NATIONAL QUALITY FORUM

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REGIONALIZED EMERGENCY

MEDICAL CARE SERVICES (REMCS)

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EXPERT PANEL MEETING

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WEDNESDAY

OCTOBER 17, 2012

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The Expert Panel met at the

National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Stephen Pitts and Suzanne Stone-Griffith, Co-Chairs, presiding.

PRESENT:

STEPHEN PITTS, Grady University, Co-Chair
SUZANNE STONE-GRIFFITH, Co-Chair
TERRY ADIRIM, HRSA

BRENDAN CARR, University of Pennsylvania
Health System
EMILY CARRIER, Center for Studying Health
System Change
GABRIEL EDWARD, Office of the Assistant
Secretary Preparedness and Response
WES FIELDS, CEP America

DAVID LEVINE, University Health System
Consortium
ANTHONY MACINTYRE, George Washington
University Medical Center
DAVID MARCOZZI, ASPR
GREGG MARGOLIS, ASPR
LINDA MCCAIG, CDC

MELISSA MCCARTHY, George Washington
University
RYAN MUTTER, AHRQ
ANNMARIE PAPA, University of Pennsylvania
SALLY PHILLIPS, Department of Homeland
Security
MICHAEL RAPP, Centers for Medicare and
Medicaid Services (via telephone)
KATHY ROBINSON, National Association of
State EMS Officials
JAY SCHUUR, American College of Emergency
Physicians
MANISH SHAH, University of Rochester Medical
Center
MIKE STOTO, Georgetown University
SHELLY TIMMONS, Geisinger Medical Center
(via telephone)
ARJUN VENKATASH, Yale University
ELLEN WEBER, University of California San
Francisco Medical Center

NQF STAFF:

HELEN BURSTIN

ANGELA FRANKLIN

ANN HAMMERSMITH

ADEELA KHAN

JESSE PINES

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

Call to Order and Welcome 8
Angela Franklin

Senior Project Director
NQF

Welcome 8

Steven Pitts 8

Co-Chair

Suzanne Stone-Griffith 9
Co-Chair

Introductions and Disclosures of 10, 42

Interest
Ann Hammersmith
General Counsel
NQF

Project Introduction 24

Angela Franklin 24
Senior Project Director
NQF
Jesse Pines 27
Consultant

Overview of Proposed Paper and 30
Framing Questions
Helen Burstin
Senior Vice President for
Performance Measures
NQF

C-O-N-T-E-N-T-S (CONTINUED)

Emergency Preparedness: Discussion of Concepts and Measures 43

Jesse Pines 43
Consultant

Measurement Issues 44

David Marcozzi 44

Questions and Comments 58
Mike Stoto 87
Questions and Comments 104

Reconciling Daily Crowding and Disaster Surge 122, 188

Opportunity for Public Comment 187

Crowding and Boarding: Discussion of Concepts and Measures 190
Jesse Pines 190
Consultant

Questions and Comments 197

"Quality measure developers should ensure the validity and reliability of the data used for ED crowding and boarding measurement." 196

Questions and Comments 196

C-O-N-T-E-N-T-S (CONTINUED)

Crowding and Boarding: Discussion of Concepts and Measures (Continued)

"Developers should explicitly define the timestamp." 220

Questions and Comments 220

Risk Adjustments 240

Questions and Comments 243

"Quality measure developers should consider setting time-specific recommendations for unadjusted or adjusted measures of ED crowding and boarding." 267

Questions and Comments 268

Recommendation 7, the same topic, but with the added element of standardizing by triage acuity 286

Questions and Comments 288

Measures of central tendency, medians versus geometric means 297

Questions and Comments 297

Recommendation 9, structural quality measures for crowding 300

Questions and Comments 301

Recommendation 10, measures of ED outflow beyond boarding 315

Questions and Comments 315

C-O-N-T-E-N-T-S (CONTINUED)

Committee Discussion on Additional Recommendations 322

Regionalization and Accountability 343

Pathway from REMCS Concepts to REMCS-Based, NQF-Endorsed Performance Measures 371

Arjun Venkatash

Questions and Comments 374

Measure Development Discussion 425

Administrative Matters 431

Opportunity for Public Comment 432

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

2 8:44 a.m.

3 MS. FRANKLIN: Good morning,

4 everyone, and welcome to the Regionalized

5 Emergency Medical Care Measure Prioritization

6 Task Force.

7 We will start this morning to

8 discuss prioritization of measures for the

9 field.

10 Before we get started, let's just

11 go ahead and welcome our Co-Chairs, Dr. Steven

12 Pitts, Suzanne Stone-Griffith.

13 My name is Angela Franklin. I am

14 Senior Director for the Project.

15 I have with me Adeela Khan, our

16 Project Analyst and, also, Jesse Pines, our

17 consultant on this project.

18 With that, I will turn it over to

19 our Co-Chairs, who will start us off with

20 introductions.

21 CO-CHAIR PITTS: Hello. Am I on?

22 Okay. Great.

1 This is Steve Pitts.
2 Welcome to the meeting.
3 By way of introduction, I am an ER
4 doctor. Most of my career has been spent
5 working clinically in the emergency department
6 at Emory University in Atlanta. In the last
7 five or ten years, I have gotten involved with
8 statistics-type stuff and spent a year at the
9 National Center for Health Statistics, and
10 have just dipped my toe into this business of
11 crowding in emergency medicine. I apologize
12 in advance for not knowing lots of facts, but
13 I am going to do my job as a policeman.
14 Thank you.
15 CO-CHAIR STONE-GRIFFITH: Good
16 morning.
17 I am Suzanne Stone-Griffith. I am
18 delighted to be here, a bit of a departure
19 from other meetings that I have been a part
20 of. I am really looking forward to this
21 process.
22 I think with that, and in the

1 spirit of time, Ann, I am going to turn it
2 over to you for full introductions and
3 disclosures.
4 MS. HAMMERSMITH: Okay. Good
5 morning, everyone.
6 I am Ann Hammersmith and NQF's
7 General Counsel. I am here to guide you
8 through the disclosures of interest.
9 As Suzanne said, we combine
10 introductions with disclosures of interest,
11 for the sake of time. It is a little bit
12 easier for everybody.
13 Several months ago, you received a
14 form from us, a rather lengthy form, which you
15 filled out. Thank you for doing that. This
16 morning what we are going to do is ask you to
17 go around the table and disclose anything that
18 you think is relevant that will be done by the
19 Committee today.
20 Please do not recount your CV. We
21 will be here for a very long time if you do
22 that. We know that you are experts. That is

1 why we selected you to serve on the Committee.
2 What we are interested in you
3 disclosing is any grant funding, but only if
4 it is relevant to the work that is being done
5 today with the Committee; research funding if
6 it is relevant to the topic today; speaking if
7 it is relevant to the topic today. Some of
8 you will have nothing to disclose, which is
9 perfectly fine. Just because you disclose it
10 does not mean it is a conflict of interest.
11 It is simply a disclosure.
12 I am going to remind you that you
13 sit as an individual on this Committee.
14 Sometimes we have members who perfectly
15 innocently will say, "I'm So-and-So, and I am
16 here representing the American Society of"
17 fill in the blank. Actually, you are not here
18 representing anybody. You are not
19 representing your employer. You are not
20 representing people who may have nominated you
21 to serve on the Committee. You sit as an
22 individual expert.

1 And then, finally, I am just going
2 to remind you that things that you disclose or
3 conflicts that members may have are not
4 necessarily financial. People often say, "I
5 don't have a financial conflict of interest,"
6 which is great. But because of the unique
7 nature of the work we do here, you could have
8 something to disclose -- it may or may not be
9 a conflict -- where no money has changed
10 hands.
11 For example, you served several
12 years on a Committee that looked at topics
13 relevant to what you are going to discuss
14 today, that would be something we would like
15 you to disclose to the ground.
16 So, with that, I am going to have
17 you go around the table, tell us who you are,
18 what your day job is when you are not here
19 laboring for NQF, and then tell us if you have
20 anything you would like to disclose.
21 So, I always pick on the Chairs
22 first to start us off.

1 CO-CHAIR PITTS: Steve Pitts. I
2 am currently working clinically at Emory
3 University Hospital in the emergency
4 department.
5 I do have some contract funding
6 through ASPR, the Emergency Care Coordinating
7 Committee, which is a small portion of my
8 salary. Otherwise, I spent one year as a
9 Fellow at the National Center for Health
10 Statistics. Other than that, I am pretty much
11 just a regular doctor.
12 Thank you.
13 CO-CHAIR STONE-GRIFFITH: Again,
14 Suzanne Stone-Griffith. I am the Vice
15 President of Emergency Services, EMS, and
16 Trauma for HCA in the Continental Division.
17 I am actually based out of Denver now,
18 although I think it says Nashville in some
19 documents.
20 I have served in previous times on
21 the consensus panels for the emergency
22 measures and ambulatory care measures. I have

1 also been part of the ENA Crowding Task Force.
2 I have worked with the emergency department of
3 Benchmark Alliance on some of the measure
4 definitions.
5 MEMBER WEBER: I am Ellen Weber.
6 I am a Professor of Emergency Medicine at the
7 University of California, San Francisco, where
8 I also work clinically.
9 The only grant funding I currently
10 have is a very small part as an expert
11 stakeholder for an AHRQ-funded grant that is
12 coming out of Stanford to talk about quality
13 indicators.
14 I have served with Suzanne at the
15 ED Benchmark Alliance. I am a member of the
16 SAEM Interest Group on Crowding in Emergency
17 Medicine.
18 And the other thing, I guess -- I
19 don't know if it is a conflict -- but I did
20 have a grant from the SAEM to study what they
21 did in England to solve their emergency
22 department crowding, and got that grant both

1 from SAEM as well as the Bupa Foundation. But
2 that is now finished.
3 MEMBER STOTO: Good morning,
4 everyone.
5 I am Mike Stoto, on the faculty at
6 Georgetown University. I am also an adjunct
7 faculty member at Harvard School of Public
8 Health and do most of my research at Harvard.
9 I am the co-PI there one of the CDC-funded
10 Preparedness and Emergency Response Research
11 Centers. There are nine of them. Two of the
12 Centers focus on measurement as a theme, and
13 ours is one of them.
14 A lot of the work that we have
15 been doing was summarized in a White Paper
16 that was cited in the background for this. I
17 will be saying a little more about that later
18 today.
19 The other thing is that I am also
20 the Chair of what is called the Model Design
21 Working Group for a group that is preparing
22 the National Health Security Preparedness

1 Index, which is obviously related to this as
2 well. That group is meeting again on Friday
3 to try to come up with some specifications for
4 that Preparedness Index.
5 MEMBER FIELDS: My name is Wes
6 Fields. My day jobs are as a Director of the
7 largest partnership of emergency medicine in
8 the country and part-time clinical faculty at
9 UC-Irvine.
10 I have spent a lot of time the
11 last few years doing policy development and
12 advocacy pieces with federal regulatory reform
13 and the AC rule-writing in mind. I am more of
14 a bundler to create new research projects,
15 which means I am very popular with a lot of
16 people in and out of the room who do research
17 in this sector. And I am very happy to be
18 here today.
19 MEMBER MARGOLIS: Good morning.
20 My name is Greg Margolis. I am
21 the Director of the Division of Health Systems
22 and Healthcare Policy in the Office of the

1 Assistant Secretary for Preparedness and
2 Response at HHS. And I don't have any other
3 conflicts to disclose.
4 MEMBER SHAH: Good morning.
5 My name is Manish Shah. I am
6 Associate Professor of Emergency Medicine at
7 the University of Rochester, where I work as
8 an emergency physician. And also, I work as
9 one of the County EMS Medical Directors.
10 Most of my work has revolved
11 around pre-hospital care, particularly of
12 older adults, and how to improve the care we
13 deliver. I have AHRQ, CDC, and other grants,
14 but nothing directly related to this.
15 MEMBER ASPLIN: Good morning.
16 My name is Brent Asplin. I
17 usually have a voice, but I don't. This will
18 be the best contribution so far to an NQF
19 committee. I will just sign it in.
20 (Laughter.)
21 I am President of Fairview Medical
22 Group in Minneapolis, part of Fairview, which

1 is an integrated system there, and emergency
2 physician and Immediate Past Chair of a
3 Quality Performance Committee. And I don't
4 have any relevant conflicts to disclose.
5 MEMBER ADIRIM: Good morning.
6 My name is Terry Adirim. I am a
7 pediatric emergency physician. In the past,
8 I have been in academic medicine work in pre-
9 hospital and EMS; currently, the Director of
10 the Office of Special Affairs of the Health
11 Resources and Services Administration. I
12 represent HRSA on the NQF Board. I don't
13 think that is a conflict, right? And that's
14 it.
15 MEMBER PAPA: Good morning.
16 AnnMarie Papa. My day job is the
17 Clinical Director of Emergency Nursing at the
18 University of Pennsylvania and Penn
19 Presbyterian, a medical center.
20 A couple of volunteer things: I
21 am the Immediate Past President of the
22 Emergency Nurses Association and have had the

1 opportunity to sit on the SAEM Regionalization
2 Task Force and a number of committees that
3 worked on crowding and throughput with ACEP
4 and ENA.
5 MEMBER ROBINSON: Good morning.
6 Kathy Robinson. I appreciate the
7 opportunity to participate today.
8 I am a Program Manager for the
9 National Association of State EMS Officials
10 and, also, a Past President of the Emergency
11 Nurses Association. I have had parallel
12 careers in EMS and emergency nursing.
13 With NASEMSO, we receive some
14 grant funding from HRSA and the National
15 Highway Traffic Safety Administration, but I
16 really don't have any relative interest
17 business to disclose.
18 MEMBER CARR: Good morning,
19 everybody.
20 I am Brendan Carr. I am sorry I
21 was late.
22 I am an emergency physician and a

1 policy researcher at the University of
2 Pennsylvania, and I work part-time a day a
3 week in Greg Margolis' office at ASPR.
4 Other than the fact that I have
5 had research funding for conference work
6 around regionalized emergency care systems and
7 a lot of my research funding from AHRQ and CDC
8 are tied to these issues, I don't think I have
9 pertinent disclosures.
10 MEMBER VENKATASH: Hi, everyone.
11 My name is Arjun Venkatash. I am
12 currently a Robert Wood Johnson Foundation
13 clinical scholar at Yale, trained in emergency
14 medicine at Harvard.
15 And the only conflicts I believe I
16 have are that I have serve on the ACEP
17 Clotting Performance Committee and last year
18 received support from ACEP to do a mini-
19 fellowship here at NQF. That included work on
20 the previous phase of this project.
21 MEMBER SCHUUR: Jay Schuur from
22 Brigham Young Women's Hospital. I am a

1 practicing emergency physician. I also do
2 health services research.
3 And conflicts: I chair the
4 Quality Performance Committee for the American
5 College of Emergency Physicians, and I think
6 that is it.
7 MEMBER LEVINE: Good morning.
8 I am David Levine. I am an
9 emergency medicine physician. My day job is
10 I am Vice President of Informatics and Medical
11 Director at UHC, which is the University
12 Health System Consortium, the academic medical
13 membership organization.
14 My only conflicts, with UHC, we do
15 benchmarking and performance. And so,
16 obviously, emergency medicine is one of those
17 sets of measures that we present to our
18 membership, although we do not create the
19 metrics.
20 And then, in my previous life as
21 an emergency medicine department medical
22 director, I served on a number of SAM interest

1 group committees that dealt with crowding.
2 MEMBER McCAIG: I am Linda McCaig
3 with the National Center for Health
4 Statistics. I work on the National Hospital
5 Ambulatory Care Survey, and I have nothing to
6 disclose.
7 MEMBER CARRIER: Hi. I am Emily
8 Carrier. My clinical training is in emergency
9 medicine. My current day job is as a
10 researcher at the Center for Studying Health
11 System Change.
12 Relevant to this project, I have
13 current research funding from the CDC for a
14 study of regional healthcare preparedness
15 collaboratives and have had previous funding,
16 mostly a number of foundation grants,
17 primarily Robert Wood Johnson Foundation, for
18 a large, ongoing qualitative study that
19 touches on many of these issues.
20 MEMBER McCARTHY: Hi. I am
21 Melissa McCarthy. I am a faculty member at
22 George Washington University in health policy

1 and emergency medicine.
2 And I guess the only relevant
3 conflict is my career development work, but,
4 through AHRQ, it definitely touches on
5 crowding and its impact on quality emergency
6 care.
7 MEMBER MacINTYRE: Hi. Good
8 morning.
9 I am Anthony MacIntyre. I am also
10 an emergency physician at George Washington
11 University. In fact, Jesse and I commiserate
12 frequently about our inadequate EHR that has
13 recently been implemented, but this isn't
14 about EHRs.
15 (Laughter.)
16 My academic career is focused on
17 emergency preparedness and response at all
18 levels, facility, state, federal, and
19 international. I guess I am not sure I really
20 understand the term "regionalized" in this
21 context.
22 But I guess the two things I have

1 to disclose that might be construed as
2 conflicts are: one, I was the coauthor of the
3 MSCC document, which HPP currently uses in its
4 funding grant cycles. And then, the other is
5 I recently stepped down, serving four years as
6 the Chair of the Emergency Management
7 Committee for D.C.'s Emergency Healthcare
8 Coalition.
9 MEMBER PHILLIPS: Good morning.
10 I am Sally Phillips. I am with
11 the Office of Health Affairs at the Department
12 of Homeland Security, Deputy Assistant
13 Secretary. I guess I would say in my previous
14 life I led the Public Health Emergency
15 Preparedness Research Portfolio at AHRQ in
16 support of HPP and ASPR, and nothing else to
17 disclose.
18 Thank you.
19 MS. HAMMERSMITH: Okay. I may
20 have some people on the phone. I am going to
21 call on you.
22 Is Mike Rapp on the phone?

1 (No response.)

2 Is Rebecca Katz on the phone?

3 (No response.)

4 No? Okay.

5 And then, a Committee member just
6 walked in. Two. Okay.

7 We are doing introductions and
8 disclosures. So, if you could tell us who you
9 are, who you are with, and if you have
10 anything relevant that you want to disclose to
11 the Committee in terms of research funding,
12 grant funding, speaking, et cetera. But only
13 if has to do with the topics before the
14 Committee.

15 MEMBER MARCOZZI: Dave Marcozzi
16 from the Department of Health and Human
17 Services, Assistant Secretary for Preparedness
18 and Response. No disclosures.

19 MEMBER MUTTER: Ryan Mutter,
20 Agency for Healthcare, Research, and Quality,
21 HHS. No disclosures.

22 MS. HAMMERSMITH: Thank you for

1 making those disclosures.

2 Do you have any questions of me or

3 anything that you want to discuss with each

4 other based on the disclosures this morning?

5 (No response.)

6 Okay. Thank you. Have a good

7 meeting.

8 MS. FRANKLIN: Thanks, Ann.

9 So, we will go quickly to the

10 project scope and activities, just quickly.

11 So, today I just want to highlight to everyone

12 that we are focused on methodological issues

13 and not endorsement of any particular

14 measures. We are looking to lay a groundwork

15 for development, testing, and endorsement and

16 implementation of measures in this topic area.

17 We want to review measures and measure

18 concepts that are available in ED crowding,

19 boarding, surge, and emergency preparedness

20 areas, and any other areas that the panel will

21 identify throughout today.

22 I want to note that we are going

1 to look for gaps and barriers to fully-
2 testable, implementable measures that could
3 pass the NQF criteria. And we are looking for
4 this group to provide recommendations for how
5 measures could be aggregated at the higher
6 levels, such as regionalized and by
7 geographical unit.
8 The purpose of our final report is
9 going to be to tie together our concepts of
10 crowding, preparedness regionalization, and
11 specifically to how we can report those
12 measures of quality at the regional level.
13 And we also want to help inform and give
14 guidance to the field as to the path to
15 measure development that could be brought to
16 NQF.
17 This project is funded by HHS, as
18 you have heard earlier.
19 With that, I think I will turn it
20 over to our Co-Chairs. Or Jesse is next. I'm
21 sorry. Jesse is next.
22 MR. PINES: Great. Thank you.

1 I think I know most everyone here.
2 For those who I don't know, very nice to meet
3 you.
4 Jesse Pines. In terms of my
5 background, I am an emergency physician and
6 health services researcher at GW, today
7 representing NQF on this project.
8 And I have had several grants
9 looking at the association between crowding
10 and quality of care from various
11 organizations, federal and university funding
12 and also foundation.
13 I would like to thank everyone for
14 coming today. Essentially, our goal today is
15 really to work on this report and really focus
16 on seeing what we can do to really provide a
17 guidance to measure developers who are
18 interested in developing crowding measures and
19 preparedness measures; also, seeing if we can
20 bring together those fields.
21 We have experts from the crowding
22 world and the preparedness world. Aside from

1 the calls that we had leading up to this
2 meeting, those worlds don't really come
3 together very much. Really, one of our goals
4 today is to really help reconcile the folks
5 who measure crowding and the folks who measure
6 preparedness in the NQF framework and, also,
7 think practically about how we basically get
8 from A to Z with measure development and
9 really provide some very concrete
10 recommendations to measure developers.
11 So, really, our goal today is,
12 again, to help us work on this report, come up
13 with specific recommendations, and basically
14 set up a runway for measure developers that
15 would, hopefully, happen in the coming years.
16 We don't have a specific plan. There is no
17 specific contract in place for measure
18 development in this field, but, essentially,
19 our hope is that, by setting up this runway
20 and by giving some real guidance to measure
21 developers, that we can figure out who the
22 players are, who are going to develop these

1 measures, and essentially what specific
2 guidance they would need, taking the
3 perspective of crowding and preparedness into
4 account.
5 So, with that, I wanted to maybe
6 turn it over to Helen. Did you want to talk
7 a little bit about the NQF process and the NQF
8 standards.
9 DR. BURSTIN: Sure. Good morning,
10 everybody.
11 I am Helen Burstin. I am the
12 Senior Vice President for Performance Measures
13 at NQF. I have actually always, as a health
14 services researcher, always loved emergency
15 departments and have always enjoyed doing
16 research in those settings.
17 I am happy Sally could be here,
18 since I was at AHRQ, and she oversaw our work
19 on emergency preparedness when I was --
20 MEMBER PHILLIPS: She was the
21 mother of that.
22 DR. BURSTIN: I was the mother, I

1 guess. I don't know. I always felt like the
2 child.
3 (Laughter.)
4 But, essentially, we would love
5 to, we are really pleased to engage again in
6 this topic area. I think that what we are
7 trying to do in this project, unlike I think
8 a couple of the ones that preceded it around
9 more of an approach around regionalized
10 emergency care services, is really be very
11 definitive about what is the pathway toward
12 saying, how do we get to a set of measures
13 that would really allow us as a nation to
14 measure issues around crowded and
15 preparedness.
16 So, we thought it might be helpful
17 just to give a little bit of a backdrop about
18 how NQF evaluates measures, as you are
19 beginning to think through what measures might
20 look like.
21 Next, please.
22 So, why NQF endorsement? For

1 those of you who don't know, obviously, from
2 where we sit, an important piece of this is
3 the fact that, if you have standardized
4 performance measures, there are tools that
5 allow us to assess quality in a way that
6 allows us to have comparable information to
7 really be able to compare providers and
8 others.
9 As many of you know who have sat
10 through our panels -- and many of you have
11 -- the NQF endorsement is intended to really
12 reflect rigorous scientific and evidence-based
13 review, input from patients, families, a whole
14 wide range of stakeholders, and people really
15 across the entire industry.
16 Next.
17 So, these are our evaluation
18 criteria. I won't do a deep dive, as we often
19 do before committees start working, because
20 you don't have any measures before you today,
21 but we thought, again, just as a backdrop,
22 just to give you a sense of it.

1 So, NQF has always used the top
2 four criteria, but over the years they have
3 gotten more and more precise and, in fact, a
4 higher bar in certainly the last five years
5 that I have been at NQF. And they are also
6 hierarchical.
7 So, the first one around
8 importance to measure and report is a must-
9 pass criterion. If it doesn't pass that first
10 one, we just stop our assessment.
11 And probably the cornerstone of
12 that one is the level of evidence for the
13 measure focus. We really focus there in on
14 the quality, the quantity, and the consistency
15 of the evidence, and consistency tends to be
16 very important for both guidelines as well as
17 measures.
18 We also want to see if there is an
19 opportunity for improvement. We don't want to
20 be measuring things that are topped-out or
21 things where variation is not going to be seen
22 across providers.

1 And finally, we do anchor
2 ourselves to the National Quality Strategy and
3 other high-impact areas. We want to make sure
4 we are really looking at an area that makes a
5 difference. I often describe this to groups
6 as, you know, is the juice worth the squeeze?
7 It is a lot of work to get these measures. Is
8 it really worth it? Will it drive improvement
9 at the end of the day?
10 Scientific acceptability is the
11 second one, and I have got another slide
12 following up on validity, because it is such
13 a major concern. But, essentially, are the
14 measure specifications precise enough that
15 comparisons are possible? Is there
16 reliability and validity testing of the
17 measures at either the data element level or
18 the score level?
19 Usability and use was recently
20 updated. The idea here is to really ensure
21 that audiences who want to use those measures,
22 whoever they may be -- and in this particular

1 project, it is a very wide lens of who may
2 look at these measures, from the community
3 folks to regional folks, to people in EDs, and
4 others -- can they use those results for both
5 accountability as well as performance
6 improvement?
7 Feasibility. Can the measure be
8 implemented without a lot of burden? Can you
9 capture it increasingly, in this day and age,
10 with electronic data and moving towards
11 electronic health records?
12 And finally, not so much in this
13 space because there are so few measures, but
14 if you look at areas like cardiovascular care
15 or diabetes, for example, a lot of our efforts
16 now are really focusing-in on trying to select
17 the superior measure among competing measures
18 or at least harmonizing measures across
19 different sites of care. This may be relevant
20 in this field; for example, if we want to be
21 able to cascade up and down, to have measures
22 that work at an emergency department, but also

1 could roll up to give you more regional or
2 local assessments of services. So, something
3 we will talk about as we get further.
4 Next.
5 We also over the years have been
6 doing additional work on evidence and have
7 moved towards really a significant
8 hierarchical preference for outcomes.
9 Outcomes, particularly those linked to
10 evidence-based processes and structure, is
11 really the place we would most like to go. We
12 want to ensure there is at least a plausible
13 relationship to process and/or structure. And
14 if we are going to have process measures, in
15 particular, they have got to be the ones as
16 close as possible to the outcomes. The ones
17 that are really distal and so far away that
18 you could measure them and measure them and
19 measure them and never move the outcome is not
20 where we want to be anymore. We have really
21 started eliminating many of those measures
22 from our portfolio.

1 Next.

2 I mention this just briefly. I

3 will leave it up here in a bit more detail.

4 Again, we do require testing of the measures

5 for reliability and validity. We allow that

6 either to be done at the score level, which is

7 often used for claims data or things we have

8 just a lot of data, just to look for signal-

9 to-noise, for example, or at the data element

10 level. If there is one particular element you

11 really want to be able to capture, can you

12 test it and show you can reliably collect it?

13 The rest of it here, we won't go

14 through.

15 Next.

16 Threats to validity is a major

17 part of what our Committee spent a lot of time

18 on. This just goes through some of them.

