16 359:6,7 360:4
working 7:11,13,16 11:10,10 20:8 22:8 113:15 181:21 193:8,10 193:18 196:17 225:11 244:3 325:4 344:14 346:8 349:17 365:6 366:18
works 68:12 69:6 70:17 142:9 151:14 153:18 162:1 364:2
world 90:19 91:1 93:15 94:15 182:17 291:19 328:19
worried 312:8 315:11
worry 21:2 309:4 310:16,20
worrying 327:10
worse 306:4
worth 274:20 276:4 341:14
wouldn't 41:2 58:8 74:15 87:13 127:3 135:20 142:15 195:20 202:16 217:12 218:15,19 221:20 222:17 223:6 230:1 276:2 305:22 309:4 310:13
wrap 234:2 283:2
wrestle 171:8
wrist 188:7
write 83:21 84:1 102:7 128:21
write-up 223:3
writing 181:14
written 94:14 112:6 147:2 215:6 236:4 263:20
wrong 29:2 36:8 212:13
wrote 367:5

X

X 306:11 337:20

Y

Y 2:9 306:11
yea 182:11
year 18:17 52:22 66:1 117:12 122:13 147:9 149:19 152:17 163:11 172:4,6 174:7 187:20 193:19 277:12 302:8 306:13
years 31:12 33:16 34:7 44:17 48:12 48:12 52:2 60:18 72:7,16 73:10 77:18 80:19 82:3 104:13,13,16 110:4,13,14 114:2 117:10 124:1 127:17 144:17 155:2 157:21 175:20 180:14 181:14 183:18 184:17 189:6 191:19 197:14 209:20,21 214:5 219:12 234:9 246:16 253:5 288:10 306:19 333:21 337:19
yeoman's 376:3
yeses 79:3
yesterday 5:7 6:7 6:10 7:9,14,16 9:4 10:7,21 15:9 16:5 19:1 20:14 22:12 22:14,17 23:12,21 24:11,20 28:8 29:21 32:15 33:13 34:14 49:16 80:14 85:11 87:5 108:7 116:21 123:9 135:1,8 141:4 199:16 231:22 243:1 287:11 289:16 290:18 291:14 311:22 320:12 322:20 325:18 339:9,22 346:6,14 347:14 348:3 355:16 363:13 364:17 373:17
yesterday's 46:7,8
yes/no 21:17 22:3 255:19 343:9
York 1:19 188:16
young 331:16
younger 123:20 124:4 131:8 135:12 246:10 262:1 263:7

Z

Z 306:12
zero 120:14 252:22
ZIP 162:1

0

0031 3:10
0032 3:11
0033 3:10
0034 3:9
0037 3:14
0038 4:10
0039 3:5
0041 3:4
0043 3:19
0226 3:4
041 62:15
0579 3:12
0617 3:19
0629 3:15

1

1 3:2 25:9 62:18 65:8 66:8 67:21 68:6 71:10 107:15 107:19 166:7 172:18 226:5 227:5 369:7 373:15 374:10
1st 70:3 72:2,4
1,000 41:2 44:10 242:8
1,115 26:16
1,400,000-plus 260:8
1.b.2 317:19
1.c.1 288:9
1.c.14 256:2
10 133:3 259:18 295:18 302:3,16 302:18 303:16 305:9 308:6 309:21
10-minute 108:8
10:04 108:13
106 3:7
109 3:8
11 43:21 44:2 62:11 252:22
11:20 186:2
12 89:6 133:3 172:1 180:17 197:18
12:14 242:12
12:15 244:11
12:30 244:9
12:35 244:12 245:2
12:45 244:2
13 213:8 249:5
14 1:6
15 244:7,9
15th 372:18
1525 3:22
16 33:16 117:10
160,000 357:8
1653 3:21 265:9
1659 3:5 46:11 81:4
17 372:17
18 53:7 262:4,5,20
18,000 213:10

186 3:13

2

2 260:5 305:15 372:3 373:16 374:3,9
2(a)1.10 86:13
2.a.1 252:17
2.a.1.1 215:11
2.a.1.2 216:7
2.a.1.3 220:22 269:9
2.a.1.8 309:10
2:44 376:5
20 181:14 183:18
20s 112:18
20-year 183:13
2002 126:17 127:6
2004 174:1
2007 202:10
2008 27:1 28:3 70:13 174:2
2009 63:9 126:11 184:8
2010 63:16
2011 1:6
2012 137:1
2020 27:15 357:17
21 155:1
225 3:17
226 25:2
23 248:17,22,22 249:14 260:6,9
235 317:14
24 3:3 117:10 180:12
25 160:21
250 337:3
2660 1:9
28th 227:15 230:1 230:2
29th 369:21
299 3:23

3

3 27:2 172:2 177:12 218:7 292:16 317:19
3,000 212:2
30s 112:18
30th 369:21 371:3 372:6
30-day 337:11
301 4:8
306,000 260:8
31 121:16
31st 25:10 31:13 227:5
31,000 213:9
319 4:13
32 154:20 175:19
33 117:8
34 110:2 120:8 161:12
368 4:16
369 4:18
37 186:14,16
376 4:21
38 301:2,10
39 47:22

4

4 256:2
4.b.1 252:16
4.c.1 290:13
4.0H 54:9
40 121:18 122:6,13 122:19 127:19,20 129:11,16 130:18 131:2 132:6,19 133:16,21 134:10 134:13 135:2,9 146:4 148:7,12 149:3
41 226:13
42 122:6 127:17
43 246:13 247:14 251:15 252:2 299:4
46 197:13 200:21
49 127:19,20 129:11 130:18 132:6,19 133:16 133:21 135:3,9 146:4 148:4,4,8 148:12 149:3 200:20

5

5 3:2 253:4 254:2 262:3,5 288:11
5-18 262:1
5:00 6:1
50 3:5 48:2,4,11 53:7 93:6 110:3 122:6,13,21 129:16 130:19 134:7,14 148:4 340:20
50-64 93:7
50-75 110:21
525 287:3
53 26:15
57 213:12
579 171:19 173:8

6

60 197:17 209:21 210:19
617 253:2 287:20
629 208:19
63 28:1 155:22
64 48:12 155:1 250:8 253:4 254:2 262:9 263:2 279:8 279:8 288:12
65 48:12 49:8 54:10 93:7 172:1 186:18 187:22 192:1,11 194:13 197:14 200:2 201:13 209:19 210:17 214:15 246:9,16 249:19 250:7,21 253:5 254:3 262:10 263:1 288:10 299:6 300:3
69 121:18 122:19 126:13 127:17 130:19 131:2 134:7

7

7 248:18
700 337:2
74 126:13 138:5 148:4
75 110:4 209:20 210:18 214:15
77 155:21
78.5 175:16

8

8 81:1 263:4
8:00 1:10
8:12 5:2
80 295:6
81 112:19

9

9 263:4
9:52 108:12
90 27:16
92 82:15
93.3 284:4
97.6 273:8
98.6 273:8

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Population Health and Prevention Endorsement Maintenance

Before: NQF

Date: 09-14-11

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Court Reporter