19 Again, conceptually, is it related to an

20 important area of care or strongly linked to

21 an outcome? Again, a measure that is

22 unreliable can't be valid. So, that is a

1 starting point for us.
2 We want to make sure that patients
3 aren't inappropriately excluded from
4 measurement. Some of the most complex
5 patients, we always complained, are left out
6 of research studies and sometimes they are
7 left out of guidelines. And so, sometimes
8 they are left out of measures. So, we really
9 prefer that those approaches be stratified
10 rather than excluded.
11 We also want to, whenever
12 appropriate, measures, if they are outcome,
13 should be risk-adjusted. We increasingly are
14 in this world of measure scores being
15 generated with multiple data sources and
16 methods. We want to make sure there is some
17 comparability if people are going to be using
18 different data sources. And we want to avoid
19 systematic missing or incorrect data.
20 Next.
21 Usability and use, I mentioned
22 briefly. Just two quick points on this. The

1 last bullet there is we have updated this.
2 So, we look at it to see whether the measures
3 have actually made a difference, not just if
4 they are being used. Are they driving
5 improvement?
6 And here, the idea is are we
7 actually making progress towards improvement,
8 but also is there any evidence of unintended
9 consequences. Many of you in the ED space,
10 for example, lived through the pneumonia
11 measure, antibiotics within four hours, which
12 I think we heard pretty clear indications from
13 the field -- that was just when I came to NQF
14 -- that this was actually causing harm in
15 emergency departments. We quickly did what we
16 call an ad hoc review, re-reviewed the
17 measure. The measure was changed.
18 But we really want to get a handle
19 as much as possible, as you think through
20 these measures, of what is really important to
21 measure going forward. It is also important
22 to think about, if we systematically measure

1 that and it may be adopted for an
2 accountability application, are there any
3 likely responses that may result in unintended
4 consequences, I think is something we want to
5 just make the case of.
6 Next.
7 We oftentimes talk about
8 measurement, measurement, measurement. We are
9 NQF. But, again, the end goal here is
10 improvement in either healthcare, provider-
11 based healthcare, or population health,
12 obviously, given the focus today.
13 This was some work initially Don
14 Berwick had done, recently updated. Really
15 just making the case we understand measurement
16 has lots of uses for both improvement but also
17 selection. It is important to remember that
18 we want to try to get to a set of measures
19 that can both drive improvement, but also be
20 useful for accountability.
21 Next.
22 Feasibility we have talked about a

1 bit. Again, try to get the data elements in
2 a way that is easily retrievable or collected
3 as part of routine care. I have heard about
4 Jesse's pain points on the EHR and EDs. So,
5 I won't go there. But, again, is there a way
6 to capture some of these data moving forward?
7 Next, and I think probably last.
8 This was some work, RWJ's project
9 on Aligning Forces for Quality it put forward.
10 I thought it was useful for today, in
11 particular. Even if we begin thinking about
12 eMeasures, the reality is there are so many
13 different sources of data that we are going to
14 want to pull into these that go way beyond
15 what you are going to get just out of the EHR
16 on your desk. Just a reminder for us.
17 Next.
18 And I always end with this slide
19 because I think it is important for us to
20 remember that we are in sort of a difficult
21 place at the moment of lots of things we
22 really want to measure that we can't quite

1 measure yet, but we also know we can't improve
2 what we don't measure.
3 So, with that, I will stop and
4 turn it back over to Jesse.
5 MR. PINES: Great. Thanks so
6 much, Helen.
7 So, any questions for Helen?
8 MS. FRANKLIN: Dr. Gabriel, did
9 you want to introduce yourself quickly?
10 MEMBER GABRIEL: I am, fortunately
11 or unfortunately, not a physician, but Ed
12 Gabriel, the Principal Deputy Assistant
13 Secretary from ASPR. I am glad to be here and
14 participating in the group.
15 MS. FRANKLIN: And I just have one
16 more question.
17 Arnika, are you there?
18 THE OPERATOR: Yes, I am here.
19 MS. FRANKLIN: I wanted to check
20 to see if we had a Michael Rapp or a Rebecca
21 Katz on the line, and if their lines could be
22 opened, if so.

1 THE OPERATOR: Okay. Not at this
2 time.
3 MS. FRANKLIN: Okay. Great.
4 Thanks.
5 MR. PINES: Great. Thanks so
6 much.
7 So, essentially, what I wanted to
8 do is get the discussion started this morning.
9 We have people from a lot of different
10 backgrounds, a lot of different areas of
11 expertise.
12 One of the issues that I think
13 came up on our earlier conference calls was
14 sort of making sure that everyone was on the
15 same page in terms of understanding what we
16 were trying to do with preparedness
17 measurement and crowding measurement.
18 So, essentially, one of the things
19 we had talked about was having two really
20 short presentations this morning from Dave
21 Marcozzi and, also, from Mike Stoto to give us
22 an overview of some of their work on

1 preparedness measurement. Really, our hope is
2 in the next half hour or so to really get on
3 the same page in terms of the goals of
4 preparedness measurement, some of the major
5 issues, so we can start getting into the major
6 meat of this, which is going to be specific
7 recommendations for measure developers.
8 So, at this time I am going to go
9 ahead and turn it over to Dr. Marcozzi.
10 MEMBER MARCOZZI: Thanks, Jesse.
11 I appreciate it.
12 I first just want to recognize two
13 staff members in the back who are part of
14 ASPR, Peggy Sparr, who is actually in charge
15 of evaluation for ASPR, and Dr. Rick Hunt,
16 newly brought on from CDC to ASPR. Certainly,
17 their expertise with regard to this
18 discussion, we would solicit their advice if
19 we break up to ask them any questions that
20 further the discussion that I am going to
21 present here today.
22 Let's just kind of couch where we

1 were with preparedness before 2012 and where
2 we are heading for preparedness for the next
3 five years.
4 As a result of a Presidential
5 Directive -- and that was Presidential
6 Directive 8 -- there was a shift from a
7 planning-based scenario to a capability-based
8 scenario or capability-based planning. That
9 was an important change. You can't make plans
10 for every type of event. There was
11 recognition within the Administration that you
12 have to establish some core capabilities,
13 apply those capabilities to, hopefully, any
14 event, and have an 80 to 90 percent answer.
15 Certainly, there has to be some vectoring
16 right or left for a chemical event versus a
17 large-scale biological event versus a
18 pandemic. Those are all different types of
19 specific events. But the response and the
20 preparedness response activities are some
21 foundational core capabilities that we can
22 project to any type of those events.

1 And that was a key shift from
2 where we were before to where we are now. To
3 that end, the release of the healthcare
4 preparedness capabilities which are in line
5 with the public health capabilities -- so, CDC
6 in 2011 released 15 public health
7 capabilities, and then we, subsequently --
8 ASPR, "we" -- but this was a consensus-driven
9 capabilities document that was released in the
10 beginning of this year that looked and spoke
11 to eight specific capabilities.
12 I think we will have probably
13 significant interest in two of the
14 capabilities. And then, I am going to jump
15 over to what we are going to discuss here
16 today. It is in and around performance
17 measures.
18 The eight capabilities are through
19 coalition development, emergency operations
20 center, the ability to mobilize volunteers, so
21 a volunteer capability, a fatality-management
22 capability, and what I think will have

1 importance here will be the medical surge
2 capability.
3 So, there are eight capabilities,
4 and I certainly didn't list them all, that we,
5 then, had to think about how are we planning
6 on measuring. One of the challenges we face
7 in preparedness is, when we stand in front of
8 the press or stand in front of the Hill with
9 regard to testimony, is: are we better
10 prepared than we were before?
11 In an effort to try to establish
12 some sort of markers and marks on the wall
13 with regard to preparedness, there were
14 measures put forth for each capability. The
15 first capability is community or coalition
16 development. And previously, our measures had
17 spoken to, do you have plans in place? Do you
18 have people, and you count noses, who come to
19 the table?
20 But, unfortunately, we found that
21 that really does not establish a true
22 performance measure because counting how many

1 people are at the table or counting how people
2 were involved in the exercise does not
3 necessarily translate into better
4 preparedness.
5 What we found was that, actually,
6 established some better preparedness were
7 formalized coalitions that allowed for IAAs,
8 MOUs, charters, business development plans, in
9 conjunction with different healthcare
10 entities. Let me just speak to healthcare
11 entities for one moment.
12 When I speak to coalitions and
13 healthcare entities, the Hospital Preparedness
14 Program is misnamed. The Hospital
15 Preparedness Program provides monies to
16 awardees, then gives monies to coalitions.
17 Coalitions are subsequently defined as
18 hospitals, long-term care, primary care, EMS,
19 emergency management, public health.
20 All of that nexus, that core
21 group, is what we define as a healthcare
22 coalition. And certainly, within this

1 document, there are others defined.
2 So, now you understand where we
3 are with regard to coalitions and the
4 development of coalitions. And there are some
5 synergies certainly within the Affordable Care
6 Act and the Accountable Care Organizations
7 that are standing up. We are looking at how
8 to blend our efforts with regard to what the
9 ACOs are going to be doing, and looking to
10 leverage some of the efforts with regard to
11 that work.
12 However, in its simplest form, we
13 are trying to put money forth to have partners
14 come together to work better to effect a
15 response. And when we describe "partners," we
16 are only not describing hospitals; we are
17 describing other healthcare partners,
18 truthfully, a health community, to come to
19 bring to bear to effect a response.
20 So, that is the unit of measure.
21 The next step, and I think where we have
22 interest in this discussion, is really a

1 paradigm shift for what we describe as medical
2 surge today.
3 Classically, medical surge has the
4 -- pick a percentage -- 20 percent, it is
5 approximately 20 percent above whatever the
6 typical capacity is of what previously were
7 hospitals. And we have changed that paradigm.
8 We have done that for specific reasons.
9 The first is we had to put a
10 performance measure out there that allowed it
11 to be independent of an evolving healthcare
12 system. As our healthcare system changes and
13 adapts and becomes more modern and evolves,
14 the measure we put out there we hope lasts for
15 the next five years. That is the grant cycle,
16 and that is the high-water mark on the wall
17 that our awardees look to as to actually
18 establish success and define success.
19 The second was we had to allow
20 these capabilities, we had to approach it from
21 a sustainable model. And this is irrespective
22 of finances. This echos the door-to-balloon

1 time of 90 minutes, in essence. It is
2 irrespective of size. It is irrespective of
3 scope. It is irrespective of capabilities
4 that you have. You know your end goal. You
5 know your deliverable, and that is what the
6 expectations are for the Hospital Preparedness
7 Program.
8 So, let me just speak to what that
9 performance measure is and how the paradigm
10 has shifted from the 20 percent above on a
11 system of healthcare that is trying to get
12 leaner and meaner every day with just-in-time
13 supply chains and staffing that is trying to
14 just right-size-fit the number of patients we
15 have within facilities. So, there is no new
16 staff that are waiting to receive patients.
17 There is no new space that is awaiting
18 patients to just be received. And a just-in-
19 time, as-lean-as-it-can-get healthcare
20 delivery system, which is what the Hospital
21 Preparedness Program stands on, this
22 performance measure integrates within that.

1 So, what we are describing is the
2 ability, and it is evidence-based. And I am
3 forgetting that part. It is evidenced, and it
4 is operationally-tenable, this new performance
5 measure.
6 We call it IBA, Immediate Bed
7 Availability. But, truthfully, it is
8 immediate care availability. It is the
9 ability to accept 20-percent higher acuity
10 patients within your facility within four
11 hours.
12 Now that is irrespective of the
13 disaster. That is all-comers. So, the MI
14 that just hit the door, vice, the explosive
15 event that just occurred. Notice I did not
16 caveat that. It is all-comers presenting to
17 your facility -- pardon me -- to your
18 coalition. That is the unit of measure. You
19 have to have the ability to accept 20-percent
20 higher acuity patients within four hours. We
21 build it into the system. The tagline is:
22 this is medical surge with no new staff, no

1 new stuff, and no new space.
2 The evidence base on which we
3 stand, Gab Kelen out of Hopkins, a 2006 Lancet
4 article talked about reverse triage and talked
5 about the ability of our healthcare system to
6 be able to accept higher-acuity patients with
7 no adverse outcomes.
8 So, standing on that evidence
9 base, we then shifted to an operational
10 construct. What is the average discharge rate
11 currently within our healthcare systems today?
12 Our average length of stay is approximately
13 4.9 days, plus or minus. You can figure that
14 out.
15 So, we average slightly less than
16 approximately 20-percent discharge per day;
17 again, slightly less than that because we know
18 that there are more. But if we have a 4.9
19 length of stay, then we can kind of start to
20 think that this is an operationally-tenable
21 goal. And then, we had to put a mark on the
22 wall within four hours.

1 Without four hours is a large
2 stretch, and we think about three pillars to
3 be able to establish -- our coalitions need to
4 be able to establish this performance measure.
5 The first is the ability to throughout the
6 time assess acuity. Now that could be done
7 from an evidence-based standpoint or the truth
8 is, when the internist on the floor writes
9 "Out of bed ad lib" or "Tolerate PO ad lib,"
10 that is a potential triage, surrogate triage
11 marker, because those patients or at least
12 that internist is assessing that they have the
13 ability to walk around on their own and they
14 have the ability to tolerate PO.
15 So, whether or not this has an
16 evidence base -- and we can certainly cite
17 different types of triage methodologies, and
18 Dr. Hunt could speak to this much more than I
19 -- or operationally and with a logic model
20 behind it, but it is the ability to assess
21 through time the acuity throughout their
22 healthcare coalition.

1 Second, the second pillar of this
2 is the ability to rapidly offload patients.
3 So, just as we would do onsite in a disaster,
4 we would ask, "Anybody who can stand up and
5 hear my voice, please move over to Mr.
6 Gabriel. He will be glad to help you with any
7 of your concerns or issues." And all those
8 walking-wounded would then get up and move
9 over to providers.
10 The higher-acuity patients would,
11 obviously, then, need to be subsequently
12 triaged. We are kind of, in essence, doing
13 the same thing and providing the same
14 principles that we do within responding to an
15 event, but within a healthcare coalition.
16 And that healthcare coalition
17 then, if you think about it, this is not done
18 ad hoc. This is done, when you sign and you
19 come on and you are admitted to our facility,
20 you are signing paperwork. Your first piece
21 of paperwork is a HIPAA form. Your second is
22 a "you are going to pay us" form.

1 The third is you are part of a
2 National Healthcare Coalition. In the event
3 of a disaster and that you are deemed a lower-
4 acuity patient, we will make appropriate plan
5 of care for you as an outpatient, so that your
6 outcome is the same, or as close to the same
7 as it can be.
8 And if you need to be retriaged,
9 then this is a constant flow and back into the
10 system. So, triage is not static, as we all
11 know who have done operations. This is a
12 continuous flow through the event.
13 Then, during the event that the
14 trigger goes off and you hit the button and we
15 have to execute, those patients already are
16 understanding that they are deemed lower
17 acuity. We have rapid discharge plans in
18 place, and within four hours a Greyhound bus
19 is pulling up, and that ankle fracture you
20 were planning on pinning tomorrow doesn't get
21 pinned, goes home with crutches and a splint,
22 and gets pinned in a week. Or that soft-call

1 chest-pain ruleout that is awaiting the stress
2 gets discharged and gets his stress in a week.
3 And they get on their Greyhound bus or they
4 have their family members coming to the door,
5 and they get offloaded rapidly.
6 The third pillar of the execution
7 of this performance measure is the ability to
8 accept higher-acuity patients to lower-acuity
9 beds. This is a difficult road to walk.
10 However, it is consistent with what we saw the
11 Institute of Medicine speak to with regard to
12 crisis standards of care. We move from
13 conventional delivery of care today to
14 contingency, to crisis.
15 IBA is the ability to execute
16 contingency care and to give the healthcare
17 coalition greater depth to provide appropriate
18 levels of care before they have to shift to
19 crisis standards of care. So, those three
20 pillars are what is needed to execute IBA.
21 That is the performance measure
22 that the Hospital Preparedness Program is

1 going to be focusing on over the next five
2 years. It has an evidence foundation. It is
3 operationally-tenable. And we think that this
4 will be achievable, and we hope that we can
5 stand 200 coalitions across the nation or 400
6 coalitions across the nation, with 1,000 beds
7 per coalition, that can get the job done
8 within four hours.
9 That is establishing local
10 resilience, regional resilience, and national
11 resilience. And that is the target we are
12 trying to achieve.
13 I would be glad to take any
14 questions.
15 CO-CHAIR PITTS: I lost you a
16 little bit at one point. What are the three
17 pillars again --
18 MEMBER MARCOZZI: Sure.
19 CO-CHAIR PITTS: -- for my
20 concrete thinking.
21 MEMBER MARCOZZI: The ability to
22 continuously monitor care across your

1 coalition, that is the first goal. Monitor
2 acuity, not care really, acuity. The second
3 is the ability to rapidly offload, and the
4 third is the ability to rapidly onload. In
5 short, those are the three pillars.
6 Jay?
7 MEMBER SCHUUR: How are you
8 defining coalitions? And is it sort of self-
9 defined? Can a group of hospitals that may be
10 an ACO or private group do that? Is it going
11 to be a governmental function?
12 MEMBER MARCOZZI: A great
13 question, Jay. We don't have any defined
14 -- we have no definition with regard to
15 coalitions. We know what the measures are.
16 We know what the partners must be. But, as
17 the awardee, we tell the awardee we want a
18 hard-boiled egg, but we don't tell them how to
19 boil the egg.
20 So, we know that they have
21 deliverables and expectations. We don't tell
22 them -- you know, some places may have five

1 long-term care facilities involved. Some may
2 have one. Some may have seven primary care.
3 Some have five.
4 And we are seeing different
5 coalitions are established per our awardees.
6 Fifty states are awardees. For instance, we
7 can't project that. One of our awardees is
8 Guam. Well, defining a coalition for Guam is
9 much different than the coalition for New York
10 City. So, you have to be very careful what
11 the feds project out on what defining
12 coalition is.
13 Will it blend with ACOs? We are
14 hopeful it does, Jay. I think it needs to.
15 MEMBER ADIRIM: Thank you. I
16 wasn't sure how you were identifying people to
17 speak.
18 This was very interesting. I
19 think you brought up a good number of concepts
20 that are helpful in moving forward and looking
21 at how to measure preparedness or integrate
22 preparedness into the work with regionalized

1 emergency care.

2 I think some of the concepts that
3 I am hearing you are talking about that could
4 be a challenge in measuring these things is
5 that most of what you are describing really is
6 process. You stated that there was evidence
7 for your particular measure, the 20 percent of
8 increased bed availability. I think, though,
9 I would like to think more about outcomes.
10 Like what are you trying to accomplish? That
11 would be something that I think would be
12 interesting to look at.

13 The other thing, too, is whether
14 or not that measure that you are developing
15 can be tested, which is a challenge, of
16 course, in preparedness because, you know,
17 disasters don't happen every day. So, those
18 are a couple of things that I thought you may
19 want to think about.

20 And the other thing, too, is I
21 heard you talk about performance measures.
22 So, I think a little bit of clarity on

1 performance measures versus quality measures
2 would be useful as well. I mean, I have other
3 comments, but those were some of the main
4 things that kind of came to mind as you were
5 speaking.
6 MEMBER MARCOZZI: Yes, I tell you,
7 you hit the nail on the head with regard to
8 the ability to test this. We are looking
9 right now at exercising what IBA is and how to
10 do it. Actually, this is the first year out
11 of the gates. So, everyone needs to know this
12 is a crawl, walk, run approach. If we deluge
13 our awardees too much too fast, the cart is
14 broken and the wheels come off the wagon.
15 So, this is incremental and
16 staged. Everyone is trying to figure out
17 their coalitions look like and how to execute
18 those performance measures.
19 So, with regard to exercises, we
20 have some mandatory -- certainly, the Joint
21 Commission has their mandatory exercise and
22 drills, requirements, and we have our own.

1 Our exercises are actually large-scale, but we
2 have not been able yet to test, and we plan on
3 testing, IBA as it evolves.
4 It is integrated within the daily
5 delivery of healthcare today. It is process-
6 oriented and not as outcome-oriented as -- we
7 would love to drive to eventually an outcome-
8 oriented approach where we look at the effect
9 of mortality and morbidity on this on this
10 process that we are trying to put in place.
11 But, in essence, the ability to care for
12 higher-acuity patients we hope, then,
13 translates into better outcomes for those
14 affected by disasters.
15 Brendan?
16 MEMBER CARR: I have two
17 questions. The first is I am wondering about
18 white space. I am wondering if there is
19 anything as part of the HPP that suggests to
20 the country that there should not be a lot of
21 space that is left without membership in the
22 coalition.

1 And the second is, if you can give
2 it, your opinion about whether or not, as
3 these develop, if they become appropriate
4 denominators for boarding. You know, one of
5 your pieces here, piece two or piece three is
6 the ability to onboard patients. That is
7 dependent upon whether or not you just
8 effectively reverse triage in pillar two. But
9 is piece three tied to boarding measures at a
10 coalition level, at a regional level?
11 MEMBER MARCOZZI: Our hope is
12 -- and is really a grant discussion -- but our
13 hope is, unfortunately, we have a $350 million
14 program and a $2.5 trillion industry. So, we
15 have to figure out how to do this very smartly
16 and most economically.
17 One of the things we are trying to
18 -- if you spread that $350 million out too
19 diffusely, then we actually don't have the
20 ability to move the needle and affect an
21 outcome or affect a process. In essence, if
22 we spread it out, and some of our awardees are

1 considering doing this and now changing, had
2 previously spread it out to every hospital
3 within their state. That is about $60,000 per
4 hospital. If the average budget is about $200
5 million, plus or minus, $60,000 is really not
6 going to be able to move the needle too much.
7 This is a grant discussion, but
8 one of the things we are thinking about is our
9 awardees should think about consolidating for
10 effect and trying to address a white-space
11 question is I am all right if we have more
12 white space. What I am not all right with is
13 our awardees and our coalitions can't get the
14 job. So, I would much rather stand on 100 or
15 200 coalitions that can get the job with done
16 with slightly more white space and maybe some
17 hospitals that fall out because they are not
18 as engaged, and they are not prepared. This
19 is not something they would like to be
20 involved in.
21 That said, any hospital can be
22 involved with a coalition. They just may not

1 be getting the funding to be able to support.
2 We are looking to try to get funds to each
3 coalition, $1.5, $1.8, $2.1 million, so we can
4 affect the ability for them to execute the
5 capabilities in the performance measures. So,
6 consolidating for effect is something we are
7 looking at.
8 With regard to white space, one of
9 the discussions that we have had is we are
10 trying to look at covering about 80 percent of
11 the nation with regard to our grants. That is
12 our hope. That is what we are trying to
13 achieve. And hopefully, we are trying to get
14 those measures and get our coalition input in.
15 What is your geographic region? Who are your
16 partners? Who do you cover? What is your
17 population size that you have the breadth to
18 be able to affect? And with that data coming
19 in, we will at least have some idea on how
20 close we are to the 80 percent and whether or
21 not we need to revector.
22 The second question was --

1 MEMBER CARR: The second question
2 is about synergy with this initiative, synergy
3 with boarding.
4 MEMBER MARCOZZI: Oh, yes,
5 boarding. Sorry.
6 MEMBER CARR: You know, the
7 synergy to add your $350 million to someday a
8 metric that pushes coalitions to think
9 strategically about their capacity.
10 MEMBER MARCOZZI: So, in truth, I
11 am heartened at the fact that we are having
12 this discussion today and trying to bridge and
13 weave. Truthfully, what we need to do id we
14 need to weave a thread of healthcare -- pardon
15 me -- we need to weave a thread of
16 preparedness within healthcare. That has to
17 be done. Preparedness can't stand alone.
18 The opportunity to have
19 discussions on crowding and preparedness need
20 to happen. The truth is, Brendan, to that
21 end, our measures did not specifically target
22 and think about crowding as much because, if

1 there is crowding tomorrow and we address some
2 of the issues and it gets better, still our
3 mark on the wall is you can accept 20 percent
4 irrespective of places that have the ability
5 to accept and don't have a crowding issue and
6 places that do. So, we try to be independent
7 of operational constructs and crowding. So,
8 that was the prism we looked through when we
9 tried to establish the measure.
10 CO-CHAIR PITTS: Arjun?
11 MEMBER VENKATASH: I guess my
12 question kind of gets back to a little bit of
13 what Brendan was just asking about white
14 space, in a sense that I think there are two
15 ways to think about it.
16 One is in terms of what areas are
17 just not covered by coalitions. But what I am
18 thinking about is, when we think about
19 performance measure, validity. The question
20 I would have is, when a coalition comes
21 together locally, if it doesn't include all
22 the relevant players within that locality, you

1 could see a situation where an IBA-type
2 measure looks really good for that coalition,
3 but misses the mark because they just haven't
4 included all the relevant hospitals, long-term
5 care facilities, whatever else it is.
6 So, is there any capture within
7 the system to ensure that a coalition actually
8 has adequate coverage within however they
9 define that locality, be it state, county,
10 whatever, local?
11 MEMBER MARCOZZI: I don't know if
12 I have my arms around your question. You are
13 describing a coalition -- let me just see if
14 I can break it down -- you are describing a
15 coalition, then, for a large city that is only
16 affecting 20 percent of the city, and the
17 other 80 percent is left in this white space,
18 in essence? That is what you are describing?
19 So, you are saying that they could establish
20 the IBA, but not actually have the ability to
21 respond to their large-scale area?
22 MEMBER VENKATASH: Right. So,

1 they could form it. They could report
2 performance. We could do an exercise, and it
3 would look great, right? They would show that
4 they are able to offload/onload both, meet all
5 three pillars for their system or the
6 coalition as it is defined, but it misses the
7 target because the general population is
8 missed.
9 MEMBER MARCOZZI: Yes, I follow
10 you. I have to tell you, it is interesting.
11 We have not had that posed at all, only
12 because we have come from the construct that
13 100 percent of our population is covered by
14 the Hospital Preparedness Program. We haven't
15 shifted that pendulum way right.
16 Now it may, with coalitions, and
17 that would be something we might have to
18 revise this measure to say we revised the
19 coalition measure, the first capability, that
20 your coalition needs to cover 80 percent or
21 each coalition within your awardee's region
22 has to cover 80 percent of your population.

1 But, right now, I will be honest
2 with you, there is blanket cover. The
3 Hospital Preparedness Program is diffuse and
4 touches the entire nation. We think that that
5 may be depending on which way we have look,
6 because we have paper tigers out there. A guy
7 coming into a meeting and then leaving, that
8 is not prepared; that is just a guy coming to
9 a meeting, yes.
10 CO-CHAIR PITTS: AnnMarie?
11 MEMBER PAPA: Thank you.
12 At the risk of being shortsighted,
13 and just again to I guess dovetail onto what
14 you said, Arjun, I wonder as I look around the
15 room do we have all the right players in the
16 room. We can talk about this ability to 20
17 percent uptake, and to take all of this
18 additional surge, but, again, we always are
19 looking at the mirror at the emergency
20 department, the one that really needs to
21 manage this.
22 What we have to do is look at how

1 can we coordinate with our inpatient partners
2 and our outpatient partners and the ability
3 for us to offload those patients that we need
4 to offload. So, how do we really coordinate
5 that and then what is that 20 percent that you
6 are talking about, that inpatient offload,
7 that outpatient coming in?
8 Because, yes, the coalition would
9 say, "Yes. Great. We'll do it." What we end
10 up, having to have people in bunk beds in the
11 emergency department.
12 So, I just wonder if having some
13 inpatient partners and processes, even some
14 type of research or measure that you partner
15 with an inpatient unit and that is your babe,
16 so to speak.
17 MEMBER MARCOZZI: Yes, so in the
18 interest of transparency, I am an ER doc. So,
19 I get it. I hear you. And I would always be
20 challenged when I would have door patients
21 boarding, and I would say, "Well, this is not
22 a bolus of patients to the ER. This is a

1 bolus of patients to the hospital." For some
2 reason, if you keep those doors closed, that
3 conversation typically does not happen.
4 So, this effort and this measure
5 is actually to affect the entire -- actually,
6 the truth is I have actually had discussions
7 with our critical-care colleagues around this.
8 So, what is the MICU's and what is what is the
9 SICU's perspective on this measure?
10 So, the guy who we are planning on
11 weaning from the vent, and he has been on the
12 vent for two weeks and is stable, and we have
13 got to start to wean. And all of a sudden, we
14 have an event. Well, in their MICU that
15 patient is potentially is a lower-acuity
16 patient. So, then, that patient potentially
17 you keep on the vent; you just keep sedated,
18 move to a floor, so that the nurses can manage
19 that. So that, then, you can accept higher-
20 acuity patients.
21 So, the 20 percent is not just for
22 the emergency department. It is across the

1 spectrum of care. Now one key thing about the
2 20 percent, which this may be a wordy
3 discussion and not for all those in the room,
4 but if a coalition has five long-term care
5 facilities at 200 beds per, and you have a
6 couple of hospitals, the measure for the 20
7 percent is not for the entirety of the number
8 of beds within their coalition. It is the
9 number of acute beds within their coalition.
10 So, it is not every long-term care, the 200
11 beds within every long-term facility. Their
12 measure to get from an operationally-tenable
13 goal is only for their acute care beds. And
14 that is different. We had to let our awardees
15 know that, that that was the expectation.
16 But, to address it, it is not only
17 and the intent is not only to be for the
18 emergency department. It is to be systemwide.
19 CO-CHAIR PITTS: Okay. Anthony,
20 actually you were next. And then, Melissa.
21 MEMBER MacINTYRE: Thanks.
22 Dave, you bring up a lot of points

1 sort of all within 10 minutes. For me, it is
2 kind of confusing the picture in relation to
3 this project.
4 I think several of the points you
5 made bring up several questions for the
6 project managers. One is David is obviously
7 focused at the healthcare coalition level.
8 What is you unit of measure? Where are these
9 measures going to be applied? I think that
10 should be very carefully articulated because
11 it could be at the healthcare coalition level,
12 as I read it in your paper. It could be at
13 the individual facility level. And quite
14 clearly, there are going to be different
15 measures, I think, we are looking at as you
16 move forward.
17 I think another important thing to
18 articulate -- and I think your paper touches
19 on it -- is the extreme difference between
20 preparedness and response. In fact, it is so
21 important, I would recommend you change the
22 title. It isn't just about preparedness; it

1 is about preparedness and response. And you
2 do cite how it is much more difficult to
3 develop measures for a response, but we still
4 need to get there to have measures for that as
5 well.
6 The third thing is, when we look
7 at response, much of the conversation is
8 dominated on surge. Quite clearly, that is an
9 important thing for any healthcare system to
10 be able to do. But I would encourage you to
11 look at some other work out there, including
12 some that the Veterans' Administration has
13 done, where response and surge -- surge
14 actually takes sort of a tertiary priority to
15 two other things, the first being safety and
16 security. If you can't keep your facility
17 safe and secure, then you can't surge.
18 And the secondary sort of priority
19 is continuity of operations. If you can't
20 keep your operations going, then you can't
21 surge.
22 So, there is sort of a tiered

1 approach to this: safety/security, continuity
2 of the operations, and then surge. And I
3 think some of that might help shape this
4 framework.
5 MEMBER McCARTHY: I think I was
6 thinking on a very similar vein because I was
7 going to ask about these capabilities needing
8 to be prioritized. Because you can't have any
9 medical surge until you have a coalition
10 developed, and I am not sure we do have strong
11 coalitions developed. So, it seems to me that
12 you do have to kind of prioritize and start
13 there, and then increase the competency.
14 MEMBER MARCOZZI: Yes, that is
15 exactly what we are seeing. We are at step
16 one out of the gates. We are seeing forming
17 coalitions currently. Some places, I will be
18 honest with you, are already well-formed and
19 mature coalitions. In fact, Virginia already
20 has a very well-formed coalition. Seattle has
21 a very well-formed coalition. So, they are
22 actually moving beyond and now trying to

1 accomplish some of the other capabilities in
2 and around medical surge.
3 But we go from literally some of
4 our awardees have no coalitions to some of our
5 awardees are trying to actually to be the
6 exemplary, the A-plus students.
7 CO-CHAIR PITTS: Wes?
8 MEMBER FIELDS: I am really
9 intrigued in a couple of ways. One of the few
10 good things about a disaster response is that
11 it is one of the few times in a metropolitan
12 service area where market forces are
13 suspended.
14 And one of the interesting
15 corollaries on the public safety side is it is
16 also one of the few times when Medicare-
17 provider hospitals see EMTALA suspended.
18 And thirdly, a lot of the surge
19 capacity you might need within an area of
20 impact, I am concerned, as Arjun has implied,
21 might be in the part of town that is not part
22 of a coalition.

1 So, I am kind of wondering if the
2 best investment for the resources you have for
3 this is to look at a different set of rules of
4 engagement for Medicare-participating
5 hospitals in these scenarios and essentially
6 a different kind of EMTALA that wasn't focused
7 on the needs of the patient, but of a
8 population that was in harm's way.
9 Because it may be that that is
10 what you need to begin to try to create and
11 measure and promote, is the ability of all
12 providers within a service area to respond and
13 how that fits together.
14 I think there are some attractive
15 alignment between EMS agencies and hospital
16 systems in highly-consolidated markets like
17 Seattle that might make that doable.
18 So, speaking in favor of using the
19 resources to think about what all providers
20 within an area, whether it was rural or metro,
21 how they would collectively respond. I think
22 that could be useful.

1 CO-CHAIR PITTS: Okay. I think we
2 can take a break here and proceed to the next
3 step, which is Mike Stoto, to give a
4 presentation. Okay? Am I missing something?
5 Ellen? I'm sorry. Ellen, I
6 didn't mean to cut you out.
7 MEMBER WEBER: Maybe this is
8 stating something people are thinking about or
9 inadvertently saying, but it seems to me that
10 this is a totally scalable idea. And I think
11 Brendan was kind of getting at this earlier,
12 which is, why not have a 3-percent or a 5-
13 percent, and could that be at the hospital
14 level? So that, in terms of getting together
15 our two ideas about crowding, boarding, and
16 preparedness -- because, first of all, you
17 could potentially measure that for real
18 because there is not going to be a disaster,
19 but there are going to be 3-percent, 5-percent
20 surges. So, does the hospital have a way to
21 deal with that?
22 It is kind of one of the things I

1 think we need in this report, is how does this
2 connect? How does your ability to handle a
3 daily surge connect to your ability to handle
4 a disaster? Although I think that there could
5 be complete separations on that, I think the
6 adaptability, the accountability, the
7 flexibility of any organization to be able to
8 do what you are talking about at a lower scale
9 would at least start those conversations
10 between the inpatient, the outpatient, and
11 between perhaps a neighboring hospital when
12 you have no more beds, the primary care
13 clinics when you need to offload some of the
14 lesser acute patients. So, it does seem to me
15 that everything you are talking about would
16 totally apply to the crowding issue.
17 MEMBER MARCOZZI: Can I jump off
18 of that? Sorry.
19 CO-CHAIR PITTS: Sure. Yes, go
20 ahead.
21 MEMBER MARCOZZI: So, yes, I think
22 that, again, I am hopeful that we can actually

1 jump right off of that and try to figure out
2 how we could blend our efforts here with the
3 performance measures that we are trying to
4 shoot for. So, that is great feedback.
5 The second thing I would talk
6 about from EMTALA's standpoint for one second.
7 So, I mean, here are the triggers for EMTALA,
8 right? So, the hospital has to declare a
9 disaster. Then, the Secretary of HHS needs to
10 declare a public health emergency. Then, the
11 President of the United States need to declare
12 a Stafford Act to execute an 1135 waiver,
13 which is what you are speaking about, about
14 patient dispersal and EMTALA waivers. So, you
15 are talking about high bars.
16 Now, and again, transparency, that
17 is an "and," right, public health emergency
18 and Stafford Act. There is actually floating
19 out there a law that actually makes it an
20 "or". So, even if we make it an "or," public
21 health emergency or Stafford Act, we still
22 have a high measure. The Secretary still has

1 to come in front of everyone and say, "We are
2 declaring a public health emergency." And she
3 will look to the Assistant Secretary for
4 Preparedness Response for that advice on an
5 event.
6 But this speaks to what I tried to
7 hint at with regard to local, regional, and
8 national resiliency. But I think that this
9 measure speaks and tries to accomplish, that
10 if we have a 50-car pileup and there are 100
11 patients presenting, the region has the
12 ability to respond, and it creates regional
13 resilience. But the Secretary of HHS does not
14 have to stand up and say, "We are declaring a
15 public health emergency to be able to execute
16 IBA."
17 Now IBA allows -- pardon me --
18 PHEs and 1135 waivers allow the dispersal of
19 those patients appropriately to affect that
20 care, and EMTALA and allowing those 1135
21 waivers, if they give bolus to the closest
22 facility, which we saw certainly in Madrid,

1 events like that, to be able to push those
2 patients back out to other facilities if we
3 allowed those 1135 waivers.
4 But the truth is IBA works if an
5 1135 waiver is accomplished or even if it is
6 not accomplished. So, it is integral within
7 the system, and it can be used in either way.
8 Thanks for the 1135 comment. I am
9 all about 1135 waivers.
10 CO-CHAIR PITTS: We can do a
11 couple of short things.
12 MEMBER ADIRIM: I just didn't want
13 Dr. Weber's point to be lost because I think
14 it is really probably one of the best points
15 that was made, that a way to integrate these
16 concepts into the work that is being done
17 here, I would imagine would be to develop
18 measures that could help you measure whether
19 or not you are prepared, but also are related
20 to other everyday measures. So, I just
21 thought that her point was right on target.
22 CO-CHAIR PITTS: Sally, do you

1 want to get your fair share?
2 MEMBER PHILLIPS: Yes, I mean, it
3 will come up again. I think one of the
4 things, as we are trying to develop this sort
5 of a measure complex is, having worked in this
6 area for a long time, we are sort of leaving
7 the individual clinician out of this. As we
8 discussed in many ways, these are performance
9 measures for a program and for a system. But
10 one of the things is we are potentially asking
11 them to go in a way that is contrary to a lot
12 of the quality measures we have developed as
13 far as quality of care and ED delivery and
14 timing.
15 When we talk about, well, we will
16 delay that treatment or that surgery, then
17 that reflects back on their quality measures
18 of how they sort of set up their practices and
19 how hospitals are being measured. So,
20 somewhere in the middle there is a culture
21 change of getting people to understand under
22 extraordinary times those quality measures.

1 So, it sort of puts this
2 juxtaposed. It is a little bit of where you
3 were going with the systemwide. But if you
4 bring it down to the clinician level, full
5 participation in what we are talking about is
6 going to require a little bit of tweaking
7 because we finally have gotten people to start
8 instituting quality measures into their care
9 and measuring performance, and in many ways
10 asking them in this first step of, when you
11 are surging, sort of making these alternative
12 decisions, it puts them in conflict with a
13 culture of measures that they have had in
14 place. We get kind of ratcheted up around the
15 system and forgetting that the system is made
16 up of a lot of clinicians who have just kind
17 of come onboard really well with this.
18 CO-CHAIR PITTS: Okay. We shall
19 proceed with Mike Stoto then. Thank you.
20 MEMBER STOTO: Okay. Thank you.
21 Do someone have the slides?
22 The things I say really come from

1 some work that I have been doing with my
2 colleagues at Harvard through our CDC
3 Preparedness Research Center, and it really
4 reflects the work of a lot of people and
5 conversations we have had with a number of
6 people, including people like Anthony, who was
7 on our advisory panel. I will try to sum up
8 some of the things, the thinking that we have
9 been doing -- if you could just go to the next
10 one? -- that I think has some importance for
11 what we are here today.
12 So, I think it is important to
13 begin, and I am also happy, if we have time as
14 we go along to do that, that might be a more
15 efficient way to do it.
16 I think it is important to
17 recognize some of the challenges -- public
18 Health Emergency Preparedness is what PHEP
19 stands in our lingo -- that are somewhat
20 different from a lot of the work that NQF
21 does. One of them is that public health
22 emergencies are rare. That has two important

1 factors. One is that you can't measure
2 outcomes directly. If you don't have a stream
3 of heart attack patients coming into the
4 emergency department, then you can't measure
5 what fraction of them get asked.
6 Secondly, because they don't
7 happen very often, also, it is hard to study
8 what works. So, the evidence base is somewhat
9 thin.
10 Second is that an effective
11 response we know is complex and multi-
12 factorial, and it is hard to know what is the
13 right way to respond to any given response.
14 And we usually don't have the counter
15 factuals. We don't know what would have
16 happened if we had responded some other way.
17 What we do know is that we need to
18 have system-level measures. So, this is a
19 point of contact with Dave's point about the
20 unit of measurement has to be bigger than the
21 patient or the emergency department, and so
22 on.

1 That really gets us into the third
2 point, this idea that the public health system
3 is fragmented. We use that term "public
4 health system," it really draws on the
5 Institute of Medicine report that set up the
6 the PHEP research programs that think about
7 not only the official governmental public
8 health agencies, but also the healthcare
9 delivery system and Homeland Security,
10 employers and businesses, education, and so
11 on. That is the whole system that we needed
12 to get to work together.
13 Well, that varies quite a bit. It
14 works at the city, the county, and the state,
15 and the national level. Sometimes there are
16 regional structures embedded in that across
17 state lines like we have in the Washington
18 area. And basically, it is different almost
19 every place you look in the country.
20 And then, the partners to public
21 health vary quite a bit. Clearly, healthcare
22 is in there, EMS, and so on.

1 I think that this concept of
2 regionalized emergency care systems obviously
3 comes into play there. But, again, building
4 on what Dave said, that is the unit, but you
5 also have to think about who they relate to
6 outside of the healthcare delivery system as
7 part here.
8 Another complication that comes up
9 that I have seen in my work is that,
10 increasingly, hospitals and healthcare
11 delivery in the U.S. are parts of chains. So,
12 our Georgetown Hospital is part of MedStar
13 that has about a dozen hospitals and a lot of
14 other healthcare facilities between here and
15 Baltimore. A lot of those hospitals will
16 think about coordinating first with the people
17 in their chain, rather than the other
18 hospitals in D.C. So, that is another
19 complication.
20 Ultimately, you have, who is
21 responsible for what? You need to think about
22 that before you can come up with different

1 measures.

2 So, our goal in this paper, it was

3 cited in the Draft Report. There is a

4 slightly more updated version of it online at

5 that URL. Our goal was really to kind of

6 think about how do we apply the science of

7 assessment, the kind of stuff that NQF does so

8 well, so this area of public health emergency

9 preparedness.

10 We think in terms of a measurement

11 development cycle that involves, first of all,

12 clarifying the purpose of the measurement, the

13 accountability, QI, or is it for research?

14 Identifying the concepts to be measured, and

15 then developing specific indicators, and then

16 assessing validity, reliability, practicality,

17 and utility.

18 I think if you go back to the

19 points that Helen made about the criteria,

20 that is all embedded, but represented in a

21 slightly different way.

22 And there is often a tension, in

1 particular, between accountability and quality
2 improvement, the kind of measure you want for
3 both. For one, maybe it is not the best for
4 the other, and I will come back to that point
5 in a moment.
6 So, let's think about the second
7 step, identify the concepts to be measured.
8 You have to begin by, first of all, thinking
9 about what do we mean by preparedness.
10 Anthony, this gets at your point about
11 preparedness versus response. And I am going
12 to say a bit about that as well.
13 We start with a consensus
14 statement developed by Chris Nelson and others
15 five years ago. The capability of public
16 health and healthcare systems, communities,
17 individuals to prevent, protect against,
18 respond. You can read all of that.
19 I think that implicit in that is
20 the goal that in a public health emergency we
21 can do things to mitigate the mortality,
22 morbidity, psychological, and social

1 consequences, but 100 percent prevention is
2 impossible.
3 But particularly when you are
4 talking about a contagious, infectious
5 disease, there are things that can be done to
6 really reduce the consequences across the
7 board with an effective response.
8 So, then, the question is, what
9 does it take to do that response? So, on the
10 next slide we talk about outcomes, capacities,
11 and capabilities.
12 Because emergency is rare, we
13 typically can't measure outcomes, which NQF
14 likes to do, but we can't do that in general,
15 particularly at the system level.
16 So, it is important to think
17 through the capacities and capabilities, and
18 this reflects the thinking that Dave mentioned
19 about moving from capacities to capabilities.
20 And I think, Anthony, this is what I think
21 gets to your point here, is that the
22 capacities are what I think of as what

1 preparedness people do now to get ready, so
2 that when the time comes, they have the
3 capability to respond as needed.
4 Most of the effort we do is in
5 preparedness, in getting those capabilities --
6 excuse me -- getting those capacities in
7 place, so that we will have the capabilities
8 to do what we need to do to respond when the
9 time comes.
10 That is a point that I think is
11 easy to say, and it is a lot harder to
12 operationalize because, when you actually see
13 what people do, what is the capacity, what is
14 the capability, there is sometimes not a lot
15 of consensus there.
16 You know, we see it in the
17 assessment world when we talk about what is
18 the structure and what is the process and what
19 is an outcome. And everyone knows exactly
20 where things fall, but that problem is a lot
21 more complex in this realm here.
22 So, what it takes, we think, is

1 building a logic model that really connects up
2 what we do now in terms of building capacity
3 to what we can do during an emergency, to have
4 the capability to respond, and how does that
5 meet the goals that we are trying to reach?
6 So, the common ground preparedness
7 framework that is in the background document
8 is one example of this. On the next slide, we
9 have a model that we have been using that
10 thinks about this.
11 There are different ways of
12 thinking about this, different ways of
13 categorizing this. But this idea that you
14 have to think about how these capacities lead
15 to capabilities and help you meet your
16 objectives I think is fundamental because we
17 are not going to be able to measure the
18 objectives or the outcomes. What we want to
19 do is make sure of the capabilities, and
20 oftentimes we are reduced to measuring the
21 capacities. So, I don't want to go into the
22 detail of this, but I think that that is the

1 fundamental point.

2 So, on the next slide, we review
3 in our paper some of the things that have been
4 done. In fact, if you look back over the last
5 decade or so, where people have been worried
6 about preparedness and response, a lot of what
7 has been done really falls into the capacity
8 world, inventories, capacity assessments, and
9 so on. I have got a list of all these things
10 that we have seen before that fall in there.

11 And in fact, if we just hit --
12 there we go. Most of the Joint Commission
13 standards that are referred to here are for
14 hospitals, but they actually fit into this
15 capacity assessment as well.

16 So, on the next slide, we talk
17 about some of the strengths and the
18 weaknesses. One of the strengths -- and this
19 was really an important one early on when no
20 one really knew what to do -- is that these
21 capacity assessments communicate standards and
22 expert guidance. They tell hospitals, they

1 tell health departments what the experts think
2 need to be done. If you have done that, well,
3 that is good.
4 But the problem is that the
5 evidence to support this guidance is often
6 lacking, and there may be other ways to
7 achieve the goals than the ones that the
8 funding agencies actually put forward.
9 In addition to that, many of these
10 capacity assessment in practice aren't clearly
11 operationalized or consistent in the kind of
12 way that NQF likes to see things done. They
13 are hard to summarize across place and time.
14 And a lot of the question about who is
15 responsible for what in these things is
16 unclear.
17 So, on the next slide, what I have
18 done here, this really draws on the work that
19 CDC has done, what Dave mentioned about the
20 CDC's public health emergency preparedness
21 capabilities. These 15 are the capabilities
22 that the public health world is coalescing

1 against as the critical things, the critical
2 capabilities that we need to have in place
3 here.
4 I have marked in red and with an
5 asterisk the ones that also are in the
6 Hospital Preparedness Program. So, there are
7 some conversions there as well, which is a
8 good thing. They really reflect the latest
9 collaborative thinking about what should be
10 done with preparedness on funding.
11 And another thing I think about
12 capabilities that is important is, if you say,
13 "Here is what we want the system to do," that
14 allows different localities, different
15 hospital systems, different health
16 departments, and so on, to figure out what is
17 the best way to do it in their location to
18 achieve that capability.
19 Part of the problem with the
20 capacity approach is it tells you should do it
21 this way. And I think that it makes sense.
22 I think that this is reflected in the kind of

1 things that Dave was saying as well. We need
2 to allow these different systems and
3 localities, and so on, to figure out what is
4 the best way to do things, given the resources
5 and the structures, and so on, that they have,
6 to achieve comparable capabilities across
7 jurisdictions. Again, that is an easy thing
8 to say and a lot harder to actually
9 operationalize, but we have been thinking
10 about that.
11 So, on the next slide, I have got
12 this is the way that these things are
13 structured, these capabilities. They have a
14 definition. They say what are the critical
15 elements and the functions, the performance
16 measures. As it turns out, so far, many of
17 them don't yet have performance measures.
18 And then, these response elements
19 -- if you just click one more time -- what
20 they really do, I think these are the things
21 that build the links between the capacities in
22 the left column of the logical model to the

1 capabilities. They say, what do we need to do
2 now that is going to get us to those
3 capabilities?
4 So, this document, which is a very
5 useful document, and the same thing for the
6 HPP document, is useful in communicating
7 consensus about what we think we need to do
8 now, so we have those capabilities.
9 The challenge in many of these
10 things -- and I think this is true for the HPP
11 -- is how do you actually measure those
12 performance measures. So, on the next slide
13 I have got some definitions here.
14 Two of these CDC capabilities deal
15 with the general area of biosurveillance, and
16 they have to do with -- Capability 12 is
17 public health lab testing and 13 is epi and
18 surveillance.
19 And what they really have to do
20 with, if you look at those things, is how long
21 does it take before people can get together?
22 Have you passed proficiency tests in your

1 labs? How many infectious disease outbreaks
2 have been reported? Have you done after-
3 action reports and learned from them?
4 Those are all useful things, but
5 in the last couple of years we have actually
6 been looking at the public health system
7 response locally up to globally, to H1N1, the
8 2009 H1N1 outbreak. It turns out that these
9 things really don't predict what was
10 necessary. What was really necessary during
11 that point, during that outbreak, was, could
12 you figure out that you have all these things
13 going on in different parts of Mexico and in
14 California and New York, all part of the same
15 phenomena? That is a critical capability, the
16 ability to really integrate this information
17 and think about it and understand what it
18 means.
19 I think that is fundamentally what
20 we mean when we talk about biosurveillance
21 capabilities. But a lot of these measures
22 that we have really represent capacities, and

1 how do we go from those capacities and
2 capabilities is a challenge that we are
3 struggling with in the public health work.
4 And I think it is also true in the health
5 system world as well.
6 So, I have just put up here the
7 preparedness capabilities for mass care and
8 medical surge, which I think are the ones in
9 public health that most directly relate to the
10 stuff we are talking about here today, just so
11 you see what is there.
12 I guess I have too many words
13 here. But one thing you see in both of those,
14 and underlined and in italics, is that there
15 are no performance measures available for
16 these at this time. That really is the state
17 of the world that we have to wrestle with.
18 So, one think that I would offer
19 as an alternative to think about going forward
20 is using exercises and actual events as a way
21 of measuring capabilities. We have had some
22 experience with this.

1 The first part of this deals with
2 the work that Paul Biddinger, in particular,
3 my colleague at Harvard -- I am sure you know
4 him, Jay -- has done to develop this exercise
5 program. They have now done about, I think,
6 30 or 40 different exercises where, rather
7 than using the exercises as a training
8 opportunity, we use it as an assessment
9 opportunity to measure how well different kind
10 of systems -- some of them were hospital
11 systems; some of them were public health
12 systems; some were combinations, and so on --
13 can respond to certain kinds of events.
14 We do that by asking not only the
15 participants to evaluate how well they did,
16 but having some trained external evaluators.
17 We have studied this carefully and developed
18 checklists and scores. So, we think that we
19 actually have some valid and reliable measures
20 that can be used in this setting, to get a
21 sense of how would the system respond during
22 a particular kind of emergency.

1 Coming back to what Dave was
2 saying about the measurement, about your
3 ability to expand acuity beds by 20 percent,
4 well, how would you actually measure that?
5 This is a possible way of measuring that,
6 where we can say, well, here is a particular
7 scenario; what actually would you do? I mean,
8 who actually would you move, bump to next
9 week, and so on? How would you share
10 resources across these different hospitals and
11 in other parts of the healthcare system within
12 a region? What actually would you do to see
13 whether or not you can meet that goal?
14 The other thing that we have
15 discovered along the way is that sometimes for
16 some purposes it is more useful to have
17 qualitative rather than quantitative measures,
18 and particularly because I think so little is
19 known about what works in this area. Some of
20 the qualitative analysis about what went
21 wrong, what could have been done differently,
22 what would have gotten a better result

1 actually is a more useful thing that comes out
2 for some of these quality improvement
3 purposes. Now, for accountability, you need
4 something like these quantitative measures, I
5 think, but some of these qualitative things
6 can work best for that.
7 And then, the other thing I want
8 to mention is something that we are just
9 working on now as part of our CDC Preparedness
10 Center grant, is the idea about learning from
11 actual events. We are trying to develop a
12 registry where health departments and public
13 health systems can do something like the kind
14 of root-cause analyses that are now relatively
15 common in the healthcare system and learn in
16 a deep way about what happened, what could be
17 done better, and to share that with others, so
18 that others who have similar circumstances can
19 learn from that, and so that researchers can
20 look across similar incidents and see what
21 patterns there are.
22 As part of that, we are trying to

1 develop a kind of peer assessment model where
2 we take some of the approaches that we do from
3 this exercise program and use them to look
4 back at critical events and have valid and
5 reliable measures that come out of that.
6 But I think that, again, this is a
7 potential model to look at for assessing how
8 well the system might respond to future
9 events, by seeing how well it responded to the
10 current events.
11 So, to wrap up, I would like to
12 say there is no assessment approach without
13 problems, but I think that everything has
14 something to contribute here in the PHEP work,
15 and I think in the emergency response world as
16 well.
17 What we think we need is a
18 portfolio of measures that are useful for both
19 accountability and for quality assurance, that
20 address both capacities and capabilities, and
21 that balance the detail-specific quantitative
22 measures with more holistic qualitative

1 measures, and balancing objectivity and
2 professional judgment, and perhaps varying as
3 the needs, what we are looking, changes.
4 We need measure systems. It is
5 not just going out there and sort of doing
6 this ad hoc. We need to sort of think about
7 a systematic approach to measurement and
8 developing measures. So, the fact that we are
9 having this meeting is a big part of exactly
10 what we are talking about.
11 Thank you.
12 CO-CHAIR PITTS: Thanks a lot.
13 We are making up the agenda a
14 little bit as we go. I know it is almost time
15 for a bathroom break.
16 So, let's have a couple of rounds
17 of comments. It is a complex subject.
18 Being a relative newcomer, it is
19 intriguing to me to see how people come from
20 their separate spheres and have different
21 approaches and looking at the same thing from
22 a different direction. We will eventually try

1 to reconcile all this stuff and put it in the
2 NQF framework.
3 For now, does anybody want to say
4 anything about the presentation, any comments
5 specifically?
6 Yes, go ahead.
7 MEMBER CARRIER: Well, this may
8 cross over a little bit into the NQF
9 framework. But just thinking about both of
10 the presentations, and wondering how they
11 would translate, if we were providing guidance
12 to measure developers, how they might
13 translate into quality measures in terms of
14 things like feasibility and what the data
15 sources that could be used to measure these
16 things.
17 So, thinking about the capability.
18 And I think we heard in the beginning about
19 the importance of outcomes measures, and you
20 were mentioning the challenges of measuring
21 outcomes and how we may have to go back to
22 capabilities.

1 But, even in terms of
2 capabilities, to take an example, let's say
3 you want to move 20 percent of your acuity
4 beds. Ultimately, you would like to know that
5 not only can I, as CEO of Hospital A move this
6 20 percent of patients, here's the ones I
7 would move, but that the receiving entities,
8 whether they be long-term care facilities,
9 other hospitals, even a patient's continuity
10 provider, who would need to follow, someone
11 who you might otherwise have kept in the
12 hospital, might be willing to accept them.
13 So, that is how in an ideal world
14 we might want to measure these. In the actual
15 world, in most cases our data is limited to
16 the hospital level. We don't have the kind of
17 unified data systems that would allow us to
18 really follow the hypothetical path a patient
19 would take and really know that path is clear.
20 So now, we would be stuck with at
21 the station, which to me is not very
22 satisfying. I wonder what the group thinks,

1 if that would be sufficient, or if people
2 think that it is worth trying to develop a
3 novel data collection system.
4 MEMBER STOTO: We would be stuck
5 with what?
6 MEMBER CARRIER: Attestation. You
7 know, I check a box "yes".
8 MEMBER STOTO: Thanks. "Yes," I
9 can do that, right. yes.
10 MEMBER CARRIER: I can move this
11 20 percent of patients.
12 MEMBER STOTO: Yes.
13 MEMBER CARRIER: Which is
14 sometimes easier to do than actually doing it.
15 (Laughter.)
16 MEMBER STOTO: Right.
17 MEMBER CARRIER: And then, we
18 talked about measuring at the coalition level,
19 which would require a whole novel data
20 collection effort, the development of
21 instruments, the validation of instruments.
22 I mean, which do people think is the path

1 forward, going with measuring at the
2 individual hospital level, hoping that some
3 integrated systems will have the capacity to
4 give us a clearer picture, or pushing for
5 novel data collection that can truly capture
6 regional efforts?
7 MEMBER STOTO: No, I think that is
8 a real important problem. I would say two
9 things. One is I think that these exercises
10 that actually are done quite a lot, because
11 they are required for Joint Commission
12 accreditation, and so on, are an opportunity
13 to not just use them for the basic purpose,
14 but actually use them as a measuring purpose.
15 But there needs to be an infrastructure built
16 around them.
17 And then, secondly, I think that
18 you actually can do more than attestation.
19 So, I will give two examples.
20 One is we used this approach early
21 on. I worked on RAND, and this was, I think,
22 2003. We did tabletop exercises in California

1 to see how they would respond to a smallpox
2 outbreak.
3 But what we did beforehand was we
4 went out there and we interviewed them,
5 understood what their resources were. So, if
6 they during a tabletop said, "We do" so-and-
7 so, we knew enough to say, "No, no, you don't
8 have that." And so, we can actually have some
9 judgment about this.
10 The other thing is that I was
11 involved in evaluating, Anthony knows, the DC
12 Healthcare Coalition, and some of the work in
13 Boston. A lot of that really involves doing
14 these exercises and asking the participants to
15 evaluate how well it worked.
16 But I think we can add on to that.
17 So, for instance, when you are doing a drill
18 that involves communications, they often say,
19 "Here's how many beds we have" and report that
20 in, for instance.
21 One thing that you can do is have
22 somebody receive it and see whether or not the

1 people who received that information
2 understood it the same way that the people
3 sending the information did. And I don't
4 think that that is always the case. I think
5 that just because you can say we have got this
6 many beds, it may be understood in a different
7 way. Sometimes they say this is how many beds
8 we need or it is confused with how many we
9 have available.
10 So, I think you can look at
11 fidelity in that way. But, again, that takes
12 an effort. It is more than just doing
13 exercises. It is really developing a
14 measurement infrastructure to go with them.
15 CO-CHAIR PITTS: All right. Wes?
16 MEMBER FIELDS: Yes, I want to
17 sort of extend Ellen's analogy here. One way
18 to get to 20 percent is showing how 10
19 hospitals can pick up 2 percent. I think that
20 is truly valuable. In this context, in terms
21 of measurement, if we could connect everyday
22 problems, or not everyday problems with

1 crowding, but somewhat more dramatic problems
2 with crowding on a particular day, especially
3 if it is related to, say, things that are
4 predictable like flu season and that, I would
5 far prefer to measure how real hospitals
6 respond to real surges in demand as a preview
7 of their ability to respond in a
8 logarithmically-larger event. I would much
9 rather use the present-day response of
10 hospitals within a community or a metro area
11 than to measure what happens on a benchtop
12 exercise.
13 I acknowledge there are probably a
14 lot of things that are unique to your work
15 that probably have to be done on a tabletop.
16 But I think if we are really trying to connect
17 the dots between crowding and the real-world
18 capacity of hospitals and emergency
19 departments and EMS agencies, it would be
20 useful for our measures to look at what
21 happens when you get a 10-to-20-percent pop in
22 demand at a particular department or within a

1 particular healthcare system.
2 MEMBER STOTO: No, I agree, and I
3 probably was misleading when I talked about
4 those real events by referring to H1N1. In
5 fact, there are things that happen all the
6 time that stress emergency response systems,
7 and so on. And we should learn from them.
8 The problem is that they don't
9 stress quite the same way, the big ones we are
10 really worried about. So, I think it has got
11 to be a combination of evaluating these kind
12 of day-to-day big events and doing some of
13 these exercises.
14 CO-CHAIR STONE-GRIFFITH: I know
15 that I would like to sort of speak from a
16 recent event that has been in the news and
17 been talked about a lot, the Aurora incident.
18 One of those was our hospital; the other one
19 was the University. We have heard the
20 statistics.
21 During ACEP, right before the Dark
22 Knight presentation, ENA was there, and we

1 happened to do a debrief at Aurora and
2 included the folks at the Children's Hospital
3 and the University, which many of you heard in
4 a different light. We also had their disaster
5 preparedness folks and security folks and plan
6 ops folks there.
7 It was fascinating what came out
8 of that discussion. Our hospital, half of the
9 hospital was under construction and closed,
10 the ED, and so, all of our trauma rooms and
11 all of our code rooms. So, we had to deal
12 with that. We received 18 folks.
13 The University, what we did not
14 know, which was very interesting, or wasn't
15 really illuminated at the time, was that they
16 were only divert. They had 25 inpatients
17 holding at the time. They received 23
18 patients.
19 Now, when we said, "Well, gee,
20 what happened to those inpatients that were
21 boarding," within 45 minutes all of those
22 patients were out of the ED and they had been

1 effectively moved and absorbed and taken care
2 of.
3 My question was, "How did your
4 leadership respond after this incident to the
5 day-to-day diversion and holding that you all
6 are doing?" And their answer to me was
7 stunning. It was, well, they have really put
8 on fast track the new building tower and the
9 expansion of the ED.
10 (Laughter.)
11 And I thought to myself, we have
12 just completely missed the boat. Because that
13 incident was over in four hours. People ask
14 me all the time, "Gee, what did you do?" I
15 said, "I didn't even know about it. It was
16 the middle of the night. I was asleep." By
17 the time 4:30 came, I mean, both hospitals
18 will tell you it was over. People who came on
19 for day shift didn't even feel that. It was
20 business as usual.
21 So, I am struggling with this
22 issue of it is not just about a big disaster.

1 It is about the little day-to-day disasters on
2 top of this surge. I think we have to look at
3 it across the system. We are competitors. We
4 are an exit away from each other. We did not
5 have good communication between each other.
6 And I have heard a lot about EMS,
7 but you all know that EMS did not bring those
8 patients. They came in the back of swat cars
9 and police cars.
10 So, I think we need to think about
11 it in the context of those kinds of situations
12 because I think they are so much more common.
13 We could learn a lot about that. We have had
14 brief after brief after debrief and community
15 responses, but are we really getting to what
16 happens when that happens next?
17 It will be a different incident.
18 We won't know what it will be. But are we
19 going to respond any different? Are we going
20 to be in any different circumstance?
21 MEMBER STOTO: Well, you know that
22 is an issue in the public health world as

1 well. One of the things that we have
2 suggested is that one measure could be, did
3 you learn from this incident? Did you
4 actually do a deep analysis that got beyond --
5 what? Did you make changes based on that
6 learning?
7 That is a capacity measure.
8 Excuse me. That is a capability measure.
9 That really is a structure measure. But I
10 think, given the state of the field, that is
11 important, that we learn from these things.
12 That is something we should consider as a
13 performance measure.
14 CO-CHAIR PITTS: Just to pile on,
15 when we had the Olympic Park bombing in
16 Atlanta way back when, it was very similar.
17 By the time morning shifts got there, the 20-
18 odd people that had rolled in were gone. It
19 was pretty amazing.
20 Jesse wanted to say a couple of
21 things before we take our next break.
22 MR. PINES: Great. Thanks.

1 I just wanted to thank everyone.
2 I know, sort of looking around the room, and
3 what has happened in this first hour and a
4 half here, and I can see a lot of people
5 squirming. This is really the goal of this,
6 really to bring these two worlds who speak
7 completely different languages together and
8 really get onto the same page.
9 You know, I think we have made a
10 lot of progress, sort of thinking about
11 linking daily crowding to disaster surge. I
12 do want to continue that discussion and, also,
13 hone in on something that Emily said just a
14 few minutes ago, that really our goal here is
15 to guide measure developers and to have
16 practical recommendations for people who want
17 to do measure development in this area. What
18 do they actually need to get some of these
19 preparedness measures through the NQF process?
20 And finally, I wanted to make a
21 clarification on Mike Stoto's presentation
22 and, also, to clarify a question that Anthony

1 had about the level of measurement
2 specifically for this report. Our goal is
3 really to look at the health system and
4 potentially healthcare coalition level, as
5 essentially there is a whole world of public
6 health emergency preparedness that really sort
7 of is outside of our scope, you know, managing
8 casualties, managing bodies and things that
9 really fall under the bailiwick of a local
10 public health or under true public health.
11 Really, our focus today, what sort
12 of data do we need in order to get some of
13 these healthcare system measures potentially
14 which would go up to the healthcare coalition
15 level or hospital-level measures through the
16 NQF process?
17 I do want to make sure that we are
18 able to take a break. But, essentially, one
19 of the things that I wanted you to think about
20 is, after the break, I want to see if we can
21 take some of these preparedness measures for
22 a little test drive, and maybe we can think a

1 little bit about the IBA measure and
2 essentially what it would take to get the IBA
3 measure through the NQF criteria.
4 Thank you.
5 CO-CHAIR PITTS: Fifteen minutes.
6 (Whereupon, the foregoing matter
7 went off the record at 10:30 a.m. and went
8 back on the record at 10:54 a.m.)
9 CO-CHAIR STONE-GRIFFITH: Hi, all.
10 We would like to get started again and move on
11 to reconciling daily surge and disaster surge.
12 So, if folks could take their seats? Thanks.
13 CO-CHAIR PITTS: All right. We
14 shall continue here. We have a couple of
15 nominations for topics to discuss.
16 The first topic, it has already
17 been discussed a bit. A couple of people
18 thought about this, and I think it is an
19 important issue because daily surge is meant
20 to be different from disaster surge. The
21 question is, does good performance with daily
22 surge translate into good performance with

1 disaster surge? I think, obviously, most of
2 it is speculation because we don't have enough
3 disasters to have a sample size.
4 But Melissa McCarthy sort of has
5 some opinions about that, I think, and has
6 written a paper about it.
7 (Laughter.)
8 So, I will let her start the
9 discussion.
10 MEMBER McCARTHY: I think they are
11 not completely different animals, but they are
12 really quite different. I think it a little
13 bit goes back to Sally's comment about just
14 very different mindsets. You might be able to
15 handle daily surge quite well, but not handle
16 a SARS patient that comes in. I mean, we have
17 talked about trauma. That is really kind of
18 doing what we already do, you know, just
19 adding a few more trauma patients. But the
20 kind of threats that we are likely to face,
21 you know, we could face, and these different
22 kinds of disasters, I don't know that

1 hospitals that do a good job with daily would
2 do a good job at all with those kinds of
3 disasters.
4 I think Sally's point that you
5 want in a disaster, the personnel to respond
6 in a completely different manner. It kind of
7 goes back, I think, to Wes' point about now we
8 are thinking about the population as a whole,
9 where in daily surge we are talking about
10 fighting for each individual patient, right?
11 So, I don't think they do actually have a lot
12 in common. So, I am a little uncomfortable
13 this morning about this. That is my own bias.
14 CO-CHAIR PITTS: Feel free to
15 think some of questions here.
16 As a professed ignoramus on the
17 topic, does anybody know of any studies in
18 which that has been looked at in peered data?
19 I mean, it would be hard to imagine the
20 scenario where you might have done that, but
21 no?
22 MEMBER McCARTHY: Actually, one

1 other comment about it. I was actually
2 thinking about, from Harvard, there is a
3 business person, a famous MBA, who talks about
4 kind of different corporations and sustaining,
5 how they sustain their operations versus they
6 face kind of emerging and novel situations.
7 The way he has described this is
8 the best way to do this is to have like a
9 separate group that handles these emerging and
10 novel situations because what you need to
11 sustain, and the way you need to think about
12 sustaining and handling daily operations, is
13 very, very different than the kind of
14 creativity and mindset that you need in these.
15 And it is totally different area, but I think
16 it applies here.
17 Frank, do you have any thoughts on
18 this, too? I know you are sick, but --
19 MEMBER ASPLIN: I pretty much need
20 to go home. I apologize.
21 (Laughter.)
22 And will be as soon as I think I

1 can make the plane.

2 I think there is overlap in the

3 Venn diagram. What I am struggling with a

4 little bit is, even if operationally they

5 would be very different, would some of the

6 measurement framework still apply in kind of

7 a cascading fashion, like Ellen alluded to

8 earlier?

9 I think that I agree that the

10 operational approach is going to be different.

11 There might be components of a measurement

12 framework, though, that could scale up and

13 still apply, depending on how it is

14 constructed.

15 CO-CHAIR PITTS: Everybody here

16 knows about black swans? I mean, it is kind

17 of the way these things happen, nobody ever

18 thought of this happening before. It is tough

19 to prepare for something you have never even

20 thought of happening.

21 Mike?

22 MEMBER STOTO: Well, I think that

1 the possible answer is to think, what are the
2 common response capabilities in both the day-
3 to-day and the emergency setting?
4 So, in the public health world, we
5 need to, whether it is a routine food-borne
6 disease outbreak or a smallpox outbreak, we
7 need to be able to have people identify cases,
8 report them to the health department, track
9 the numbers, and so on. Those are kind of
10 core capabilities that are tested on these
11 routine events and in these bigger events.
12 I don't know enough about
13 emergency medicine to know what they are, but
14 I suspect there are some core things that are
15 tested in these routine events that also would
16 be critical in the more extreme ones. That
17 may be a way to structure making the bridge
18 between the two.
19 CO-CHAIR PITTS: Melissa, I know
20 you have done, you and your collaborators have
21 done a lot of work looking at individual
22 institutions and their day-to-day variation.

1 I wonder if it is possible to look at
2 performance during those peak days? Has
3 somebody done that kind of stuff? You know,
4 there must be days when the school bus arrived
5 or when there was some event of that sort that
6 led to a huge surplus of patients. I wonder
7 if that has been studied as to how do we
8 perform in those days compared to other days.
9 MEMBER McCARTHY: Yes, we have
10 looked at when acuity increases, but they are
11 so rarely really, you know. You figure you
12 have 60,000 visits in ED, and the one day that
13 you might have a couple of extra school buses
14 arrive, you know, we just don't -- I tried
15 very hard when we were looking at crowding on
16 length of stay and stuff to see whether like
17 an uptake in acuity would matter and just
18 could not show it at all.
19 I know, Brendan, you have done a
20 little work, right, in this area around like
21 trauma and its effect, if you do have a couple
22 of additional trauma patients, how it is

1 affecting emergency care, right? But I
2 haven't seen it.
3 MEMBER CARR: You know, it strikes
4 me that we are, it feels to me like we are
5 talking about the distinction between capacity
6 and operations, though. I don't know if that
7 is right or not. But, in my mind, the day-to-
8 day is different because it is operationally
9 different, but maybe what Brent was suggesting
10 is that we can find a common ground that says
11 2 percent is still 2 percent; 20 percent is
12 still 20 percent. Whether you do it right,
13 once you can make room is an operational
14 issue, not a capacity issue.
15 I mean, do the boarding folks
16 think about it in those two separate silos?
17 CO-CHAIR PITTS: Anybody here
18 boarding folks?
19 MEMBER CARR: Yes, I am looking at
20 them, and they are all looking at me.
21 MEMBER WEBER: I will jump in. We
22 have, and I think that has been one of the

1 problems I was just seeing. You know, when I
2 think about disaster preparedness, it is like
3 somebody else; it is not me. I don't
4 participate in the disaster drills because I
5 see myself as the person that is going to be
6 in the emergency department taking care of the
7 people that eventually somebody sorts out and
8 says need to be in the emergency department.
9 But, yet, when I think about it,
10 there is a lot of parallels. I mean, what you
11 were describing earlier about some people are
12 going to have to get sent home and not get
13 their stress test today. We do that every
14 day. We triage every -- we don't send people
15 home, but we make people wait a long time
16 because their problems are not as, using our
17 clinical judgment and our ESI scale, we have
18 decided that this person has lower likelihood
19 of a bad outcome if they wait than another
20 person waits.
21 So, the concept of triage and
22 prioritizing patients, and figuring out who

1 needs to move, and making capacity, you know,
2 is exactly the same, it seems to me. I don't
3 know if it would actually improve your
4 preparedness, but I would think that sort of
5 couching that, couching the two together would
6 increase the interest in preparedness and
7 possibly have some bearing on improving the
8 boarding issue. It just seems to me that they
9 are both kind of -- one is kind of sexy, but
10 a lot of us aren't involved in it, and the
11 other group is like, oh, that is day-to-day
12 operations. But we need to get more people
13 involved in that.
14 CO-CHAIR PITTS: So, I had a great
15 experience for six months working as an ER doc
16 in New Zealand. Just to illustrate this
17 plasticity of one's thinking, when I got off
18 the plane in New Zealand, I discharged all my
19 chest pain patients, regardless. When I got
20 off the plane in the U.S., I admitted all of
21 them to the obs unit.
22 (Laughter.)

1 So, what you do in a disaster, you
2 just change your moral compass, basically, and
3 you do things differently because it is a
4 disaster. I think every individual working
5 doc would do that, regardless of what you told
6 them to do, once people started to pile up.
7 MR. PINES: Just to extend a
8 little bit on what Melissa said, I think one
9 way to think about this is in terms of
10 flexibility. So, essentially, I think that
11 the way to bring this together from the
12 crowding side and the preparedness side,
13 essentially, what both are asking for is a
14 health systems flexibility to maintain the
15 same quality of care, not actually changing
16 those standards of care on days when you have,
17 like Brendan said, 20 percent more versus 2
18 percent.
19 So, essentially, when you have
20 this really abnormal day, can you maintain the
21 same level of service in the hospital? I
22 mean, I think that sort of brings it together.

1 What we know, I think,
2 empirically, and I think most of you in a lot
3 of your work you have shown this, there are
4 days when there are more people in the
5 emergency department. As there are more
6 people there, the length of stay for everyone
7 goes up. Essentially, that is an example of
8 a system that is not flexible; that,
9 essentially, on those busy days we
10 consistently can't flex-up our services to
11 basically maintain the same level of service,
12 which would be length of stay in the emergency
13 department or quality of care.
14 I mean, I think that is a lot of
15 what we have shown, is that during those
16 really busy days, that quality of care
17 suffers. Essentially, extending that to
18 disasters, what we are trying to do is on one
19 of those ultra-busy days, when a disaster
20 happens where we actually need external
21 resources to really help us, can we maintain
22 the same level of service.

1 I think, conceptually, that is
2 what we are trying to do, is really link these
3 concepts together. How do we maintain the
4 same quality during a surge of patients? I
5 mean, basically, it works on a micro-level
6 where you may have the bus crash, and also at
7 a macro-level when the Aurora happens.
8 MEMBER FIELDS: To your point, I
9 think you are probably right to be
10 uncomfortable about the way parts of the
11 hospital system would break down that are used
12 to being very efficient. I am thinking about
13 scheduled surgeries, acute rehab. Anything
14 that is predictable and probably happens
15 during business hours in the hospital, I think
16 that part of healthcare breaks down very
17 rapidly in these extraordinary black swan
18 situations. And probably a lot of those
19 resources and those providers become
20 irrelevant.
21 But I think, at the risk of being
22 political about this, emergency nurses and

1 emergency physicians and the people that back
2 them up, and acute hospitals participating in
3 Medicare, have basically been working with a
4 profound capacity problem, a profound mismatch
5 of resources and services since at least 1986,
6 if not a lot longer.
7 So, one of the parts of the Venn
8 diagram where you will have overlap is I have
9 absolute confidence, just thinking about who
10 is around the table, that when you have an
11 extraordinary event, the people who will most
12 predictably be there to help with the response
13 at the grassroots level will be emergency
14 nurses, emergency physicians, pre-hospital
15 personnel, the rest of public safety, and a
16 coalition of the willing from medical staffs
17 in the community, using whatever they can
18 bring to bear in terms of resources.
19 I think the part that is probably
20 political about this is I think that, since it
21 is pretty well-established that crowding is
22 sort of a weird metric that demonstrates the

1 lack of equity and smoothness about the way
2 services get provided in the acute care
3 sector, I think if you acknowledge that and
4 you can see how delays in treatment result in
5 bad outcomes, and that is also a metaphor for
6 lack of access to coverage, I think what we
7 are asking for is to recognize that there is
8 a kind of calculus here, and that if you are
9 willing to look at some of these kind of
10 ordinary, everyday disasters in both rural and
11 metropolitan areas, that the summation of
12 those represents what the society has to do to
13 respond to a black swan event.
14 One of the things that is
15 universal about that is that the people around
16 the table and the people in the emergency
17 department will be the interface between the
18 event and the response, along with pre-
19 hospital personnel. And I feel really good
20 about that. But I would feel better if we
21 could use the high priority society has given
22 to disaster response for extraordinary events

1 to help solve everyday problems in hospitals
2 operating in marketplaces with mandates to do
3 better for their own populations of the
4 communities.
5 CO-CHAIR PITTS: Yes, Mike?
6 MEMBER STOTO: I don't like the
7 black swan analogy.
8 (Laughter.)
9 I think that the author mixes up
10 black swans and black squirrels.
11 (Laughter.)
12 Black swans are totally different
13 from everything that has happened before.
14 Black squirrels are just a little bit grayer
15 or maybe a lot grayer than normal squirrels.
16 I think that a lot of the kind of
17 emergencies that we are concerned about are
18 more like black squirrels. They are just a
19 big version of some of the things that we see.
20 If we think about it that way,
21 then we really can build on the day-to-day
22 lessons. If we think about it and there is a

1 black swan that is just totally different from
2 anything we have ever seen, there really is no
3 way to learn from that. I think that the only
4 hope we have is thinking about these things as
5 black squirrels.
6 CO-CHAIR PITTS: So, squirrels are
7 smaller than swans. Is that the difference?
8 MEMBER STOTO: No, no, squirrels
9 are gray, but black is an extreme form of
10 gray.
11 (Laughter.)
12 CO-CHAIR PITTS: Would you
13 consider Aurora a squirrel or a swan?
14 MEMBER STOTO: A squirrel, yes. I
15 mean, unfortunately, people are shot all the
16 time. It is just that a lot of people were
17 shot.
18 CO-CHAIR PITTS: What are some of
19 the scenarios -- I know there are a number of
20 scenarios that you are interested in -- that
21 are not squirrels, that are big things? You
22 are talking about influenza?

1 MEMBER McCARTHY: SARS.

2 CO-CHAIR PITTS: SARS?

3 MEMBER McCARTHY: SARS is a
4 perfect example of we had a lot of resources,
5 but we couldn't contain. They could not train
6 personnel to contain an infection. They
7 actually had to set up one hospital to treat
8 all SARS patients because they couldn't have
9 all hospitals treating SARS patients because
10 they kept getting infected.

11 So, we learned from that, that
12 even though we had resources, we didn't have
13 the processes in place to handle that kind of
14 thing that we weren't used to doing. So, that
15 is what I worry about a little bit here.

16 Trauma is our easiest-case
17 scenario, but what happens if it was
18 infectious or it was some kind of chemical
19 hazard or radiation?

20 CO-CHAIR PITTS: Something that
21 can hurt the providers themselves.

22 MEMBER McCARTHY: Hurt the

1 providers themselves. We don't deal with
2 those situations.
3 MEMBER STOTO: That is not unheard
4 of or unusual. To deal with SARS, they did
5 surveillance. They did infection control
6 procedures. They did it at an extreme level,
7 by setting up extra hospitals. But the
8 fundamentals they did were the same kinds of
9 fundamentals we deal with in any kind of
10 infectious disease.
11 MEMBER MacINTYRE: But these
12 fundamentals changed the way in which the
13 healthcare organizations operated completely.
14 MEMBER STOTO: Yes.
15 MEMBER MacINTYRE: They changed
16 the ways in which these healthcare
17 organizations operated completely versus a bus
18 accident or the Aurora shooting; you heard it
19 was over in four hours. So, it is a much
20 different animal.
21 MEMBER McCARTHY: But it took
22 months for us to get SARS. We were lucky that

1 it wasn't highly infectious. Had it been --
2 MEMBER CARRIER: Maybe it would be
3 helpful, because disasters can present in such
4 diverse ways, maybe it would be helpful to
5 think sort of generically. Like if you
6 imagined a plot where you are X-axis was the
7 level of surge and your Y-axis was, let's call
8 it not just acuity, but maybe level of threat
9 to take into account. You know people are
10 shot. It is obviously tragic, but it is over,
11 versus something that could spiral and spread.
12 There are definitely disasters
13 that are high on both axes. In that case,
14 maybe, yes, all bets are off. You really want
15 to think -- you know, you may need to abandon
16 processes you thought would be useful. Maybe
17 the only benefit that the kind of coalition-
18 building we are talking about would have in
19 these situations is to build strong
20 relationships, creating a framework where
21 people could think creatively.
22 But there is a lot of stuff done

1 on this end of the axis, high surge, low
2 acuity. You know, I trained in New York City.
3 Anthrax in New York City was three incredibly-
4 sick people and a million people wanting
5 Cipro. I mean, to me, the overlap there
6 between disaster and surge is very strong, and
7 I could definitely see a validity to combining
8 measures or thinking about measures in the
9 same framework.
10 But maybe in other areas of this
11 plot maybe trying to measure preparedness
12 through the lens of surge is not such an
13 effective approach. Or maybe we need to think
14 about different ways, measuring the strengths
15 of the relationships generally, rather than
16 the creation of particular structures or
17 processes that may be less relevant, given how
18 weird things can actually get.
19 CO-CHAIR PITTS: I think that is
20 really a cool observation. I wonder, it is so
21 cool, that I wonder if it hasn't already been
22 thought of. Has somebody --

1 MEMBER CARRIER: It is very
2 possible.
3 (Laughter.)
4 CO-CHAIR PITTS: Has somebody not
5 got a classification of disaster that looks at
6 multiple dimensions? No? Yes? Okay.
7 Brendan?
8 MEMBER CARR: So, I don't know if
9 this will help or hurt. But I continue to be
10 intrigued about whether or not it is
11 crowding/boarding that we think doesn't fit
12 into some sort of larger, summed-up to the
13 level of we still sort of don't know geography
14 coalition or if it is everything about
15 measurement of emergency care outcomes that we
16 think doesn't fit.
17 So, I guess I would say, to move
18 this into a totally different space -- and I
19 get that we are not talking about this today
20 -- but to maybe take us outside of where we
21 are to say, do we instantly say that doesn't
22 apply, either?

1 What if I looked at -- I am from
2 Philadelphia -- what if I look at the City of
3 Philadelphia. Right now, I care about my
4 outcomes at the level of the hospital. If I
5 were to now say, well, you know, I travel all
6 over Philadelphia. Sometimes I am up north;
7 sometimes I am in the center of the City;
8 sometimes I am in the west, and sometimes I am
9 just on the outskirts, you know, in the sort
10 of southeast.
11 I would like to believe that there
12 is some coordination across that region, so
13 that if I have unplanned critical illness, my
14 outcomes are similar. I would like to think
15 that the hospitals work together to make sure
16 that, if I show up at a hospital that can't
17 take care of me, that they have thought of a
18 plan to transfer me or that they have thought
19 of a plan to bring resources to me in some
20 capacity, so that I do okay.
21 So, I guess what I am saying is,
22 are we totally uncomfortable with the idea

1 that we should be measuring outcomes at the
2 population level? Or are we saying, okay,
3 that might be okay; it is okay to measure
4 things at a population level, to make
5 hospitals in a region mutually-accountable for
6 my outcome, but boarding is different?
7 Maybe that complicated things, in
8 which case we could just go on and pretend I
9 didn't speak.
10 (Laughter.)
11 But, to me, it feels like we are
12 sort of saying we understand that it is a
13 competitive market. We also think that there
14 are times where you need to cooperate. And
15 hanging up a billboard that says, "Best cancer
16 care anywhere at our place. Come to our
17 place" is different than unplanned disease.
18 CO-CHAIR PITTS: I heard you and I
19 understand you, I think, but I am not sure
20 what the answer is.
21 David?
22 MEMBER MARCOZZI: Yes, I mean, I

1 just want to echo, in the interest of
2 transparency, Brendan and I have had this
3 discussion before. I mean, the concept that
4 he just promoted in and around trying to
5 figure out a regionalized system and trying to
6 get to the measure for unplanned acute
7 illness, so that the measure affects that
8 community, that health community, and that
9 they can respond appropriately, deliver the
10 right care at the right time to the right
11 patient, that I think is one of the pivotal
12 pieces.
13 Because, I will be honest with
14 you, we stand on, what preparedness stands on
15 is the ability to deliver -- you know, STEMI
16 care is now, we know where we are going to
17 transport, the closest cath place. So, we
18 stand on, the preparedness folks stand on that
19 ability, that system of care of delivery
20 today. If we get that piece right that
21 Brendan just spoke to, our job gets a lot
22 easier.

1 Because you don't all of a sudden
2 pull the plan off the shelf, turn to page 4
3 and go, okay, now that we are in disaster
4 mode, these are the things that I need to do.
5 You would stand on what you do today right now
6 when we are responding to a disaster, likely.
7 I mean, granted, there are shades of gray or
8 squirrels of gray or black. But, to get that
9 right, that is the foundation of what
10 preparedness stands on.
11 CO-CHAIR PITTS: Am I missing
12 somebody? Yes, Anthony?
13 CO-CHAIR STONE-GRIFFITH: I think
14 there is a temptation to look at this as sort
15 of two ends of a spectrum, daily crowding
16 surge versus disaster surge. I am falling
17 into the camp of they are very much different
18 beasts.
19 The assumptions, the motivators,
20 the willingness to bend the rules, if you
21 will, are completely different during a
22 disaster, however you are going to define

1 that, than day-to-day surge. The motivators
2 during day-to-day surge are, quite frankly,
3 very often economic. I am sure Jesse can
4 speak to that more elegantly than any of us
5 can, and we will hear about this this
6 afternoon.
7 But when you had your Aurora
8 incident, you bent the rules. And suddenly,
9 it was magically okay to have patients in the
10 hallway on the floor as opposed to in the
11 hallway in the ED.
12 I think when we look at those
13 assumptions and motivators and willingness to
14 comply with regulations, it is going to be
15 very hard to have measures that equally
16 reflect preparedness versus daily surge.
17 The other piece that is
18 interesting to me -- and it gets to your gray
19 squirrel concept -- is if we are responding to
20 these smaller disasters adequately, we should
21 have that different management team that
22 somebody was talking about. It would be awful

1 for me in my hospital if I had a mild power
2 outage, which we did have two years ago, and
3 I tried to manage that through our usual
4 committee method, where we are all going to
5 get together and sort of causally discuss
6 things, and we will have an answer in a week's
7 time. That doesn't work. You have to have
8 different methods of managing those types of
9 incidents.
10 And so, for me, the real
11 interesting, almost academic, somewhat
12 operational question is, at what point does
13 daily surge become a disaster? And there are
14 some interesting stories out there of people,
15 not a big bus rollover, not a plane crash, but
16 just a high-volume; they activate their EOP.
17 They have a different management team in
18 place, and they start to bend the rules and
19 they start to put people in hallways upstairs.
20 I think that, for me, is an interesting point
21 worthy of further investigation.
22 CO-CHAIR PITTS: Terry?

1 MEMBER ADIRIM: Yes, great. Thank
2 you.
3 I actually agree with my
4 colleagues, Anthony and Emily, about the whole
5 gray squirrel. I don't even know what those
6 mean, but that these may be separate issues
7 and it may be useful to think of them
8 differently.
9 But, to get back to a little bit
10 of what Brendan was saying, because, actually
11 you brought up a couple of interesting points
12 when thinking about how we measure whatever it
13 is that we want to measure, I am just
14 wondering the two things that I got out of
15 what you were saying perhaps is maybe we need
16 to look at some of the previous work done in
17 coordination of care, seeing if there are any
18 measures that may be applicable or can be
19 adapted for this particular use.
20 And then, the other concept, too,
21 is determining quality across a region. You
22 know, I would imagine that you would want the

1 same quality of care across the region, which
2 is what I thought I heard you saying.
3 I am wondering if we are going
4 about this the wrong way. It may be better to
5 think of it as, what are we trying to
6 accomplish? What is the outcome? What is the
7 goal that you are trying to accomplish, and
8 kind of work backwards. I don't know if that
9 makes any sense, but that is sort of how I
10 would approach it.
11 CO-CHAIR PITTS: Are you talking
12 about looking at disaster responses that
13 failed?
14 MEMBER ADIRIM: Well, no. I mean,
15 well, there are two separate issues here. I
16 am talking more about the crowding and the
17 type of care that you are expecting within
18 region, either during a disaster or with high
19 numbers of patients or just every day. What
20 is it that you are trying to accomplish? What
21 are the outcomes? These would go to
22 population kind of measures. So, kind of

1 applying the same standard, for lack of a
2 better word, across healthcare institutions
3 and kind of looking at it from what are you
4 trying to accomplish, you know, coming to
5 outcomes, as opposed to looking just
6 distinctly at the processes to some outcome
7 that you haven't defined yet.
8 Does that make sense?
9 MEMBER MacINTYRE: At least it
10 does to me.
11 MEMBER ADIRIM: Yes.
12 MEMBER MacINTYRE: And I would
13 piggyback on that and say, what are you
14 anticipating to respond to? Again, I think
15 much of the conversation trends towards surge.
16 Our facility where Jesse and I
17 work is much more likely to experience a power
18 outage, for those of you from Montgomery
19 County and the surrounding area, than it is to
20 have a surge. I am sorry, Jesse, but you are
21 not going to be able to order that CAT scan
22 when we don't have power because our CAT scan

1 is not hooked up to backup power.

2 So, I think we need to broaden

3 this conversation because there are things

4 that are much more likely than the bus

5 rollover and they are just as, if not more,

6 important to address.

7 CO-CHAIR PITTS: Brendan?

8 MEMBER CARR: I am tempted to sort

9 of respond to that because I do think that we

10 have to work within the confines of what we

11 been asked and funded to do, which is to think

12 about whether or not there is intersection in

13 this space. There are lots of important

14 things to address. I am not sure that we can

15 change the mandate of what NQF has been asked

16 to do here.

17 But I guess the other piece, to

18 talk to Terry, that I wanted to say, was I

19 think that we all agree that we want quality

20 for the region, quality for the U.S. to

21 improve. The way that we have gone about that

22 is by looking at the thing that was easiest to

1 look at, to some things at the level of the
2 hospital. That is where the data comes from.
3 It is where the accountability is. It is
4 where you can set some sort of financial
5 incentive or financial penalty.
6 But we believe that the rising
7 tide will rise all ships. So, we are trying
8 to incentivize regional health, national
9 health, community health, by incentivizing
10 hospital-based performance.
11 It is unclear to me why it feels
12 so Herculean, not from an operations
13 standpoint. I agree, as Dave said, telling
14 you how to boil the egg is not the game plan
15 here. The game plan is to sort of say, at the
16 end of the day we would like you to please
17 produce a boiled egg.
18 So, operationally, day-to-day
19 disaster, day-to-day crowding is very
20 different than I am now going to bend the
21 rules. Crisis standards of care exist for a
22 reason.

1 I am still stuck on why it feels
2 so different to say, "I want all the hospitals
3 in my city to have good performance metrics on
4 X" versus "I want my whole city to have good
5 performance on X."
6 CO-CHAIR PITTS: Jay?
7 MEMBER SCHUUR: I guess I am going
8 to comment on Terry's comment, which I really
9 agree with. I think we are going to talk
10 about a number of these issues.
11 I think it is very interesting to
12 think about outcomes for regionalization
13 because I think we will probably find things
14 that are very different if we look at outcomes
15 than if we look at processes.
16 And so, just thinking about my own
17 health system in the region where I practice,
18 I think there are a lot of things we are doing
19 because of market forces, because of hospital
20 integration, which are quite costly and add
21 very little value, and if looked at at a
22 regional level, at an outcome level, would

1 sort of change the perspective. And I am
2 thinking about transferring patients, even the
3 way we transfer patients for STEMI,
4 transferring certain patients and things like
5 that.
6 So, I think if it is within the
7 scope of our charge, thinking about measures
8 for regionalization, about population health,
9 but particularly thinking about value and
10 making sure that we are measuring outcomes as
11 opposed to processes, because if there are
12 process measures, that is what a lot of these
13 systems are doing right now, is responding to
14 the process measures that hospitals have and
15 doing things that may shorten the door-to-
16 balloon time, for example, by using
17 helicopters, send a patient a few miles to get
18 to a cath lab, where from a regional
19 perspective for the outcomes for that patient,
20 there are different processes that would be
21 set up and probably have the same outcomes at
22 lower cost.

1 CO-CHAIR PITTS: So, you are
2 saying that from the standpoint of
3 performance, I mean preparedness, the
4 performance measures ought to look at
5 integration issues and not individual hospital
6 issues?
7 MEMBER SCHUUR: This is very much
8 about Brendan's frame of sort of regionalized
9 health. Those sorts of measures, I would
10 emphasize measuring outcomes and thinking
11 about value.
12 I fall into the camp that I think
13 the preparedness issues and the measures for
14 preparedness are going to be different than
15 those for regionalized care. I think for lots
16 of us who practice in the emergency department
17 that comes from personal experience.
18 I was working the night of the
19 Station nightclub fire in Rhode Island. If
20 you had gone to the hospital the day before,
21 even earlier that day, it would be very low on
22 the level of operational efficiency, surge

1 capacity, all of those things, and the
2 outcomes were remarkable. Of the 50 or 60
3 patients who showed up critically ill, one
4 patient died, essentially, who wasn't dead
5 when they arrived.
6 And that had to do with the people
7 who happened to be working that night, in
8 particular, the emergency department attending
9 and the trauma surgeon who sort of organized
10 everything, and there was a lot of luck
11 involved. But I think the measures to capture
12 that are going to be different than the
13 operational performance measures.
14 CO-CHAIR PITTS: Arjun?
15 MEMBER VENKATASH: I think this
16 distinction in the measures between
17 preparedness and some of the operational
18 performance measures that Jay just alluded to
19 and what Brendan just said, which was our goal
20 is to think about this intersection here, I
21 think one of the things that is making that
22 challenging is the directionality of the

1 issue.
2 So, if we took the STEMI example,
3 we could measure some sort of regionalized
4 ability to have transfer agreements. And
5 then, we can measure at a hospital level their
6 door-to-balloon time. And then, we have this
7 outcome of mortality. All of these things
8 kind of go in the same direction.
9 In the same way, we have been
10 talking about how, when crowding becomes surge
11 as a spectrum, and that goes in one direction.
12 When Jesse says, well, we should think about
13 how much flex we have, I think what becomes
14 challenging is that the operational measures
15 may not go in the same way of direction of
16 performance as the preparedness measures.
17 By that, I mean if we think of
18 whatever the unit is, be it hospital, be it
19 collaborative, be it region, that is high-
20 performing on some of the process measures we
21 have for crowding or boarding, that doesn't
22 necessarily mean that they are high-performing

1 for preparedness. In fact, high performance
2 for something like boarding or crowding could
3 just mean that you have got all your just-in-
4 time processes down to a point where you have
5 maximized where you want length of stay; you
6 have minimized your amount of boarding time,
7 but you actually have no flex in the system.
8 And that is a system that doesn't have a high
9 degree of performance on the preparedness
10 side.
11 And I think getting at some of
12 that tension of whether or not these measures
13 are actually going in the same direction or
14 against each other is important in thinking
15 about how measures get developed kind of down
16 the line from this.
17 CO-CHAIR PITTS: Brent?
18 MEMBER ASPLIN: I wonder if one of
19 the reasons we are struggling at the low end
20 of emergency or disasters, kind of low-level
21 disasters and daily surge is just the whole
22 fact that we have accepted boarding as a fact

1 of life in the country. We are talking about
2 bending the rules for low-level disasters.
3 There are no rules that prevent boarding. So,
4 I think that is why it is just such a
5 different mindset for us, because we have
6 accepted this, I think, deviant system
7 response, that it is okay to just stack
8 patients in the ER. I think if there was a
9 different mindset about that not being
10 acceptable, we would not be struggling with
11 the overlap of daily surge and lower-level-
12 volume disasters.
13 CO-CHAIR PITTS: Suzanne?
14 CO-CHAIR STONE-GRIFFITH: Yes, I
15 can't help but agree with you on that, Brent.
16 I mean, we have been measuring this for a long
17 time. Over the last two years, our number of
18 holding hours or boarding hours has really
19 risen, this last year, potentially on track
20 for a 25-percent increase, where right before
21 2009 we had a 16-percent decrease.
22 So, we are actually back where we

1 started. And yet, operationally, we have
2 sustained some pretty incredible improvements
3 in things like length of stay and door-to-doc
4 and volumes and things like that. So, there
5 is some day-to-day acceptance that we board.
6 And, oh, by the way, it is not just the
7 emergency department; it is throughout the
8 hospital.
9 MEMBER ASPLIN: Yes, imagine the
10 overlap --
11 CO-CHAIR STONE-GRIFFITH: Right.
12 MEMBER ASPLIN: -- if, as part of
13 its daily operations, hospitals always had to
14 do some form of surge to prevent people from
15 staying in the ED.
16 Now Ellen can point out the
17 unintended consequences of that policy in the
18 UK, but it certainly did affect operations.
19 And from that standpoint, you would be using
20 a lot of the surge capabilities on a daily
21 basis to respond to folks in the emergency
22 department, which just doesn't occur today.

1 CO-CHAIR PITTS: David Levine?
2 There are two Davids, and I was looking at
3 Levine. Sorry. You're next.
4 MEMBER LEVINE: Thanks.
5 I just wanted to echo what Jay and
6 Arjun and the piece of what we are looking at,
7 these right metrics that we are looking at.
8 The difference between like the day-to-day and
9 the disaster, the patient population also
10 changes. So, we are looking to pick those
11 metrics and some of those door-to-doc times,
12 or whatever.
13 We have to be very cautious
14 because some of those less-urgent patients
15 that are crowding our waiting rooms that we
16 have deemed are okay to wait, actually, when
17 things are going on, like possibly an Aurora
18 -- definitely it has happened in Chicago when
19 we have had bad shoots, and whatnot -- is, all
20 of a sudden, the waiting room is relatively
21 empty of the non-acute patients. They have
22 already self-selected not coming to the ED.

1 We have to factor that into the
2 care provision metrics that we are going to be
3 using or be very cognizant of especially those
4 lower-acuity patients that may self-select and
5 not come when a disaster is happening.
6 CO-CHAIR PITTS: Jesse?
7 MR. PINES: I just wanted to make
8 quick comment. Just to sort of refocus us,
9 again, the task today is really to come up
10 with tangible recommendations for measure
11 developers. Essentially, what I am hearing
12 is, you know, I think that we are not totally
13 there, thinking that crowding and preparedness
14 are not really the same. But I think there is
15 sort of broad agreement that they are related.
16 So, as you start formulating a lot
17 of these comments, also think about, after
18 this discussion for the last hour, what sort
19 of recommendations can we make to measure
20 developers who are thinking about making these
21 measures, specifically in the context of
22 really linking these concepts quantitatively?

1 CO-CHAIR PITTS: David Marcozzi?
2 MEMBER MARCOZZI: Yes, I mean, I
3 guess that jumps right off of what Jesse just
4 spoke to around tangible recommendations for
5 measure developers. I think I am hearing
6 three different areas of interest within the
7 group.
8 The first is really what Brent had
9 spoken to around regionalized accountable
10 care. Let me just echo what Brent said. I
11 think that there is a Venn diagram here and at
12 the least they are associated; at the most
13 they are interrelated with regard to
14 overcrowding from regionalized care to
15 crowding issues to emergency preparedness
16 issues.
17 But let's speak to one very
18 tangible or try to bring a very practical
19 example. Let's do a man-down drill right now.
20 So, who owns that patient right now on the
21 street of D.C.?
22 The reason why I think we are

1 challenged with this discussion around
2 regionalized care, regionalized acute care, is
3 because there are so many parties involved
4 with that. The public owns a piece of that.
5 How fast? Law enforcement owns a piece of
6 that. Is there an AED close by and are they
7 in the rigs. EMS owns it, and EMS is not
8 engaged as much as it should be with regard to
9 this. And EMS really owns a majority of the
10 man-down drill issues.
11 Then, lastly, the piece of the
12 man-down drill is our healthcare facilities.
13 So, that speaks to the audience or the
14 potential components in and around those
15 regionalized care systems.
16 And then, where is the data?
17 Because if you want to develop what Jesse just
18 spoke to, tangible recommendations for measure
19 developers, well, then, where is the data? We
20 are close. We certainly have a lot of -- and
21 Ryan could speak to this better than I -- a
22 lot of hospital-associated data that could

1 potentially look at outcomes. We are there.
2 We are close. We could probably improve, but
3 we have got some good data there.
4 The EMS piece we actually have,
5 and no one has really had a discussion. It
6 speaks to what Jesse rolled out in his --
7 NEMSIS is already there. We can, and we have
8 the ability to, start to collect data from the
9 pre-hospital environment. So, we actually
10 have to make probably NEMSIS more robust and
11 right-size-fit-it and ask the right questions
12 to it, but if you link the NEMSIS data with
13 the outcomes data that Ryan has got visibility
14 on or that we all have visibility on, then we
15 can actually speak to that regionalized
16 accountable care -- regionalized accountable
17 care? -- regionalized acute care, providing
18 acute care in a regionalized format. So, that
19 is first.
20 The second is crowding and the
21 linkage between crowding and preparedness. As
22 I said, I think there is a Venn diagram here.

1 But I don't necessarily, not entirely,
2 although I am hearing, I am not entirely in
3 the camp that they are two separate and
4 distinct things. I think that they are
5 interrelated, but what I think Jay just spoke
6 to on a busy day and the ability to transition
7 from a busy day in the ER to a disaster that
8 he just spoke to and responded to, I think
9 speaks to the change that we are having
10 trouble grappling with. And that is a change
11 from individual-based healthcare systems and
12 conventional delivery of care today to
13 population-based systems.
14 And you have a bunch of clinicians
15 in the room. It is very difficult
16 historically for that conversation to figure
17 out really, in essence, that is what we are
18 talking about. The tipping point of when we
19 go from individual-based healthcare and
20 overcrowding, and the pneumonia who is on the
21 floor who could have gone home, but he is
22 going to keep the bed, and the ER still is

1 overcrowded, and we potentially even have a
2 sicker patient in the ER who still can't get
3 the bed because the pneumonia could go home,
4 but he is up on the floor, and the doc hasn't
5 written the discharge instructions yet, versus
6 breakpoint, trigger point, population-based
7 care where that patient immediately gets
8 discharged. Change in care, the sicker
9 patient then goes upstairs and deserves the
10 bed.
11 And that is why we are having such
12 a challenge in this discussion, I think. We
13 are waxing and waning from really the
14 fundamental issue here of a paradigm shift.
15 CO-CHAIR PITTS: So, we are going
16 to sort of migrate back to Jesse. He had a
17 couple of comments before we -- I guess we are
18 breaking at noon, right? That is my
19 understanding. So, let's a little bit more
20 about this topic, and then we will let Jesse
21 take over for a few minutes. I was going to
22 let everybody put in their two bits and then

1 we will sort of fade out toward Jesse.

2 MEMBER ADIRIM: I just have a

3 quick question, going to what --

4 CO-CHAIR PITTS: Yes.

5 MEMBER ADIRIM: -- not a question,

6 a comment with regard to what Jesse has asked

7 for, ideas for how to frame the

8 recommendations.

9 You may want to consider more than

10 one set of measures for regionalized emergency

11 care because what is coming out of this to me,

12 what it sounds like to me is that there is

13 multiple different sets that you could create

14 for this issue. So, that would be No. 1.

15 No. 2, I would encourage a look

16 at, with regard to those sets, specific

17 emergency department sets with regard to

18 coordination of care, whether or not you

19 include preparedness response in that

20 coordination-of-care set. You know, you can

21 kind of think through that. But it would be

22 coordination of care.

1 And then, also, really, again,
2 repeat looking at this from kind of an
3 intermediate outcome or outcome-based-type
4 measure. So, that would be across a system,
5 as opposed to just institutions. So, those
6 would be a couple.
7 And then, I don't want Brent's
8 point to be lost on the boarding issue, not
9 that I think that should be a separate set,
10 but that point shouldn't be lost and that
11 there should be a development of measures that
12 go to the patient's experience. Because I
13 know NQF is also concerned about patient
14 experience from their point of view, and
15 boarding may not be in really good emergency
16 departments an issue with regard to the
17 quality of care because we do excellent care
18 for those that board, but it really is a bad
19 experience for the patient.
20 So, I think it is something that
21 is definitely worth measuring, and if it is
22 measured, may affect changes in how hospitals

1 operate if there are carrots and sticks
2 associated with it. So, I didn't want that
3 point to be lost.
4 CO-CHAIR PITTS: Ryan?
5 MEMBER MUTTER: So, I have been
6 thinking about Jesse's question about
7 recommendations sort of in the context of the
8 Einstein and Deming quotes at the very
9 beginning.
10 Something I am not clear on is,
11 should we recommend that developers have a
12 path to incentivize improvement in the things
13 that they measure? So, for example, I am
14 thinking about unplanned critical illness and
15 sort of care at an area level, not just how
16 good this hospital does, but how good the area
17 does, including hospitals in that area who are
18 competitors and may question why should they
19 take steps to improve care at the area level,
20 which is going to make their competitor look
21 better and make them look better, but it will
22 make their competitor look better. It may not

1 be worth it.

2 And so, I don't know important in

3 terms of recommending -- are we okay

4 recommending measures that are important, but

5 where an incentive to improve may be hard to

6 get to, hard to identify, or do we feel that

7 it is important that there is an identifiable

8 incentive that can be used to effect

9 improvement in that thing we measure?

10 CO-CHAIR PITTS: Helen?

11 DR. BURSTIN: Okay. Thank you.

12 So, I may be the token primary

13 care/general internist in the room, and just

14 a thought off of Terry's comment about

15 integration. I think there is a real

16 opportunity to think very broadly about some

17 of the measures we already have and bring them

18 up a level in terms of level analysis. So,

19 just a few thoughts on that.

20 There are a set of transfer

21 measures that were submitted years ago looking

22 at transfers for patients with STEMI. I mean,

1 those might be very good measures to think
2 about going up a level in terms of analysis to
3 community or region. They already exist.
4 Again, thinking about that as a starting
5 point.
6 You know, all the measures -- and
7 Ryan may be able to speak to some of the newer
8 work on the avoidable ED measures, if that is
9 still happening. But there are avoidable
10 hospitalization and avoidable ED measures I
11 hope in development at AHRQ that are
12 community-level indicators. Again, those are
13 not necessarily something -- I think we have
14 heard lots from providers who feel that that
15 is not directly something for which they are
16 accountable solely. It has got to be a
17 community-level indicator of access.
18 So, those are the kinds of
19 measures I think would also be useful both for
20 just day-to-day operations, but also surge.
21 Because if you are in a community that is
22 doing a better job of not having patients who

1 don't need to be in the ED in the ED in the
2 first place, then you potentially have more
3 room on a regular basis to bring in other
4 patients.
5 The other thing is those ED
6 throughput measures, which I am sure many of
7 you don't terribly love, that were endorsed by
8 NQF as well, about time in the ED to admit
9 decision, but there is a piece of that puzzle
10 that is missing, which was we don't have the
11 second part of it from admit decision to being
12 on the floor. I mean, those are very logical
13 ways to get at some of the boarding issues.
14 Just one analogy, that the folks
15 at the Office of the National Coordinator have
16 been working on a measure looking at closing
17 the referral loop. So, you refer a patient.
18 Did they get a note? Did they send a note
19 back, et cetera? It just seems like there is
20 a lot of the sort of missing pieces of the
21 loop here that we haven't yet factored in that
22 we could take existing measures and build off

1 of them, and perhaps get that admit time to
2 boarding time.
3 And then, lastly, you know, going
4 back to Terry's point about patient
5 experience, admission through the ED is a
6 variable on HCAHPS. So, there is a real
7 opportunity and a nice research study there
8 even as well just looking at, if you can
9 actually figure out from a hospital level
10 patients who came from the ED, are there
11 variable impressions for them overall in terms
12 of their impression of the hospital, based on
13 admission through the ED, another way to
14 potentially get at some of those issues?
15 So, I think the issue of
16 integration and thinking broadly about
17 measures we already have that could be adapted
18 and modified to help satisfy these issues, and
19 perhaps not always assume they have to be at
20 the provider level of analysis, which gives
21 people hives sometimes, but think about
22 bringing them up a level, where I think you

1 won't have perhaps as much of the pushback
2 that we get about the issues of shared
3 accountability.
4 CO-CHAIR PITTS: HCAHPS, what is
5 HCAHPS?
6 DR. BURSTIN: Oh, I'm sorry. It
7 is the hospital experience-of-care survey that
8 is mandated.
9 CO-CHAIR PITTS: Okay.
10 DR. BURSTIN: It is actually now
11 incentivized for every hospital.
12 CO-CHAIR PITTS: Right. I have
13 heard about it.
14 Let's finish these things, and
15 then I will let Jesse take over and say a few
16 things.
17 Ellen? Mike? Sorry.
18 MEMBER STOTO: Okay. Thanks.
19 Two points. One is that most of
20 the NQF-endorsed measures really have to do
21 with, are defined in terms of some proportion
22 of patients having a good thing happen to

1 them. That works fine in most cases.
2 But I think that Dave is right.
3 When we talk about regional preparedness, the
4 unit really has to be at a higher level than
5 that. I think it is a different paradigm that
6 we really need to come to grips with.
7 The other point goes back to the
8 question about developing measures. We have
9 to think both in terms of what to measure and
10 opportunities to measure. When we have lots
11 of patients, we don't worry too much about
12 opportunities to measure. We focus on what is
13 the right thing to measure. But when we are
14 talking about emergencies, we don't have a lot
15 of opportunities to measure things.
16 So, that is why I think, to the
17 extent possible, that we can measure things in
18 more routine settings that have a bearing on
19 how the systems respond in emergencies, that
20 would be helpful, because there are more
21 opportunities there.
22 CO-CHAIR PITTS: You didn't want

1 to talk, Terry? Okay.

2 Ellen?

3 MEMBER WEBER: This is not

4 specifically to recommend particular measures,

5 but I did want to say something about the idea

6 of the individual versus population-based

7 care, because I actually think in many ways

8 many emergency physicians and probably others

9 would like to be able to think that way.

10 Having some kind of measures that allow you to

11 say, "This person really doesn't need to be in

12 the hospital, and the government stands behind

13 me and the cardiologists stand behind me" --

14 (laughter) -- and everybody is saying that

15 this is not an indication for a

16 hospitalization, would take a lot of onus off

17 that individual physician.

18 I mean, when I was in England,

19 there was a lot of, in the emergency

20 department, is this a good use of NHS dollars?

21 Okay? The people actually thought about the

22 fact that, when you have like this four-hour

1 target, that actually one way to deal with
2 getting patients out of the emergency
3 department within four hours was just to admit
4 everybody, and then the hospital has to deal
5 with it.
6 But they realized, one, that was a
7 really bad use of resources and, secondly, in
8 the end it would wind up blocking their beds.
9 So, they didn't go that cynical route.
10 I think that idea is, you know,
11 one of the things that I think the American
12 healthcare system -- if I may wax poetic for
13 a minute -- we always think we have unlimited
14 resources. We are always dealing with limited
15 resources, and we are always letting somebody
16 wait, so somebody else who is sicker can go
17 forward.
18 I think we actually have to agree
19 -- I don't think in a disaster we are going to
20 be able give the same level of care to
21 absolutely everybody the way we do when there
22 is no disaster. But, nevertheless, I think

1 the principles are the same, that we should be
2 having more mindset all the time about what
3 does the admission have to do with the surge
4 capacity that I might need any day. So, I
5 think there is a relationship there that we
6 should be sort of maybe thinking about in our
7 measures.
8 And getting to the issue of
9 process versus outcome, I completely agree
10 that the outcome measures might be different
11 for preparedness and for boarding. I believe
12 a lot of the process measures, what do you
13 have in place to anticipate a problem, goes
14 for all of this. And so, that may be where
15 the distinction is.
16 CO-CHAIR PITTS: Okay. Last
17 comment, Ryan?
18 MEMBER MUTTER: I think Helen
19 invited me to give a very brief update on some
20 of AHRQ's work in this area under our Quality
21 Indicators mechanism.
22 So, we completed a project where

1 we took AHRQ's inpatient prevention quality
2 indicators, which is basically a measure set
3 that uses what is going on in the hospital to
4 get a sense of what is happening in the
5 ambulatory care setting. We took sort of
6 those inpatient-oriented Quality Indicators
7 and tried to see if we could expand them to be
8 applied to ED data. When I say "ED data" in
9 talking about AHRQ, what I am talking about is
10 sort of administrative data based on bills.
11 That work has been completed. We are going to
12 have a working paper that we are going to post
13 on our Quality Indicators website very soon.
14 AHRQ has just begun a second
15 project -- the contract has been awarded to
16 Stanford -- to do some more measure
17 development work looking at community. It is
18 ED Quality Indicators, but, again, it is not
19 looking at individual hospitals and looking to
20 assess care in the ED. It is basically using
21 the ED as a window into the healthcare system
22 to basically look at what is going on inside

1 of the ED as an indicator of what is happening
2 outside of the ED.
3 As I am sure many of us do, I
4 really like Brent's model here, which is on
5 figure 1, page 7, of the Draft Report. As I
6 think about the work that we are about to be
7 doing -- is it about to magically appear on
8 the screen? That would be amazing.
9 (Laughter.)
10 Page 7. Scroll up just a little
11 bit, a little bit more. Oh, too far. Okay.
12 This contract has just been
13 awarded. We have only just had our first
14 preliminary meeting. So, what I am saying now
15 is preliminary and should be taken as such.
16 But my take is that our focus is
17 mostly going to be, if you look under the
18 input column, is mostly going to be in that
19 safety-net care and unscheduled urgent care
20 space, is probably what we will be doing. And
21 again, it is going to be community measures.
22 So, that is the update.

1 CO-CHAIR PITTS: Okay. And,
2 Jesse, did you want to be last before lunch?
3 MR. PINES: Sure. Just some brief
4 comments, and I never want to stand between a
5 big group and lunch.
6 But, again, I just wanted to thank
7 everyone. I mean, just such a great
8 discussion, and I think we have really a lot
9 of very tangible recommendations that are
10 going to come out of this.
11 What I think I have heard so far
12 is, thinking about preparedness from a
13 measurement perspective, there are some
14 potential ways to measure whether or not we
15 are prepared. Potentially, tabletop
16 exercises, thinking about some structural
17 measures of what kind of stuff that we have in
18 the event of a disaster, and, also, thinking
19 about, what Anthony said before, this is sort
20 of measuring response, which I think really,
21 from a crowding perspective and a preparedness
22 perspective, is really very different and

1 actually may use very different methodologies.
2 From a preparedness perspective,
3 the measurement of a response may be actually
4 very similar to a lot of the ways that we
5 would actually measure preparedness; for
6 example, using validated survey instruments,
7 you know, sort of after an event happened.
8 Because, like Mike Stoto was saying, we really
9 have no counterfactual, we never really have
10 a control group for that. So, really, you do
11 need some sort of a qualitative or rigorous
12 qualitative assessment that can be calculated
13 in a quantitative way, and that would be
14 potentially through some sort of a survey
15 methodology to make an assessment of that.
16 And then, on the crowding side,
17 really thinking about our crowding measures in
18 the context of preparedness. So, the
19 afternoon is going to be about thinking about
20 crowding measures, but, also, I don't want to
21 stop the discussion of preparedness, you know,
22 thinking about how we could potentially link

1 the existing measures of crowding to the
2 extent of what Helen said, I think, which is
3 fantastic, thinking about current measures
4 that NQF has that could potentially be taken
5 to a different level that would start to think
6 about like transfers at a higher level and
7 really linking the concepts together from a
8 measurement point of view.
9 And then, I think those were my
10 basic comments. Essentially, I just wanted to
11 say that I do want to continue this discussion
12 in the afternoon, really talking about
13 specifically boarding and crowding with a
14 preparedness lens, which sort of the morning
15 was preparedness in a boarding and crowding
16 lens.
17 And without any final questions,
18 final comments --
19 MS. FRANKLIN: No, I just wanted
20 to pick up on Dr. Adirim's comments about the
21 framing questions. As we continue to think
22 about this through the day, what are the

1 outcomes? What does good look like that we
2 expect to see from the measures that we are
3 going to be making recommendations about? So,
4 just keeping that in mind as we continue our
5 discussion.
6 CO-CHAIR PITTS: I think you are
7 okay to go to lunch now.
8 MS. FRANKLIN: Lunch has not quite
9 appeared.
10 CO-CHAIR PITTS: I'm sorry. I
11 noticed there is a public comment.
12 MS. FRANKLIN: Yes. I'm sorry.
13 If we have members on the call or public on
14 the call, now we would like to hear some
15 comments from them.
16 THE OPERATOR: At this time, in
17 order to ask a question, press *, then the
18 number 1 on your telephone keypad.
19 We will pause for just a moment to
20 compile the Q&A roster.
21 (Pause.)
22 At this time, there are no

1 questions.

2 MS. FRANKLIN: With that, I guess

3 we can go ahead and break for -- oh, sorry,

4 Terry.

5 CO-CHAIR PITTS: Yes, go ahead,

6 Terry.

7 MEMBER ADIRIM: Very quickly, with

8 regard to framing, I would encourage somewhere

9 in this document that, whatever measures are

10 developed or whatever sets are measured, that

11 they do keep children in mind because we are

12 so used to having to be retrofitting with

13 regard to these kinds of things. I just want

14 to make sure that, especially when it comes to

15 capabilities and measuring stuff, it is

16 different in kids. So, that is all for me.

17 CO-CHAIR PITTS: Okay. Lunch will

18 be here soon.

19 (Whereupon, the foregoing matter

20 went off the record for lunch at 11:57 a.m.

21 and went back on the record at 12:48 p.m.)

22

1 A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N
2 12:48 p.m.
3 MS. FRANKLIN: Before we get
4 started, I would like to check the line.
5 Arnika, I wanted to check to see
6 if we have a Dr. Timmons on the line.
7 MEMBER TIMMONS: Yes, I am here.
8 MS. FRANKLIN: Oh, great.
9 Dr. Rapp on the line?
10 MEMBER RAPP: Yes, I am, Angela.
11 MS. FRANKLIN: Okay.
12 MEMBER RAPP: How are you?
13 MS. FRANKLIN: Great. Thank you.
14 I just wanted to make sure.
15 If either of you want to weigh-in,
16 please feel free to do so.
17 MEMBER TIMMONS: Thank you.
18 MEMBER RAPP: Sure.
19 MS. FRANKLIN: Okay. Thanks.
20 CO-CHAIR PITTS: I think Jesse
21 will start off talking about a subject he has
22 already got prepared. Thank you.

1 MR. PINES: Great. Thanks.
2 So, essentially, what I would like
3 to do for the next few hours here is talk a
4 little bit about some of the measurement
5 issues in crowding and boarding, but also
6 really not lose the frame of preparedness.
7 Essentially, we are going to basically go
8 through some of the current measures that are
9 out there, talk a little bit about what
10 happened back in 2008 and the measures that
11 were not endorsed.
12 We did have a fairly robust
13 discussion around Brent's
14 input/throughput/output model. Actually, I
15 think it is fantastic that AHRQ is actually
16 planning on looking at the input side,
17 specifically the unscheduled urgent care and
18 safety net, and developing some measures
19 around there.
20 And then, finally, what we are
21 going to do is, and I think really the bulk of
22 this, is going to go through each of the

1 recommendations in the current draft and
2 essentially think, are these the
3 recommendations we really want to have for
4 measure developers? In the context of the
5 discussion this morning, is there any way we
6 want to modify that, modify those
7 recommendations?
8 And also, at the end I do want to
9 spend some time going around the room and
10 thinking about other recommendations. And
11 other recommendations can be in the context of
12 this morning, and are other recommendations
13 that we didn't think of for the preparedness
14 section? Or are there other recommendations
15 specifically on crowding and boarding and
16 things we would want to develop for measure
17 developers?
18 So, with that, I would like to
19 basically start with thinking about crowding
20 measurement in general. This is something
21 that I have spent many years thinking about
22 and studying.

1 There are basically two different
2 ways to measure crowding. One is from the
3 perspective of the emergency department
4 looking at measures such as occupancy. We all
5 know, coming into an ED shift, that if you
6 come to the waiting room and there are 25
7 people in the waiting room, that it is going
8 to be crowded in the ED. That is A, and there
9 are going to probably be potentially issues
10 getting patients out of the emergency
11 department.
12 But the issue with measures like
13 that is it is difficult to generalize across
14 hospitals. And really, those are point-in-
15 time measures. A lot of the work that Melissa
16 has done has really looked at the association
17 between various levels of census and length of
18 stay. Essentially, what the literature shows
19 is that at different censuses between
20 different hospitals that is associated with
21 highly-variable differences in length of stay
22 and sort of gets at the ultimate question:

1 what is crowding?

2 My opinion on that is that,

3 really, the best way to measure that is really

4 looking at it from the patient perspective and

5 looking at issues of, basically, the

6 timestamps, potentially time to provider, but

7 also looking at broader timestamps such as

8 overall length of stay and the boarding time,

9 and the other measures that actually were

10 previously endorsed in 2008. Really take it

11 from the patient's perspective as opposed to

12 from the hospital's perspective in a point in

13 time.

14 Really, I think that is where the

15 future of measure development should go. It

16 would be to look at potentially re-endorsing

17 those measures; like Helen said earlier,

18 potentially thinking about where the gaps

19 exist. And do we want to start thinking about

20 other intermediate timestamps such as when a

21 patient was seen by a provider, when the

22 decision was made to admit a patient, and

1 think about time intervals.
2 Some of the work that we have done
3 has actually looked at specifically to admit
4 to departure time across hospitals. And
5 actually, as it turns out, a lot of hospitals
6 will have a very long length of stay but a
7 very short decision to admit to departure
8 time, and also vice versa.
9 So, I think we have also got to
10 think about making recommendations to measure
11 developers that really prevent gaming and
12 really thinking carefully about what boarding
13 actually means. I think we are going to be
14 having a discussion about the definition of
15 boarding, which is really if you ask the Joint
16 Commission, which is very different if you ask
17 the stakeholders in the emergency care
18 community. So, I think coming up with a
19 uniform definition for that and a specific
20 recommendation for that will be important.
21 With that, any questions or any
22 other issues?

1 (No response.)

2 So, essentially, why don't we go
3 ahead, then, and I would like to again sort of
4 review Brent's input/throughput/output model.

5 Maybe, Adeela, you could go ahead
6 and put it up.

7 So, this is really our framework
8 for this section, which is basically using
9 this conceptual framework to think about, from
10 a measurement perspective, what measures we
11 have and in an ideal world what measures we
12 would want to have.

13 On the input side, Ryan had
14 mentioned a number of measures that AHRQ is
15 developing on the input side. Actually, that
16 was one of the recommendations that came from
17 the conference call. I don't think Ryan was
18 actually on that.

19 I don't think, Ryan, you were on
20 that conference call, but that was actually
21 one of the recommendations, to think more
22 broadly about input measures and output

1 measures, some of the measures that Helen had
2 mentioned regarding transferring patients.
3 And I think that one of the major things we
4 could think about would be taking some of the
5 existing measures and trying to fit it into
6 this framework, thinking about taking some of
7 the transfer measures and potentially
8 aggregating that at the level of the region.
9 Later on, we are going to be talking a little
10 bit about accountability and regionalization.
11 So, next, what I wanted to do is
12 talk a little bit about the recommendations
13 and start really opening up for discussion
14 around looking at the recommendations sort of
15 one-by-one, going through the document. We
16 are on page 9 here.
17 So, essentially, the first
18 recommendation we have is that: "Quality
19 measure developers should ensure the validity
20 and reliability of the data used for ED
21 crowding and boarding measurement." I guess
22 the broader question is, should we add

1 preparedness into that recommendation? And
2 how should we frame that in a way that is
3 understandable to measure developers? I mean,
4 I guess that is sort of a general
5 recommendation.
6 Go ahead.
7 MEMBER ADIRIM: I have a question
8 about that. When you develop a measure, I
9 mean, is it required that, before putting it
10 through any kind of process, don't you have to
11 ensure validity and reliability a priori? So,
12 I am just wondering about this as a
13 recommendation.
14 MR. PINES: I think that is true,
15 but I guess for this recommendation, I mean,
16 this is sort of a general recommendation that,
17 in order to go through the NQF criteria, all
18 measures would have to be reliable and valid.
19 Are there any sort of crowding-specific ways
20 we would want to modify that recommendation or
21 just sort of leave it?
22 Yes?

1 MEMBER STOTO: I mean, I don't
2 know the field, but what I get out of that is
3 the sense that there are measures there that
4 no one has looked at this yet, validity and
5 reliability yet. So, is that right? I mean,
6 is your sense that there are potential
7 measures there that just can't get through the
8 process because they haven't been studied with
9 respect to validity and reliability? That is
10 the implication of this to me.
11 MR. PINES: So, actually, in the
12 2008 process -- and I wasn't a part of that --
13 several measures actually did get through the
14 process. I am not exactly sure, Helen, if the
15 standards have changed so dramatically since
16 then.
17 DR. BURSTIN: They are probably a
18 bit more specific, a bit more precise. I
19 don't think they have changed much. Actually,
20 Suzanne was the Co-Chair of that project. So,
21 if you have questions there --
22 MEMBER ADIRIM: Speaking more to

1 the measure developers should identify
2 already-existing measures that could be
3 improved and validated, to be ready for NQF,
4 I mean, something like that.
5 MEMBER MUTTER: Yes, see, I was
6 thinking maybe sort of along the same lines.
7 I was thinking what I think is along the same
8 line, which is sort of quality measures should
9 use data that is valid and reliable. So, it
10 doesn't sound like that you are sort of --
11 part of the process is do this big data
12 validation, but use data that is valid and
13 reliable.
14 CO-CHAIR PITTS: I will continue
15 my policeman role here.
16 (Laughter.)
17 Arjun?
18 MEMBER VENKATASH: Brent I think
19 is actually the coauthor on a paper that
20 looked at timestamped data, comparing actual
21 charts within the ED and a tracking system.
22 I think that actually follows this section

1 well, which is probably the guidance we do
2 need to give measure developers, which is that
3 some reliability testing needs to be done
4 between the data source used for measure
5 development and the intended data sources for
6 application. Meaning that if it is developed
7 out of chart review or if it is developed from
8 an electronic tracking system that they use,
9 we have to know that there is some fidelity of
10 that in comparison to claims in which it could
11 be derived from or another data system or
12 manual abstraction. I think that is probably
13 a more specific recommendation for a
14 developer, and there is evidence base to
15 suggest that it is not always reliable.
16 CO-CHAIR PITTS: Emily?
17 MEMBER CARRIER: I had a question
18 maybe for Brent, or maybe for others, about
19 the literature on timestamps. Have the
20 timestamped chart data been studied in the
21 setting of a quality measurement or is it more
22 a study in general, just looking at process in

1 the absence of an ongoing quality measurement
2 and incentive program?
3 MEMBER ASPLIN: The paper Arjun is
4 referring to is the latter.
5 MEMBER CARRIER: Okay.
6 MEMBER ASPLIN: It is really
7 around process improvement and not a quality
8 measure per se. We just looked at active-
9 versus-passive timestamps, and there is a lot
10 of error in our active stamps that we have to
11 do by signing up or doing something on the
12 electronic record, and the gap between when we
13 do that and when it actually happens, if you
14 are using various active steps as proxies as
15 seeing a patient, for example.
16 I don't know how we comment on
17 this, and Mike is on the phone, but one of the
18 issues on the admin decision time to
19 departure, that a number of different parties,
20 and most recently the Measures Application
21 Partnership, had questions about was the
22 ability to game that admin decision time. I

1 don't want to relive -- this is an
2 approximately 55-minute discussion. But we
3 could get into this. I don't know that we
4 really want to go down this whole pathway.
5 But there was a specific CMS
6 directive that asked them not to use the order
7 for a bed request as the admin decision time.
8 Not universally, but by the time we grind out
9 every last ounce of energy in the room every
10 time I have had this conversation --
11 (laughter) -- people kind of begrudgingly come
12 around to that probably is the closest we are
13 going to get, is the actual order, because
14 there is no way to quantify when a decision is
15 made in our heads. And so, that might be one
16 other piece.
17 If we look at reliability as part
18 of a directive, and a recommendation from this
19 project is to look at, compare alternative
20 methodologies for determining when the admin
21 decision time is for purposes of that
22 particular measure.

1 I do believe that, because it is a
2 nested measure within the overall ED length of
3 stay for admitted patients, it is a subset of
4 that larger measure, to me, the gaming is a
5 little less of a serious problem.
6 Nevertheless, if we are going to have people
7 have some confidence in these measures, we are
8 going to have to have better data and
9 understanding of how they perform.
10 CO-CHAIR STONE-GRIFFITH: So,
11 Brent, if I could add to that, I recall that
12 our group talked a great deal about the order
13 to admit being a very specific time; whereas,
14 decision is much broader. Bed management can
15 be very specific and measured, but the bed
16 management process and the process in the ED
17 is not always in parallel.
18 I guess I would agree with you;
19 you talk about it being nested. And yet, we
20 are measuring these as individual things as
21 opposed to looking at them in the context of
22 that continuum. So, the length of stay, to

1 Helen's point, from the time I make that
2 decision until they actually get to their bed
3 or their place where they are going next,
4 wherever "next" is. I mean, we don't have the
5 whole continuum. We have really focused on
6 the ED and not the entire hospital process in
7 that as well.
8 So, those would be my thoughts.
9 CO-CHAIR PITTS: Wes?
10 MEMBER FIELDS: Yes, I want to
11 follow on what Suzanne just said. I think all
12 of us understand that crowding at best is a
13 trailing measure of hospital capacity. If we
14 really want to connect the dots between the
15 discussion this morning and your ability to
16 actually more effectively use the resources in
17 the hospital, you probably need this framework
18 of measurements to be inside of something that
19 is hospital-wide, whether it is in eDocs or
20 something else.
21 We had a really entertaining
22 experience. We passed a bill through the

1 legislature in California three years in a row
2 asking hospitals to use the eDocs because it
3 has been established as one methodology you
4 can use to dynamically manage system status
5 and bed status. And two different Governors
6 have vetoed that bill.
7 So, I am just speaking to the fact
8 that, as long as you are looking at ED-based
9 measurements, in a way you are misrepresenting
10 the management challenge as something which
11 exists inside that department.
12 CO-CHAIR PITTS: Brendan?
13 MEMBER CARR: I was wondering --
14 again, I will call them the "crowding folks"
15 because I am not really one of them -- to help
16 me understand what we missed with the three
17 endorsed ones. Because I feel like we could
18 get very far into the weeds on what
19 recommendations they need to make crowding
20 better, crowding measurement better, but these
21 three, to me, you know, they feel like we are
22 80 percent of the way there.

1 Help me to understand why we
2 need --
3 CO-CHAIR PITTS: Of the three
4 different measures that CMS is proposing or is
5 using?
6 MEMBER CARR: Using, right?
7 CO-CHAIR PITTS: Yes. Yes, using.
8 MEMBER CARR: 495, 496, 497. Do
9 we need 10 more recommendations about crowding
10 measures or should we move towards crowding to
11 disaster, crowding to population?
12 CO-CHAIR PITTS: Yes, I will bow
13 to the people who are expert.
14 Yes, Helen?
15 DR. BURSTIN: I was going to just
16 reiterate what I said this morning, that I
17 think what is missing there is admit decision
18 to being in a bed upstairs, because that is
19 the other piece of the bottleneck that we are
20 never looking at. We only looking at the ED,
21 when, in fact, a lot of those patients are
22 staying in the ED because we can't make room

1 for you upstairs. So, I think without that
2 piece of the puzzle, it is hard to get the
3 full picture.
4 I also think it would be
5 interesting to see what we can learn about
6 taking these metrics and actually trying to
7 look at them at a regional level. Can those
8 data do well at a level that is beyond the
9 individual provider level, which I think is
10 really important as well?
11 MEMBER CARR: The latter I agree
12 is critical, but I am still sort of not
13 understanding why my decision matters that
14 much if I know ED arrival time and ED
15 departure time.
16 MEMBER McCARTHY: Well, it is the
17 hospital, what Wes is speaking to, I think,
18 about it is really like Ryan's idea of these
19 primary care access. You are measuring in the
20 ED, but you are really measuring primary care
21 access. The boarding time is measuring
22 hospital access, right? We are capturing it

1 in the ED, but it is all about the hospital
2 side. So, I think we do need that
3 information.
4 MEMBER ASPLIN: Helen, what about
5 497 --
6 DR. BURSTIN: Because the admit
7 time oftentimes doesn't necessarily translate.
8 I think you mean the decision to -- I am not
9 sure I know what "admitted" -- is admitted
10 time when you are in a room upstairs in a bed
11 or not? I think that is not clear to me.
12 MEMBER ASPLIN: I know the intent
13 was the departure time to --
14 DR. BURSTIN: The proxy.
15 MEMBER ASPLIN: The proxy of being
16 in a bed. The delta would just be whatever
17 transit time that you had. We wouldn't call
18 them depart from the ED until they are
19 actually on their way to the bed.
20 MEMBER CARR: Can I have one more?
21 CO-CHAIR PITTS: Sure.
22 MEMBER CARR: Is the intent, then,

1 to tease out what is me, right, as a
2 practicing emergency physician, ordering too
3 many tests, ordering too many labs, being too
4 slow to make a decision versus tease out the
5 hospital, and the hospital not making capacity
6 for me to admit my patients?
7 And I guess, if that is the
8 intent, is that the right message? Are we all
9 in this together or should we be splitting to
10 decide who is at fault?
11 CO-CHAIR STONE-GRIFFITH: I would
12 say our original intent was really to try to
13 understand at the point where the ED has done
14 everything that they can now what part is
15 owned by really a variety of leadership forces
16 within the hospital and that hospital capacity
17 management.
18 I think what has changed sort of
19 between the time we started this work to now
20 is where holding and boarding was so
21 significant in the emergency department, now
22 it is in a variety of places. It is more than

1 just about the ED. It is about the PACU. It
2 is about the cath lab recovery unit. It is
3 about the interventional radiology. It is
4 about wherever we can find a nook and cranny
5 and put patients.
6 If this really needs to transcend
7 to being patient-centered and about the
8 availability of resources on the hospital
9 side, should this even be broadened? Because
10 now the ED is to some extent competing with
11 boarding patients in the PACU or in some other
12 place. So, then, there is another pecking
13 order in play here a bit.
14 CO-CHAIR PITTS: Terry? Or, okay,
15 AnnMarie.
16 MEMBER PAPA: It is no problem. I
17 think it is also, too, about the coordination
18 of care, Brendan. We do have to own the piece
19 in the emergency department where, if the
20 physician or the provider or the nurses aren't
21 coordinating their care, so that you can get
22 it done in a timely manner -- and that piece

1 takes a long time, as you said earlier; some
2 hospitals have a long time from the time they
3 see the provider until the time the decision
4 is made, and others, the other way around.
5 How do you coordinate that? And
6 who does own it, so that you know exactly what
7 you are measuring and what you are going to
8 improve? Because there are ways to game the
9 system. You make a decision to admit, and
10 your decision is made at two o'clock. By the
11 time you get somebody to accept the patient,
12 it could be two hours later.
13 So, who owns that? Does the ED
14 own that because that two hours was a struggle
15 for you to find a service that wasn't capped
16 or didn't have this, or whatever, until they
17 have to leave?
18 So, I think it is really a
19 combination of the two and how we can best
20 coordinate it, so that for the patient the
21 experience that they have is the best that we
22 can give. And then, of course, the outcome.

1 CO-CHAIR PITTS: It sounds like we
2 are having that 55-minute --
3 (Laughter.)
4 MEMBER ADIRIM: Well, what I was
5 going to say, I was going to get back to what
6 Brent was saying because I was struggling like
7 Brendan was about why it has to be when the
8 physician makes the decision. So, it sounds
9 like that what you have moved to is that you
10 want to look at it from an institution
11 standpoint.
12 Then, it gets back to what Brent
13 was saying; it is when the bed was ordered.
14 I mean, right?
15 CO-CHAIR PITTS: I can tell you,
16 from pouring through the NHAMCS database,
17 which we have talked about HCUP -- NHAMCS, for
18 those of you who might not know, is a sample
19 -- it is not a sort of census -- of all ER
20 visits. It is a sample that is nicely
21 representative. As a consequence, it is a
22 much narrower database, not as many cases, but

1 a much deeper database in terms of the amount
2 of information per case.
3 It includes time intervals. Among
4 other things, it includes time of arrival,
5 time of departure, and, in theory, time seen.
6 Time seen is very difficult to get at, as you
7 can imagine, if you are looking at a true
8 national sample, not people who report to you,
9 but an actual sample of all ER visits.
10 Because in a fair number of ERs, you have a
11 hard time getting that data.
12 I think we decided on the time of
13 bed ordering. Yes, bed ordering was the
14 instruction to the surveyors. It is present;
15 you can find in about 80 percent of the cases.
16 So, that means 20 percent of the time you
17 can't, and that means it is probably hard to
18 find. That is what the national level of
19 compliance might be with that item, if it is
20 defined as the time the bed was ordered.
21 MEMBER ADIRIM: You know, not to
22 keep hammering this in, but, again, if we are

1 looking at it from the patient perspective,
2 then the other two measures are more
3 important. It is when they get there, when
4 they see the doctor and when they get
5 dispositioned. So, I don't think they are
6 cognizant of when the decisions are made, when
7 beds were ordered. So, I think the other two
8 measures kind of -- right? I mean, wrong? I
9 don't know. Does it kind of capture what we
10 are looking --
11 CO-CHAIR PITTS: I will leave that
12 for the record, I am sure.
13 Okay. Jesse?
14 MR. PINES: So, I think one of the
15 reasons why CMS thought that the boarding time
16 was potentially game-able is based on some of
17 the data that we actually showed them where we
18 did a field test of these measures and
19 actually found that some hospitals will have
20 an average length of stay for admitted
21 patients, essentially, which is what the
22 patient sees, of six hours, but will have a

1 boarding time of two hours; whereas, some
2 places will have an average length of stay of
3 10 hours and will have a boarding time of one
4 hour.
5 So, really, it is sort of an
6 artificial number in the middle. I think that
7 it is actually very useful for hospital QA to
8 see where the delay is. Really, the purpose
9 of NQF-endorsed measures is for public
10 reporting. I guess the broader question is,
11 how meaningful is that internal QA measure,
12 really comparing between hospitals? Because
13 if you compare the hospital with two hours
14 versus one hour, it looks like the hospital
15 with the 10-hour length of stay is actually
16 performing better.
17 CO-CHAIR PITTS: Sorry, I am
18 blind. Wes?
19 MEMBER FIELDS: I just want to ask
20 a dumb question that we can sort of answer
21 later, but it relates to observation status,
22 which I also think is something which has

1 changed a lot since 2008. Heavy pushback on
2 appropriateness for admission from CMS for
3 Medicare patients, in particular. So, it is
4 not really clear to me whether or not the 495
5 and 497 are really only be used for patients
6 being admitted to inpatient status or if there
7 is an intention around observation services.
8 Because, potentially, I think
9 there is a lot of good things that could be
10 done both in longer-term observation units as
11 well as short-term observation units in the
12 ED. But I am really not sure how they fit
13 with the measure and with the reporting.
14 CO-CHAIR PITTS: Ellen?
15 MEMBER WEBER: Yes, I just sort of
16 wanted to speak to the value of this 497
17 because, although it may be sort of not what
18 the patient sees, it is very important to
19 changing the process. I think if you have to
20 report it, and it looks like in our hospital
21 three hours to evaluate a patient and another
22 three to four hours to get them to a bed, that

1 looks pretty crazy.
2 Actually, Australia has a three,
3 two, one rule, which is three hours in the ED
4 and two hours for a consultant, and one hour
5 from the time of admission to a bed. So, they
6 just came up with it. I have no idea if it is
7 evidence-based.
8 But it does suggest that, if you
9 are doing 50 percent as the workup and 50
10 percent is getting to a bed, your internal
11 processes are really messed up. I think there
12 is a value to not just reporting them, but
13 just identifying. Because, otherwise, what
14 will happen is people will try to shorten the
15 whole visit, and that is not what we want to
16 do. We don't necessarily want to make the
17 time in the ED where you getting the workup
18 less valuable. So, I think it is important to
19 say this is a bureaucratic part, and that is
20 the part that also should be measured.
21 CO-CHAIR PITTS: Kathy? Kathy,
22 yes.

1 MEMBER ROBINSON: Thank you.
2 I guess in thinking about this
3 particular recommendation, I am struggling to
4 think about crowding and boarding when there
5 really has not been any discussion about
6 another piece of that, which to me is
7 ambulance diversion, the amount of time that
8 it takes to offload patients from an EMS
9 stretcher to an ED stretcher sometimes. And
10 if we are talking about patient experience, a
11 greater picture really encompasses those other
12 elements.
13 CO-CHAIR STONE-GRIFFITH: Yes, so
14 very true.
15 Brent?
16 MEMBER ASPLIN: This is a little
17 response to Jesse's question. I mean, to me,
18 if we could figure out a way that we were more
19 confident about the reliability of the admin
20 decision time, that would help us sort out
21 trends over time in output-related factors, in
22 hospital access, boarding, et cetera, and this

1 growing phenomenon that you and Steve and
2 others just nicely pointed out in the new
3 paper this year around how the throughput
4 section of the model is starting to drive a
5 lot of our congestion and problems. And that
6 is probably growing at least as fast, in many
7 settings faster, over the last six years,
8 three to six years, than the boarding piece of
9 it, with all the imaging, intensity of
10 workups.
11 I think that bucket is actually
12 going to have tremendous pressure on it with
13 the readmissions reduction program and with
14 the move towards global payments. Because I
15 can tell you that, as a Pioneer ACO, we are
16 going to try to work as hard as we can to
17 create alternative pathways to
18 hospitalization, kind of like we talked about
19 at our conference a couple of years ago.
20 I think this whole diagnostic
21 phase is going to go faster than the boarding
22 problem over the next 10 years. And knowing

1 admin decision time and having both 95 and 97
2 helps you sort out, because that is the
3 pendulum, as Ellen points out, or the marker
4 at which point there is a transition between
5 the diagnostic pieces and the waiting-for-the-
6 bed pieces. There might be some value in
7 seeing that over time. That is my best guess
8 as an answer to your question.
9 CO-CHAIR PITTS: Okay. So, that
10 was about -- I am trying to get my own mind
11 organized here -- that was about validity and
12 reliability of these measures, or the data, I
13 suppose.
14 And Recommendation 2 was that:
15 "Developers should explicitly define the
16 timestamp." So, which exact interval should
17 we be talking about? And we actually talked
18 on it already, I think.
19 Suzanne, I know I have heard you
20 talk about that, that within HCA you have a
21 fairly-uniform way of defining that, that is
22 not the time that bed was ordered. Is that

1 right?

2 CO-CHAIR STONE-GRIFFITH: We

3 actually separate it from bed-ordering time

4 because we would like to encourage bed

5 notification in the system. So, if I say,

6 "Hey, don't tell anybody upstairs that we are

7 going to need four ICU beds until the patient

8 is wrapped up with a bow and I am allowed to

9 put that order in," how do we commission

10 resources upstairs? Back to that just-in-

11 time, I might need to call a nurse in or not

12 let a nurse go home early or think about other

13 factors.

14 So, we think of them as very

15 interdependent but running on a parallel path.

16 So, as opposed to ordering a bed, we use an

17 order to admission or an order to admit, which

18 is what we think of as a complete statused

19 order. I have to have a date and a time. I

20 have to have an accepting provider. I have

21 got to have a bed type and the status of that

22 patient. When I have that, then I put in the

1 bed order.

2 But that is not what is everywhere

3 or what is being used. And I would even say

4 in our own company it is a nine-step process

5 to make this happen. So, it is by no means

6 easy.

7 CO-CHAIR PITTS: Right.

8 Helen, how exactly is that defined

9 in the NQF -- or you are looking for it?

10 Okay.

11 DR. BURSTIN: I have got the specs

12 open right now.

13 CO-CHAIR PITTS: Okay.

14 DR. BURSTIN: It is very unclear,

15 but we will share them with folks. There is

16 an entire algorithm that is associated with

17 the measure, but we will see if we can figure

18 it out.

19 CO-CHAIR PITTS: So, I mean, it is

20 really hard, if you are doing a national

21 survey like NHAMCS, to instruct the surveyors

22 on what to look for. It could lead to pretty

1 radically-different results.

2 I think there is a time that you

3 decide to admit. There is a time the bed was

4 requested. There is a time that a bed was

5 received. And there is also the time when you

6 have got hold them and intending to admit the

7 patient.

8 So, the one that we have actually

9 tried to use is the time when the bed was

10 requested, right? Right.

11 And keep in mind, you know, this

12 is not the UK or it is not Australia. We have

13 a million different ways of documenting stuff

14 in the U.S. And so, which thing is most

15 likely to be found in a chart? I think in a

16 paper chart, the old paper chart, we used to

17 write "admit to," you know, time it.

18 What is everybody's feeling about

19 that? There are quite a few people who still

20 use paper charts. I mean, typically, nurses,

21 the documentation is better than the doctors.

22 You know, doctor in the room, doctor out of

1 the room with a timestamp there.

2 What is your impression about the

3 best way to get universal responses, given our

4 current system?

5 MR. PINES: So, also, just to

6 clarify, in the current version we did mention

7 two consensus groups that did actually come up

8 with consensus measures for a lot of these

9 timestamps, one of which was convened through

10 the ENA and actually a separate one through

11 EDBA. That will be included as part of this.

12 But, essentially, I think it is

13 important to have explicit definitions. I

14 think there is no disagreement there. I think

15 in the 2008 measures it is not totally clear

16 exactly what the decision to admit is, whether

17 that is the administrative bed or you see

18 someone, an 80-year-old with chest pain pops

19 up on the tracking screen, and you sort of

20 know that you are going to admit him. What

21 does that actually mean?

22 And also, just to expand the

1 discussion a little bit, I want to talk a
2 little bit about the boarding time because
3 this has been something that has been very
4 controversial. Specifically, when does
5 boarding start and when does this group really
6 want to start boarding?
7 There have been a number of
8 definitions out there. The Joint Commission
9 Patient Flow Standard, the definition is four
10 hours after the decision to admit. And that
11 is also varied between these other documents
12 from two hours to some of the documentation
13 says that it is right after the decision to
14 admit.
15 CO-CHAIR STONE-GRIFFITH: Jay?
16 MEMBER SCHUUR: So, just as a
17 point of information, I think what 497, the
18 current CMS specs are essentially that the
19 timestamp for decision to admit represents the
20 physician's decisions and actions thereof, but
21 it is not the admit order. If you read the
22 definitions, it is inherently difficult. It

1 is inherently subjective.
2 So, my specific comment would be,
3 could the recommendation be that the NQF or
4 some organization comes up with consensus
5 standards around this? Because I think if we
6 leave it up to measure developers, the issue
7 is there are these two papers. I was on one
8 of them. A number of people here were on one
9 or the other.
10 We came up with different
11 standards for a couple of timestamps. And so,
12 if it left up to measure developers, are we
13 going to have a whole bunch of well-designed
14 measures, but still not agreement on the
15 actual timestamps?
16 DR. BURSTIN: And that could be
17 one output of this group. I mean, if you
18 think that is appropriate to try to put in
19 this report for ASPR, we would be delighted to
20 try to use this group to try to hone-in on
21 those definitions.
22 CO-CHAIR PITTS: Okay. Great.

1 MEMBER McCARTHY: I think it is
2 worth it, even though it may not be as precise
3 as we want it. We should just try to come up
4 with it. Boarding is really important.
5 DR. BURSTIN: And keep in mind,
6 these things could be subject to change. As
7 something changes in the environment, we can
8 do it. We did it probably about three or four
9 years ago around definitions and calculations
10 of medication adherence because there are so
11 many different definitions. We just had our
12 mid-management committee spend hours, and they
13 just put it out there. At least for now, we
14 seem to be getting all the measures in the
15 same format, which does help at least reduce
16 the noise in the measurement system, as
17 opposed to trying to get the real quality
18 signal.
19 MR. PINES: And also, I think one
20 of the things that we are planning as part of
21 this document is to do a side-by-side of the
22 two systems that are out there, the ENA and

1 the EDBA documents. We can potentially come
2 up with some recommendations about reconciling
3 those documents.
4 CO-CHAIR PITTS: Well, just a
5 quick question. What were the pros and cons
6 of the four hours versus the two hours? I
7 think NQF does have some input on that. Was
8 there a recommendation by NQF at all to do
9 that? No? It is just JCAHO? Okay, yes.
10 Then, I won't get into that. Thank you.
11 Brent, do you have something?
12 MEMBER ASPLIN: Well, along that
13 line, I mean, to me, if we could get the admin
14 decision time figured out, that is the beauty
15 of 497, which is you are just measuring it.
16 Because, again, taking it from a
17 patient's perspective, you know, once you are
18 told you are being admitted, as far as you are
19 concerned you are waiting to be admitted.
20 There is nothing magical that is going to
21 happen at two hours, that you are suddenly
22 going to go, "Wow, I was waiting for a bed,

1 but now I am boarding."
2 (Laughter.)
3 So, that is where I have always
4 been in the -- you know, there is going to be
5 a certain amount of boarding with each
6 admission. "Boarding" doesn't have to be a
7 bad word. I mean, we just want to track it,
8 record it, and really long times aren't good.
9 If you are thinking about it from a patient's
10 standpoint, as soon as you start waiting, that
11 is when it starts.
12 But I don't know; that has
13 fluctuated depending on group, and various
14 groups have chewed on it. Some people really
15 want to have the boarding term itself
16 connotate something bad. And the folks that
17 are in that camp -- and several people in the
18 room may be, so that is fine -- that is where
19 the drive has been to -- you can't have it
20 start at zero because, then, everybody will
21 have a boarding for transition time. I just
22 have not gotten caught up in that personally.

1 CO-CHAIR STONE-GRIFFITH: I think
2 the Joint Commission has stated on several
3 occasions that they are worried about the
4 negative consequences of the transition in
5 care from, let's say, the emergency department
6 to the floor. But we really haven't wrapped
7 any quality around that handoff or that
8 transition. We haven't said, if you are -- I
9 don't know -- an abdominal pain and you
10 boarded four hours in the ED to go to a
11 telemetry floor, what is the downstream
12 consequence of that versus two hours? We
13 really haven't wrapped anything from a quality
14 around that.
15 I mean, we have in some patient
16 types, like getting someone quickly to a cath
17 lab or some of the impacts of long boarding.
18 But, in terms of putting a timestamp on it, I
19 am with you, Brent; I would say let's just
20 look at it and see what that looks like over
21 time. I don't know how magical four hours or
22 two hours or one hour is.

1 MEMBER ASPLIN: Well,
2 theoretically, for any given condition -- and
3 the shape of the curve will be different --
4 but you could see an optimal outcome,
5 transition time, to allow for transition of
6 information and exchange and all that, where
7 transitions that occur prior to that time
8 could have adverse outcomes because there
9 wasn't enough time to prepare or exchange
10 information.
11 And then, obviously, we have seen
12 data around really extended time periods
13 before they move up, where, again, quality
14 starts to fall. So, it is sort of an arc of
15 outcomes, which is going to depend on
16 diagnosis as to what the optimal shape is.
17 CO-CHAIR PITTS: I think that the
18 pharma criteria also had subsets for mental or
19 behavioral categories. I will just note this
20 as an aside, and based on analysis I have
21 done, that it looks to me like almost that the
22 entire anomaly with psych disorders has to do

1 with transfer rather than admission. The way
2 it is phrased right now, it looks like
3 transfer is not a consideration. In fact,
4 there is no difference between admitted
5 patients with psych disorders and regular
6 patients without psych disorders. But if you
7 look at transfer, there is no admission, so
8 you don't think of boarding. That is where
9 all the difference is.
10 DR. BURSTIN: Just one more point
11 of information. It turns out that this was a
12 measure that was endorsed as time-limited.
13 They actually had additional time to test the
14 measure. We are actually expecting the
15 results any day now. So, it might be really
16 useful to share back with this group those
17 testing results and see if, in fact, there is
18 an opportunity to see whether they are getting
19 it right.
20 I did, actually, pull up the
21 detailed specs. You are absolutely right, it
22 does have strata, one of which is the global

1 score, one of which is the psychiatric
2 population, one of which is patients formally
3 admitted to observation, and all those. So,
4 there was those strata. Again, we will have
5 to see how that plays out in testing.
6 CO-CHAIR PITTS: Okay. So, the
7 next topic here would be about risk
8 adjustment.
9 MEMBER STOTO: Can I --
10 CO-CHAIR PITTS: Oh, sure, yes.
11 Sorry.
12 MEMBER STOTO: Sorry. As you
13 know, I am an outsider to this field, but I am
14 sitting here thinking, what does the
15 discussion have to do with regionalization,
16 which I understand to be -- and maybe it
17 doesn't. But, then, the last comments here
18 you made about transfer, it sounds like maybe
19 it is. So, I think it would be helpful to be
20 more explicit about these issues.
21 CO-CHAIR PITTS: Well, yes, it is
22 certainly related to our ability to transfer

1 patients within communities. I mean, the
2 community capacity for handling psych problems
3 determines to a great extent the amount of
4 boarding in my hospital.
5 Wes?
6 MEMBER FIELDS: Yes, I just want
7 to follow without perseveration here. But I
8 really think we are, in 2012 and looking
9 forward, probably in jeopardy of measuring
10 things we shouldn't be measuring or putting
11 out metrics which people will respond to in
12 the hospital industry that they probably
13 should ignore.
14 For example, I think there are
15 probably three components of crowding that
16 have been pretty well-established. One is the
17 low-acuity patient who potentially could be
18 seen in a community setting. The other is the
19 patient who is typically a Medicare
20 beneficiary waiting for an inpatient bed.
21 But the third, which I think we
22 really need to be encouraging researchers to

1 look at, is other dispositions within the
2 community. I think in my practice, whether or
3 not a senior is capable of going to assisted
4 living who previously was living independently
5 but failing, that is a pretty big deal.
6 Working through that transition of care takes
7 time.
8 I think that it is instructive
9 that England has pulled back from the four-
10 hour rule. I think trying to tell hospitals
11 to hurry up to make their decision is not
12 necessarily the right incentive.
13 There is a substantial
14 entrepreneurial hospital operator in
15 California whose name will go unmentioned, who
16 OIG is currently investigating, because he
17 does such a great job of admitting a whole lot
18 of patients who meet InterQual criteria within
19 two hours. It just turns out that the gaming
20 is on the inpatient documentation about the
21 medical necessity for the admission.
22 So, I just feel like there are

1 other dispositions which are valuable and
2 which would actually reduce cost that we are
3 not measuring. I think that any population,
4 and the behavioral health population is
5 another great example, really what Brent and
6 others need to work on is the reiteration of
7 the throughput model that looks at population
8 subsets and looks at payer classes. Because
9 what the appropriate transition of care is
10 really depends on both where they fit in a
11 subpopulation by diagnostic category or
12 disease or degree of comorbidity, but it also
13 depends on their payer class.
14 I just feel like these are not
15 adequate measures for a complex problem. I
16 also feel like potentially, even if it in the
17 short-term aggravates the crowding problem, we
18 may be able to add value substantially by
19 doing a lot of services in the emergency
20 department or in an observation area that were
21 previously done in inpatient status. I think
22 that is worth a really hard look.

1 CO-CHAIR PITTS: Ellen?
2 MEMBER WEBER: I was just going to
3 say, regarding the question of boarding, I
4 wanted to make sure I understood, we are
5 talking about when does boarding start, not
6 what the harms of boarding are. And I think
7 that we need to keep that distinction clear.
8 I think, actually, the greater
9 harm is the lack of clarity about who is in
10 charge of the patient during that transition.
11 That is why the four hours is just awful,
12 because it is like, well, if you are not
13 boarding until four hours, who is in charge of
14 you?
15 We actually, I think, several
16 years ago had a Joint Commission inspection,
17 and they said, "Well, who is in charge of the
18 patient during that first couple hours?" We
19 really had to kind of sit down and decide at
20 what point does the admitting doctor actually
21 take over the care. So that, if there is a
22 problem, someone is in charge.

1 So, I think it is an argument for
2 making the time to begin the definition of
3 boarding short. It doesn't mean that boarding
4 for three hours is bad. It probably is, but
5 it is probably like, well, okay. But we
6 shouldn't allow a four-hour -- because we
7 don't want to penalize somebody on the other
8 end. Because the lack of clarity at the
9 beginning of the transition is the highest
10 quality risk.
11 And I would totally agree, I mean,
12 one other way to think about it is that, if
13 you are going to be put in the hospital, it is
14 true that there might be an alternative and we
15 get you home. Great. But that time could be
16 short because you are going to be in the
17 hospital; we don't have to do a whole lot of
18 stuff right now. Whereas, if you are going
19 home, you know, that might be a longer period
20 of time, and that is where our value-added is.
21 So, let's figure out where we can do something
22 versus where the hospital can do something.

1 CO-CHAIR PITTS: Emily?

2 MEMBER CARRIER: So, I think this
3 is just taking what Wes and I have been saying
4 one step further. I mean, what we have been
5 talking about in these matters today are
6 processes. So, are there outcomes that we
7 could identify that would capture what is bad
8 about boarding, what is bad about being stuck
9 in the ED for a long time, when the length of
10 stay is not being driven by specific clinical
11 issues that are being addressed as efficiently
12 as possible? Are there outcomes that could
13 capture this, so we are not stuck with this
14 blunt instrument of processes?

15 CO-CHAIR PITTS: Patient
16 satisfaction?

17 Jay?

18 MEMBER SCHUUR: So, a quick
19 response to Wes, I think the answer is not to
20 not measure these processes because, still, at
21 many hospitals the performance on these, it is
22 not where we think it should be, and it is

1 just not visible within the hospital
2 administration.
3 I think the answer is to develop
4 measures for the examples you give. So, if
5 there are measures for how we care for
6 transitioning older adults to home, and have
7 measures around that, then we can measure
8 those important pieces of care.
9 MEMBER FIELDS: I actually think
10 that is also the outcome question answer that
11 Emily raised. Ultimately, this stuff makes a
12 lot more sense in terms of actually improving
13 the quality of population health and reducing
14 cost if it is diagnosis-specific or condition-
15 driven. I don't think it is one-size-fits-all
16 anymore.
17 CO-CHAIR PITTS: Okay. Jesse says
18 he knows something about risk adjustments.
19 MR. PINES: Great discussion on
20 boarding.
21 Next, I want to talk a little bit
22 about risk adjustment and really how the data

1 should be reported. We did a paper a couple
2 of months ago in Annals that basically looked
3 at the previous NQF-endorsed measures in the
4 NHAMCS data and actually found that at the
5 hospital level there were actually a number of
6 exogenous factors that really went beyond ED
7 volume. For example, the case mix in the
8 emergency department and many other factors
9 were directly associated with the length of
10 the stay and the waiting time and a number of
11 other measures.
12 So, really, the question here is,
13 how should these data be reported? In the
14 current version of Hospital Compare and the
15 2008 measures, they recommended unadjusted
16 median as a way to report the data.
17 So, what I want to talk about next
18 is what sort of risk-adjustment methodology
19 should potentially be developed. Can we use
20 existing data? For example, one of the things
21 that they do in Canada, Canada reports data
22 using stratified by the CTAS score, which is

1 basically the triage criteria. In Canada, it
2 is basically required that everyone uses CTAS,
3 which is different in this country. There is
4 a lot of heterogeneity in the triage systems.
5 So, from the patient's
6 perspective, they come in, they spend five
7 hours in the emergency department. Regardless
8 of whether or not they go to a big, tertiary
9 care academic center or a small, rural
10 hospital, the prospect of reducing length of
11 stay in a big, tertiary care center may be
12 more difficult. So, essentially, that is why
13 the recommendations are basically as written.
14 The current version says that both unadjusted
15 and adjusted data should be reported. In
16 order to report adjusted data, however, there
17 would need to be the development of some
18 validated risk adjustment methodology, which
19 does not yet exist, or alternatively,
20 potentially make a recommendation about maybe
21 some sort of standardization of triage
22 classification.

1 CO-CHAIR PITTS: Suzanne, you are
2 fixing to hit the button? Do you have
3 something to say? No? Oh, I'm sorry.
4 Yes, Jay?
5 MEMBER SCHUUR: So, I would
6 suggest, my comment here is I would suggest,
7 rather than risk-adjusting, just reporting
8 stratified data. It is maybe just sort of
9 semantics, but rather than adjusting the
10 actual numbers, just make people report it
11 based on whatever metric you are going to
12 stratify by, because I think it is going to be
13 very difficult to truly risk-adjust.
14 And the second comment is I would
15 not recommend using a triage criteria to do
16 that because I think there are a lot of
17 operational improvements that have essentially
18 gotten rid of triage. Either it means people
19 have to use traditional triage or the data you
20 are going to get is actually not particularly
21 important.
22 MR. PINES: Yes, and also, just to

1 clarify the stratification, we actually tried
2 to create a simple stratification system.
3 What EDBA uses is just is it volume-stratified
4 in like 20,000-visits-per-year categories.
5 And essentially, what we found was that that
6 is predictive of length of stay in other
7 measures, but actually doesn't capture even a
8 fraction of the variation. Actually, the case
9 mix was more important.
10 CO-CHAIR PITTS: Yes. So, I was
11 really excited by that. What might you use
12 instead of triage category? Have you
13 considered actual potential things?
14 MEMBER SCHUUR: I would suggest
15 visit volume and case mix index or some
16 measure of disease acuity. I think it is
17 going to be tough to get, from the datasets we
18 have now, to get severity.
19 But I wouldn't want to overadjust
20 because I think this whole issue with hospital
21 readmission or all these things, how much do
22 is the hospital on the hook for these

1 processes? My personal bias is that hospitals
2 should be more on the hook than we should
3 risk-adjust for patient factors.
4 CO-CHAIR PITTS: I'm sorry. Case
5 mix index, is that a formal term? I don't
6 know what it means. Or what is that?
7 MEMBER SCHUUR: I mean, there is a
8 formal CMI classification that is used in
9 calculating Medicare rates and other things.
10 So, that is one method that can be used.
11 CO-CHAIR PITTS: AnnMarie?
12 MEMBER PAPA: And I was going to
13 ask you about that as well because the CMI for
14 the hospital is the hospital CMI. Depending
15 on what your admission rate is from the ED, it
16 could really fall through.
17 How about your facility code,
18 which is really how your facility is billing
19 for the acuity of care that you are providing
20 in the emergency department as opposed to your
21 triage rate? That probably is a better
22 measure of exactly what resources that the

1 patient used.

2 I mean, I think CMI is fine, but
3 in a hospital like ours at Penn we have a high
4 CMI, but we have a lot of cardiac surgery. I
5 rarely see those cardiac surgery patients in
6 the ED. So, just a thought.

7 CO-CHAIR PITTS: And it is only
8 CMS patients, right, or everybody?

9 MEMBER PAPA: Only CMS patients
10 for -- CMI is your Medicare reimbursement.
11 That is how Medicare --

12 CO-CHAIR PITTS: So, it is only
13 calculated from the Medicate patients?

14 MEMBER PAPA: For that. But your
15 facility codes, every patient in the emergency
16 department has a facility code.

17 CO-CHAIR STONE-GRIFFITH: I think
18 in some places now the facility code is
19 probably only -- while it may be consistently
20 applied, it is probably only 40 percent of the
21 story. I think some of the other folks have
22 used the physician E&M code for that very

1 reason, because the hospital is only 60
2 percent of the HCPC. But you can't get to
3 that.
4 CO-CHAIR PITTS: Ryan?
5 MEMBER MUTTER: One thing you have
6 got to watch out with CMI, too, is that
7 critical access hospitals, of which there are
8 1200, don't have it. So, you may end up
9 having to be a bit more blunt and use hospital
10 characteristics, sort of teaching status and
11 things like that.
12 CO-CHAIR PITTS: Jay? Oh, I'm
13 sorry. Brent?
14 MEMBER ASPLIN: So, is this recent
15 thread in an effort to do a stratified cohort,
16 use cohorts to report the data? Or is this
17 thread to actually stratify it at an
18 individual patient level? Because I agree
19 with Jay.
20 MR. PINES: So, again, just to
21 clarify what we did, we actually tried to
22 create a simple stratification system with

1 NHAMCS data that actually had and actually
2 used the reason for visit, common reason for
3 visit classifications as proportions to
4 basically see what really drove performance on
5 these measures, and actually found that there
6 were so many factors that were independently
7 predictive that, unless we made the strata
8 tiny, there was really no simple
9 stratification system, which is sort of the
10 reason why I think really the next step is to
11 come up with some sort of a valid risk
12 adjustment methodology that really takes into
13 account factors that the hospitals can't
14 control.
15 One of the things that we have in
16 the report that is predictive of performance
17 is things like percent Medicaid and percent
18 Black and other minorities. Essentially, in
19 our recommendation, those would not be
20 actually in there. It would be more issues
21 like a case mix, the MSA, ED volume, and
22 things like that.

1 But that, in the final reporting,
2 just to make it understandable for patients
3 and consumers, that you would both see the
4 adjusted and the unadjusted data.
5 MEMBER RAPP: This is Mike Rapp.
6 Could I just make a couple of points about the
7 risk adjustment of these?
8 Hello? Can you hear me?
9 CO-CHAIR PITTS: Yes, go ahead.
10 MEMBER RAPP: Oh, I'm sorry.
11 Well, I guess there are a couple
12 of points. We are talking here more about the
13 regional aspect or the system aspect. So,
14 when you talk about risk-adjusting, I think
15 one of the points we made on a preliminary
16 conference call for this was, if there are
17 factors that are, quote, "predictive," it
18 would seem it is the hospital's job to try to
19 deal with those factors. In other words, you
20 put on more resources to deal with patients or
21 particular types of patients and that sort of
22 thing.

1 To risk-adjust it, so to speak,
2 means that you basically will disguise the
3 results of what is the amount of time that it
4 takes to accomplish one thing or another. So,
5 studies, and so forth, that connect up worse
6 outcomes with crowded situations, it is not a
7 risk factor for the patient. You don't think
8 in those terms. You think of do whatever is
9 necessary to be able to expeditiously take
10 care of things. So, I am just generally
11 opposed to the idea of this.
12 And secondly, when you do that, if
13 you are talking about at a regional level, I
14 think where you risk-adjust like this, you
15 think in terms of, well, the hospital, and so
16 forth. Although these are hospital measures,
17 we are trying to think about how do you roll
18 them up, but at a system level.
19 So, I just wanted to make those
20 points. And then, I heard the discussion
21 about how do you define what the decision to
22 admit is, and I haven't necessarily followed

1 this. But, generally speaking, when CMS
2 implements measures, the specifications of the
3 measure make clear what the factor should be.
4 Now, apparently, it may not be clear enough,
5 and that could be worked on. To me, it would
6 be the admission order, but somebody said
7 that, apparently, some CMS documents may
8 suggest that it shouldn't be that. But I
9 think it is worthwhile to try to pin that
10 down.
11 Certainly, in the hospital
12 measures in general, CMS has meetings with the
13 Joint Commission virtually every week. When
14 people raise questions about this, they make
15 an effort to answer them and, ultimately, come
16 up with more specifics as to how you should
17 approach those sort of definitional problems.
18 CO-CHAIR PITTS: Ellen?
19 MEMBER WEBER: What I thought, I
20 see risk adjustment as sort of
21 counterproductive to do what we are trying to
22 do here, which is to make sure that everybody

1 gets the same level of care. Although I
2 believe there are a lot of things out of the
3 hospital's control, this is actually a way
4 potentially for them to get resources. So, I
5 don't know what we would really be
6 accomplishing by risk-adjusting.
7 Of course, I am at a teaching
8 hospital, and part of me would like to say,
9 well, it is going to take us longer, but,
10 okay, maybe is there value to that? I don't
11 know. If there is no value to that, to the
12 patient, they should know that. Maybe they
13 want to be at a teaching hospital, and it is
14 going to take longer. But if they don't want
15 to be at a teaching hospital, maybe they
16 should go somewhere else. But don't tell my
17 CEO I said that.
18 CO-CHAIR PITTS: Yes, Brendan?
19 MEMBER CARR: And isn't there also
20 a distinction -- I mean, it seems to me that
21 risk, I echo what Mike and Ellen are saying
22 about the diagnostic side, right? But the

1 administrative delay to boarding that you
2 described before seems to me like absolutely
3 it shouldn't be risk-adjusted. We are
4 proposing risk-adjusting the entire length of
5 stay, right? But we all think that it takes
6 longer to work up a sick person. Are we okay
7 with the fact that it takes longer to find a
8 bed for a sick person? I mean, that feels to
9 me like a different animal. I get risk-
10 adjusted workup. I don't at all get risk-
11 adjusting placement.
12 MR. PINES: All right. So, I
13 think the broader question is, should a 10-bed
14 rural emergency department be compared to a
15 100-bed innercity public emergency department
16 as apples to apples? That is, I think, really
17 the question that we are talking about here.
18 And it is good that we are hearing a lot of
19 different opinions on that.
20 So, what I am hearing, is the
21 group thinking that we should not make a
22 recommendation for risk adjustment. Can we

1 take maybe a straw poll on how many people
2 don't want to recommend risk adjustment?
3 MEMBER CARR: Can I just ask, when
4 you say risk adjustment, it feels like a very
5 loaded word. So, that means comorbidities to
6 those of us who live in that world, how sick
7 the patient is.
8 You just gave an example of the
9 size of a facility, which is a different
10 animal, I think.
11 MR. PINES: Right. So,
12 essentially, in that risk-adjustment model it
13 could be something like ED volume; it could be
14 something like the case mix. If you have a
15 higher proportion, for example, of trauma
16 cases, maybe your overall length of stay would
17 be longer or shorter.
18 Essentially, what risk adjustment
19 does, it basically allows you to really
20 compare apples to apples. So, let's say you
21 a Penn would be compared to a Jefferson as
22 opposed to Penn being compared to a tiny,

1 little, rural hospital.

2 MEMBER CARR: Yes, but you don't

3 have to have them all in the model. You can

4 put in hospital factors and leave out patient

5 factors.

6 MR. PINES: So, essentially, we

7 are not making any recommendation about what

8 actually would go into the model, except for

9 in the current version of the report we think

10 that socioeconomic factors should not be in

11 that model. But, essentially, we would

12 recommend that some validated risk-adjustment

13 methodology in the current version would be

14 developed. But, essentially, the group could

15 make a recommendation about what actually

16 should go in there.

17 CO-CHAIR PITTS: Okay. This is

18 important. I think we should let everybody

19 speak.

20 So, Emily?

21 MEMBER CARRIER: I mean, this

22 might go into the process of developing a

1 validated risk-adjustment model, but the only
2 data point I have seen was the paper that I am
3 sure everyone is familiar with that came out
4 in JAMA a year or so ago, looking at length of
5 stay and comparing safety-net to non-safety-
6 net hospitals. And that didn't find a
7 difference.
8 So, although I agree, Jesse, that,
9 intuitively, comparing an urban hospital with
10 crazy sick patients and volume and lots of
11 issues versus a much smaller, suburban or
12 rural hospital intuitively seems wrong, the
13 only data point I have seen doesn't show that
14 there is actually a difference to be risk-
15 adjusted for.
16 MR. PINES: Yes, we published a
17 paper a couple of months ago in Annals that
18 used the NHAMCS nationally, tried to create a
19 simple stratification system. We were
20 actually not able to do it because there were
21 so many exogenous factors that did impact
22 length of stay significantly. It was a

1 different paper, yes.

2 MEMBER CARRIER: But, I mean, was

3 the outcome that certain classes of hospitals

4 had systematically longer lengths of stay that

5 you felt like --

6 MR. PINES: Yes. Yes, basically,

7 ED volume, MSA, teaching status, and,

8 actually, even more importantly, the case mix

9 based on the reason-for-visit classification

10 was a big factor.

11 MEMBER CARRIER: Okay. So, I

12 understand from your conversation before that

13 that those were lots of little factors. I

14 mean, for me to risk adjust for something, I

15 want to see something that applies very

16 broadly. I was understanding lots of little

17 factors contributing in different ways at

18 different levels to different hospitals.

19 MR. PINES: So, essentially, what

20 we initially wanted to do is basically take

21 the stratification system that is used by

22 EDBA. Our hypothesis was that it was all

1 going to come down something like visit
2 volume. So, essentially, you could do a
3 stratification system. But, essentially, what
4 we found was in the adjusted model, having all
5 those things in the model together were all
6 independent predictors. So, even after
7 adjusting for ED visit volume, case mix and
8 all these other factors were still very
9 significant.
10 MEMBER CARRIER: I mean, is there
11 anything unique about that data or --
12 MR. PINES: Yes. Yes, they were
13 very, very significant. So, essentially, even
14 adjusting for other factors -- we can send out
15 the paper -- but that, actually, case mix,
16 some of the case-mix variables were actually
17 a lot more important than ED volume.
18 CO-CHAIR PITTS: All right. So,
19 on the one hand, there is should we adjust at
20 all in principle, and the second, if we think
21 that you should adjust, is it even possible to
22 do so? So, you are saying, basically, it is

1 possible to do so. But another question is,
2 should we do it at all? Did I get that right?
3 Yes?
4 MEMBER WEBER: To Brendan's point,
5 which I think is a good one, do we do it for
6 all the measures or do we do it for some of
7 them? Because the issue of complexity, that
8 is a value-added. If I can do that and send
9 the patient home, that may be better than
10 having a short length of stay and admitting
11 them.
12 So, I think we have to think about
13 that is a real unintended consequence. So, I
14 back off a little bit on what I said. But I
15 think there are some measures, like the admit
16 time to bed, should be not risk-adjusted. But
17 the length of stay before that decision may be
18 risk-adjusted. But the time to providers
19 should not be risk-adjusted, because if you
20 just have that kind of caseload, you have just
21 got to get more providers or figure out your
22 system better.

1 MR. PINES: And just as a quick
2 comment, also, next we are going to talk about
3 time targets. The way that Canada does time
4 targets is actually by CTAS. They basically
5 have specifically time targets for specific
6 classes of patients. We don't have the
7 benefit of CTAS. So, I think if we did want
8 to do time targets, if we didn't one time
9 target like they had in the UK, we would need
10 some sort of risk-adjustment system.
11 CO-CHAIR PITTS: Arjun? And then,
12 Jay.
13 MEMBER VENKATASH: I know Michael
14 alluded to this earlier, but I am going to go
15 back to it for one second, which is the task
16 at hand to some degree was to think about the
17 implications of these measures for
18 understanding preparedness in regionalized
19 emergency care and that intersection. From
20 the perspective of that intersection, what we
21 are thinking about and what we are discussing
22 at hospital-level operational measures may not

1 necessarily inform that to the same degree.
2 What I am almost thinking is it is
3 very different thing to say what is unadjusted
4 boarding measured at a regional level. I
5 could see how that is a window into capacity
6 that we have on the inpatient side within some
7 form of community. And that could be very
8 helpful for understanding preparedness.
9 Understanding hospital-level
10 adjusted or unadjusted boarding may not really
11 inform that regional side at all and the
12 preparedness part of this equation at all.
13 So, I would almost say that, to some degree,
14 perhaps the recommendation is that you don't
15 measure at the hospital level, that it needs
16 to be measured at a regional level unadjusted,
17 because, then, you actually can say, okay,
18 within this community, we know that we have
19 long length of stay or we have high amounts of
20 boarding. And then, that community can use
21 that in terms of actually have something to
22 track.

1 Because I think if you adjust it
2 away, if you adjust away the characteristics,
3 you have lost the whole concept of what you
4 are trying to capture within a region, which
5 is the variability in terms of what kind of
6 capacity exists.
7 MEMBER SCHUUR: I agree with what
8 Arjun just said, and then I have one other
9 comment, which is I think it is important to
10 think about what the measures are used for,
11 for either public reporting or for
12 accountability and payment.
13 While I tend to think that we
14 shouldn't adjust away, definitely shouldn't
15 adjust away hospital factors, I also wouldn't
16 want to punish safety-net hospitals and under-
17 resourced hospitals, which may have the worst
18 outcomes, by implementing a measure that is
19 going to punish them for having long length of
20 stay. It would be the exact opposite
21 consequence than you would want from this, I
22 think.

1 CO-CHAIR PITTS: And being
2 relatively new to this, the NQF ultimately
3 attaches to CMS and becomes a -- there is a
4 sanction that applies, 1 percent of Medicare
5 reimbursement or something of that sort? No?
6 DR. BURSTIN: It is not nearly
7 that direct.
8 CO-CHAIR PITTS: Okay.
9 DR. BURSTIN: Not really.
10 Basically, all measures that are endorsed by
11 NQF, you know, the committees have deemed them
12 as being appropriate for a full range of
13 accountability applications, whether that is
14 public reporting or pay for performance. So,
15 there is a wide range of groups of
16 applications.
17 There is another group called the
18 Measures Application Partnership that also
19 works that helps say which measures are
20 appropriate for which program. But, again, we
21 do want to make sure that it is appropriate
22 for any of those accountability applications.

1 And again, this is where level of
2 analysis might be important. It is really
3 also endorsed measures for specific levels of
4 analysis. So, there may be some of these that
5 are at the provider level, and there are some
6 of these that may be at the system level.
7 Those are considerations that I think it would
8 be helpful for this group to think about as
9 well, if the bigger systems issues are really
10 what you are trying to drive to.
11 MEMBER TIMMONS: This is Shelly
12 Timmons on the phone. May I make a comment?
13 CO-CHAIR PITTS: Yes, go ahead.
14 MEMBER TIMMONS: I just wanted to
15 say, about the hospital-specific length-of-
16 stay issues with socioeconomics, and so forth,
17 it really does have a major downstream effect
18 on throughput from the ED and beyond, because
19 patient resources used in a given region are
20 going to necessarily affect a length of stay.
21 If you have a large population of
22 patients who don't have resources for home

1 care, rehab, or even family support in the
2 large trauma system, for example, the length
3 of stay is adversely affected. And that,
4 then, backs up the whole entire hospital and
5 system from a preparedness standpoint.
6 So, I don't necessarily think we
7 should completely discount hospital-based,
8 safety-net-hospital-type data because those
9 things do impact the care and preparedness of
10 the region.
11 CO-CHAIR PITTS: Thanks a lot.
12 Wes?
13 MEMBER FIELDS: Yes, if we are
14 working on the straw poll, I would not be in
15 favor of risk-adjusting for consumers. I
16 think, in that case, raw data about length of
17 stays, it has got to be something that they
18 deserve see unfiltered or unadjusted.
19 I think I agree very much with
20 Arjun that the same thing is true if we are
21 really serious about trying to move towards
22 status of a region, and how well all hospitals

1 perform collectively within the region.
2 And then, the final sort of
3 thumbs-down would be that, if this is a matter
4 of reimbursing hospitals, you don't want to
5 disadvantage safety-net facilities, although
6 I am not sure what that means anymore in our
7 Brave New World, but I am quite sure you don't
8 need to protect rural hospitals because they
9 will almost always look great on HCUPS and
10 great on length of stay. And that is the only
11 real benefit of having low volume through
12 their emergency departments.
13 MR. PINES: So, just to clarify,
14 the current way that the recommendations are
15 written is that both unadjusted and adjusted
16 data would be reported. So, at the level of
17 the region, I agree that I think in the later
18 discussion on regionalization, I think taking
19 these measures to the regional level and
20 creating some incentive for hospitals to
21 cooperate, to reduce systemwide boarding and
22 crowding, I think are important.

1 But I think that we do lose a lot
2 of information just by reporting unadjusted
3 data. Particularly, certainly from the
4 perspective of knowing how a hospital is
5 doing, you are sort of are able to better
6 compare apples to apples, and it doesn't
7 uniformly make the small hospitals, rural
8 hospitals look better. Because, just by the
9 nature of their size and the way they are set
10 up, it is a lot easier to have a shorter
11 boarding time when you have got five or ten
12 beds in the ED and 20 beds in the hospital.
13 And also, when we move on to talk
14 about time targets, I think that without that
15 risk-adjustment methodology, we would not
16 really be able to any sort of stratification.
17 CO-CHAIR PITTS: Great. It looks
18 like we have exhausted the risk
19 stratification.
20 So, let's go on to time targets.
21 Ellen is the received expert here.
22 The recommendation states,

1 "Quality measure developers should consider
2 setting time-specific recommendations for
3 unadjusted or adjusted measures of ED crowding
4 and boarding." Pros and cons of that?
5 I think it has been abandoned in
6 the UK. No?
7 MEMBER WEBER: I will speak to
8 both the pros and the cons, I guess, because
9 I am fairly familiar with it.
10 So, the four-hour target went in
11 2004, kind of graduated to the point that 98
12 percent of patients needed to be out of the
13 emergency department in four hours. The 98-
14 percent figure came from the government.
15 Actually, the emergency physicians wanted it
16 to be 95 percent. So, the idea is that 5
17 percent of patients would be exempted from
18 this. So, the sicker people, or whatever, you
19 would have 5 percent of those patients did not
20 need to meet those targets.
21 Just sort of in the background,
22 what this really did for the emergency

1 departments was they created clinical decision
2 units. So, the patients they wanted to keep
3 longer who had sort of a clear-cut diagnostic
4 pathway, like chest pain or cellulitis, or
5 whatever, they kept them in the clinical
6 decision unit. They were off the clock; they
7 went home. So, what it really did was force
8 the hospitals to find beds for the patients
9 that needed to be admitted.
10 In 2010, when the Labor government
11 was voted out of office, the new government
12 came in. And part of this was to undue what
13 Labor had done. That is the UK way.
14 But, also, they were concerned
15 that the focus on time was taking away focus
16 from quality. So, what they did was they said
17 we are going to have a dashboard of measures.
18 One of them will be the time in the
19 department, and the four-hour target was
20 reduced to 95 percent. But it is not the kind
21 of cutoff it was where everybody comes
22 charging into your department and says, "We

1 are not going to meet it this quarter," and so
2 forth. So, it is one of their quality
3 measures now.
4 And there really wasn't a lot of
5 evidence one way or the other for whether it
6 was bad. In fact, we are about to release a
7 paper that shows, at least from the
8 administrative data, that there was not an
9 increase in admissions, not an increase in
10 resources.
11 But one of the things we weren't
12 able to do is follow like the patients who got
13 admitted and have been just sent to some ward
14 because it was the only available place.
15 The upside was that the admitted
16 patients got beds. The EDs were far less
17 crowded. They also got a lot of resources, as
18 the hospital did, to either redo their
19 processes or build, or whatever. So, there
20 was some money involved, at least at the
21 beginning, although not later on.
22 The patients for the most part

1 have really liked it and have said, "This is
2 great." In fact, there was some concern that
3 patients would like it so much that they
4 wouldn't go to see their GPs.
5 The downside was, the potential
6 tension from the emergency care was having a
7 sick patient who really shouldn't go upstairs
8 and kind of thinking, well, is this going to
9 be my 99th-percent patient that I really can't
10 allow to stay down here? So, there was a lot
11 of pressure, and the physicians were able to
12 kind of say, "You know, this is more important
13 than the target, and I am going to keep the
14 patient here."
15 But that did create a lot of
16 stress in the departments, a little bit, not
17 a lot, but there was some degree of the rest
18 of the wards were resentful of the emergency
19 departments because they thought they were
20 getting all this money, and they had their own
21 targets, and so forth.
22 But, for the most part, I would

1 say it worked to get rid of crowding, and it
2 doesn't seem to have been a negative effect.
3 It is a very blunt instrument, but, on the
4 other hand, it is an instrument that is pretty
5 easy to put in, and people manage to make it
6 work. And I think they made it work to the
7 benefit of the patient.
8 CO-CHAIR PITTS: So, I think I may
9 have created a scenario in my head that
10 explains how it happened, and it is probably
11 incorrect. And that is that they massively
12 expanded the obs capacity. Did that happen at
13 all?
14 MEMBER WEBER: Yes. Actually,
15 that is a good point. Many departments had
16 these, but those who didn't started to expand
17 what they called their clinical decision
18 units. So, they basically kind of did what we
19 are talking about doing here anyway, which is,
20 for other reasons, to expand your observation
21 capacity, so that people don't have to be in
22 the hospital. Their observation units were

1 mostly ED-run, but some of them were run by
2 their internists to move people in and out
3 fairly quickly.
4 CO-CHAIR PITTS: Don't they have a
5 specialty called acute care medicine which
6 is --
7 MEMBER WEBER: Yes, they do, yes.
8 Well, it is sort of a fledgling -- it is a
9 little bit different. The clinical decision
10 units were largely run by the emergency
11 physicians, and they would take the chest --
12 those were the people who they said had a low
13 risk of a high-risk condition. Okay? So,
14 that is where they would observe their head
15 traumas, and so forth.
16 The acute physicians work in
17 something called the admission assessment, no,
18 the admission unit -- or, no, I forget what it
19 is called -- the admission assessment unit.
20 It was a medical assessment unit and a
21 surgical assessment unit, but they are
22 actually admission units where there are acute

1 physicians whose job is to sort them out, get
2 them through all the testing, figure out
3 whether they can go home in 23 to 48 hours, or
4 whether they need an "ology". You know, do
5 they need a specialist now and need to move
6 upstairs to one of those wards?
7 CO-CHAIR PITTS: Brent?
8 MEMBER ASPLIN: So, I would
9 suggest one intermediate step to having a
10 static target would be just going back to the
11 measures from 2008, and I think you talked
12 about it on the call that I was not on, and
13 reporting not only median, but 90th
14 percentile. And the data would really start
15 to shine a light on how skewed the data are
16 and where the performance is when the wheels
17 are coming off versus just the median.
18 If I had it to do over again --
19 that suggestion was made about a week after
20 our meeting -- I wish we had done that. I
21 think median is helpful, but just median and
22 90th rather than a static target. Plus, I

1 mean, who are we kidding? Politically, there
2 is not going to be a static target in this
3 country anytime soon.
4 MR. PINES: Just to clarify, in
5 the next section, I think Recommendation 8
6 does talk about the median and the 90th
7 percentile. But let's make sure we also talk
8 about time targets and beyond the politics.
9 Is this something that we want to recommend to
10 measure developers?
11 CO-CHAIR PITTS: Emily?
12 MEMBER CARRIER: I just had a
13 question for Ellen, thinking about how the UK
14 experience might not bond to the U.S. When
15 patients were admitted to the clinical
16 decision unit -- like let's say I was a
17 patient who, prior to four-hour time target,
18 would have spent a really long time in the ED
19 having various things done, and now I am sent
20 to the clinical decision unit at 3 hours 30
21 minutes. Is there an additional charge in the
22 same way an obs admission would carry an

1 additional charge for the patient?
2 MEMBER WEBER: Because it is the
3 NHS, I don't think there is any specific
4 charge. What I understood, the way it works
5 is the acute care hospitals contract with the
6 primary care trusts, and they basically
7 classify their patients as either simple or
8 complex. If they are complex, the hospital
9 gets a certain payment for them. If they are
10 simple, they get a different payment.
11 So, anybody, basically, who went
12 into the CDU was likely to be a complex, but
13 so would be an admission. Or it would be
14 somebody who got everything done in the first
15 three hours, who had a fairly complicated
16 history of abdominal pain, had a consultant,
17 went home.
18 MEMBER CARRIER: Okay. So,
19 sending someone to obs in the U.S. would have
20 different implications in terms of resource
21 use than, it sounds like, in the UK in terms
22 of --

1 MEMBER WEBER: Well, it is an
2 interesting question. I guess, yes, I mean,
3 sending somebody to obs rather than just
4 keeping them in the ED might, if you have an
5 observation unit set up with separate billing.
6 The question is, there are a lot
7 of issues there because you have to be there
8 a certain amount of time. You have to be
9 there overnight for anybody to make any extra
10 money. So, it would really be more likely
11 that a hospital might want to do that to avoid
12 the readmission issue, to avoid unnecessary
13 admissions they are not going to get paid for,
14 where they would sort of provide strategic
15 support, shall we say, for that observation
16 unit, even though they couldn't bill
17 separately for it.
18 But a lot of places do bill
19 separately. They have figured out how to do
20 it. It is still much less expensive overall
21 for the healthcare system, yes.
22 CO-CHAIR PITTS: So, in the U.S.,

1 if you have obs patient, they don't generate
2 a second H&P to the ER obs? They just
3 generate a discharge fee, basically, I think.
4 Whereas, when I was in New Zealand they had an
5 obs unit, and all the medicine obs patients
6 got a second H&P the next morning when they
7 made rounds. It was nice to be on that
8 service because it was always morning rounds.
9 Whereas, in an ER obs situation, you might
10 discharge somebody at night.
11 So, there was a little bit of
12 qualitative difference between an ED admission
13 to obs versus the UK model obs admission, at
14 least in my brief experience.
15 MEMBER WEBER: Well, you are
16 talking about the UK obs admission where the
17 ED kept the patient was different than the obs
18 where you were on a separate service that
19 rounded on them the next day, right?
20 CO-CHAIR PITTS: Although where I
21 was, it was mixed together geographically,
22 yes.

1 MEMBER WEBER: Yes. Well, who was
2 in charge is the question.
3 CO-CHAIR PITTS: Five beds for ER,
4 15 for the inpatients.
5 MEMBER WEBER: Yes. Okay. So,
6 when you have a single payer, it is very
7 confusing.
8 (Laughter.)
9 CO-CHAIR PITTS: Yes. And we were
10 always trying to get one of their beds for our
11 patients.
12 Wes?
13 MEMBER FIELDS: Yes, I think this
14 is more like measure development, but I think
15 it is worth trying to think through what the
16 crosswalk would be. I think it would be
17 fairly straightforward, but a lot of it does
18 require measurement in terms of what is most
19 cost-effective and what is going to do the
20 best in terms of outcomes for patients by
21 diagnostic category.
22 But I think the ED-oriented

1 observation would figure to be shorter stay,
2 more intensive, probably more imaging or more
3 ancillary. But what is the right length of
4 stay for that category? What are the right
5 set of diagnoses?
6 The thing that I think is maybe
7 the most nuanced about this is what they call
8 acute care medicine in the UK, we would call
9 a hospitalist service. What is interesting to
10 me about that, thinking about the whole first
11 contact care/primary care debate in terms of
12 acute care continuum problems, is that it
13 would be an internist by training, but it is
14 certainly not the primary care physician and
15 it is certainly not a provider who is based in
16 the community. They likely practice full time
17 in the hospital. I think the argument would
18 go in the American system that makes them more
19 efficient and probably a little bit more
20 rapid.
21 But I think it is worth beginning
22 to figure out the measurements, both in terms

1 of cost and outcomes, about when aggressive
2 short-stay observation that is ED-oriented is
3 appropriate and when that 24-hour-plus thing
4 comes into play, that it is more likely to be
5 done in an inpatient setting where the
6 hospitalist is the primary provider.
7 And I see both of those things as
8 an important part of that gray scale that
9 falls short of the statutory three-day stay
10 for a Medicare inpatient. I think these are
11 really worth understanding and measuring, even
12 though they are probably a little bit beyond
13 the scope of what we are doing today.
14 CO-CHAIR STONE-GRIFFITH: Ellen, I
15 remember you speaking about this before. In
16 my mind's eye, I almost see a third door that
17 people are now coming through that is not the
18 emergency department. It is a place where
19 they get those fact-track services. They get
20 treated and assessed rapidly, but it is not
21 always the ED.
22 So, it speaks to who gets observed

1 out of the ED as someone who comes through
2 that ED, and we need to spend that time,
3 versus now a different portal altogether.
4 MEMBER WEBER: Just to speak to
5 that, that is somewhat what happened there.
6 This acute assessment unit that was run by the
7 internists, hospitalists, whatever, was
8 another entry into the hospital. Some places
9 a GP could call up and send their patient to
10 actually a unit that was nurse-run. They
11 would say, "I want you to do this test and
12 this test and this test, and then I want you
13 to call this consultant." And that was even
14 separate from this other.
15 But it was a way of bypassing in a
16 good way the emergency department when a
17 doctor wanted to keep control of what was
18 happening with the patient, wanted to hear
19 directly back from the consultant, didn't just
20 turn them loose over to the emergency
21 department. And then, if they needed to be
22 admitted, they didn't go to the emergency

1 department to then get admitted. They got
2 admitted through the acute assessment unit.
3 And that is a big issue, I think,
4 that we haven't talked too much about here in
5 terms of the input, is the difficulty now that
6 a lot of people are having figuring out a way
7 to directly admit patients to the hospital
8 without using the ED, because our systems are
9 so dysfunctional.
10 MR. PINES: Also, I just want to
11 clarify and I want to make sure I am getting
12 the right read on this particular
13 recommendation, because it sounds like there
14 could be some unintended consequences of using
15 time-based standards.
16 I think there are a lot of
17 different ways to do time-based standards.
18 And we wouldn't be really saying that we would
19 have to follow the UK model, you know, four
20 hours and 98 percent, but that, broadly, we
21 would make a recommendation that time-based
22 standards could be potentially meaningful.

1 I think that we could write that
2 in the reports in such a way that we could
3 recommend time-based standards, but say that
4 that would be basically up to the measure
5 developer.
6 MEMBER WEBER: I would agree. I
7 think even though the UK took away the four
8 hours, they would have been happy, the ED
9 physicians would have been just keeping it at
10 four with the 95 percent. And we clearly know
11 now New Zealand and Canada are picking this
12 up. So, I think the trend right now is
13 towards people having these targets, not
14 shying away from them. And those are more
15 nuanced.
16 CO-CHAIR PITTS: Brent?
17 MEMBER ASPLIN: Yes, if we were
18 going to move in time-based standards, I would
19 be more open to it on just the boarding time,
20 the 497 measure, given the changing role of
21 what we are doing from a diagnostic
22 standpoint, the time we are going to be

1 spending looking at alternatives to admission,
2 et cetera. That might be a place to start, is
3 in that aspect of the overall measure,
4 provided the gaming issue could be addressed,
5 to the extent there is one.
6 CO-CHAIR PITTS: Was there a lot
7 of use of the obs unit for getting a CT scan?
8 MEMBER WEBER: Actually, no,
9 because they do very few CT scans.
10 (Laughter.)
11 They do zero abdominal CT scans.
12 MEMBER ASPLIN: I think they
13 observe instead of scan.
14 MEMBER WEBER: Actually, the thing
15 about resource utilization, including obs unit
16 patients did not go up. In other words, they
17 didn't throw them into the obs unit and then
18 order a CT scan. They threw into the obs unit
19 truly to observe.
20 They actually are very anti-labs.
21 You know, you don't go into the abs unit just
22 to get your labs back. You do it to get your

1 treatment for your cellulitis, for your
2 Tylenol overdose, or whatever. You follow an
3 algorithm, and so forth.
4 So, yes, there was not quite so
5 much what you were going forward with.
6 CO-CHAIR PITTS: So, boarding
7 sounds like a good interval.
8 MEMBER WEBER: And I agree, I
9 think boarding is a great way to start this
10 because it is exactly what we were getting at
11 earlier, which is we don't want to penalize
12 the complex workup. That is what these CDUs
13 in England did. They just gave the EDs an
14 opportunity to do the complex workups they
15 were doing anyway. But what we do want to
16 penalize is the long evaluation period after
17 the ED has now done a three-hour workup.
18 CO-CHAIR PITTS: Recommendation 7
19 touches really on the same topic, but putting
20 in the added element of standardizing by
21 triage acuity. I assume that what that means
22 is that it is four hours, depending on your

1 circumstances. I am not sure I understand the
2 intend of that recommendation.
3 MR. PINES: Sure. So, this was
4 actually something that came up on one of the
5 first Work Group calls, where the Canadian
6 system basically stratifies by triage acuity,
7 where the more serious patients should stay
8 longer. I think it is eight hours versus the
9 more minor patients can stay four hours.
10 In order to do something similar
11 here, we would need either our own risk-
12 adjustment system or, alternatively, to
13 recommend a standardized triage system. We
14 know that ESI triage is the triage scale that
15 is most commonly used. That is not used
16 everywhere.
17 In order to truly standardize by
18 triage scale in this country, we would have to
19 make a recommendation that hospitals that are
20 not on ESI, or whatever triage scale we
21 recommend, would move to that. So, that was
22 the source of this recommendation.

1 CO-CHAIR PITTS: AnnMarie?

2 MEMBER PAPA: You know, I agree on

3 a standardized triage score, absolutely. But

4 I can say, from a nursing perspective --

5 please don't shoot me -- but some nurses, when

6 we are triaging, we consider who the provider

7 is in the back.

8 (Laughter.)

9 And we know Dr. Smith is going to

10 order two tests and move the patient, and Dr.

11 Jones is going to keep them there for eight

12 hours and do Q one-hour testing and get serum

13 porcelain levels on every patient. So, we

14 take that into consideration. There is a lot

15 of subjectivity with that.

16 Plus, within the nursing -- and we

17 have to own this as well -- some of the nurses

18 are much better at making that prediction

19 because they have got a little bit more

20 experience. Certain hospitals you can triage

21 after being there for six months. Our place,

22 you have got to be there two years before you

1 triage. So, there is a lot of that
2 interrelated piece with the nurses as well.
3 So, I would really tend to look
4 more at another score. I don't know. Prefer
5 the other nurses in the room to speak up. But
6 sorry.
7 CO-CHAIR PITTS: It is a real
8 issue. In Australia, I think everybody gets
9 a score, right, and they actually tally that
10 and see how compliant you are with those time
11 intervals.
12 But I agree with you. And I guess
13 it was you, Jay, who was saying that, who
14 needs to triage? Wasn't that you? I think it
15 was.
16 (Laughter.)
17 On the other hand, we would love
18 to have some sort of national standard of
19 severity classification. It would be really
20 important to compare.
21 But, anyway, Ryan, you have
22 something?

1 MEMBER MUTTER: I am not a nurse,
2 but the economist's perspective, ESI tends to
3 take on an institution-specific meaning. A
4 lot of times what you see happen is the
5 average severity in an institution is a 3.
6 But a 3 in one institution is not comparable
7 to a 3 in another. So, just something to
8 watch out for.
9 CO-CHAIR PITTS: Yes, I have
10 looked at heart rates. You know, that is
11 objective. It varies a bit.
12 Yes?
13 MEMBER PAPA: And I just wanted to
14 say, I don't know, I don't have as much
15 experience with the CTAS method, so I am not
16 sure that that is quite as subjective, for
17 those of you who may have had the opportunity
18 to work with it, I don't think that is quite
19 as subjective as the ESI, just from my limited
20 experience with it. I don't know.
21 MR. PINES: There actually have
22 been some studies looking, comparing ESI to

1 other time-based triage systems. And
2 actually, ESI is the most reliable system, but
3 that doesn't get at Ryan's issue, which is the
4 between-hospital differences. But, basically,
5 within a hospital, when they tested, ESI is
6 more reliable than other triage scales in
7 terms of just inter-rater reliability, one
8 person saying what is a 3 or a 2.
9 CO-CHAIR STONE-GRIFFITH: Wes?
10 MEMBER FIELDS: Just something
11 quick and obvious. Acuity and length of stay
12 don't always correlate. A patient walks
13 through the front door with chest pain, and
14 EKG data is obtained within five minutes. A
15 STEMI is present. The patient is in the cath
16 lab in less than 30 minutes.
17 So, I don't think you want to feel
18 good about that patient being in the
19 department for three hours because somebody
20 forgot to do the EKG or they thought it was a
21 stomachache.
22 MR. PINES: Well, you know, I

1 think the other that would dependent in this,
2 if we do recommend time-based measures and do
3 want to have some sort of a stratification
4 system, the benefit of having that by triage
5 level, and essentially why I think that is by
6 triage level in Canada, is that the physicians
7 and providers actively taking care of the
8 patient sort of know what the target is for
9 that individual upfront rather than after the
10 fact.
11 So, if we did some sort of a risk-
12 adjustment model and we said you should have
13 been in the ED six hours, the providers may
14 not know that until later. So, I think the
15 benefit of having some sort of triage
16 classification, actually, there is sort of
17 active knowledge, when that patient is in the
18 ED, how long they should be there.
19 CO-CHAIR PITTS: Jay?
20 MEMBER SCHUUR: The first concern
21 I have about the triage as a standardization
22 is just the fact that a lot of operational

1 improvements in many EDs are sort of getting
2 rid of it. So, I think it is sort of already
3 outdated, the idea that everyone is using it.
4 But second is I am all for finding
5 a risk stratification mechanism to look at an
6 accurate thing. I think that is in the
7 research realm right now. There is not a good
8 one for the ED with datasets we have
9 available.
10 But I would be concerned, if you
11 think about value and cost, which we all
12 should be thinking about, that it will bake,
13 if you use the triage example, it will bake in
14 the overuse we are all doing. And so, if we
15 are doing way too many CT scans already, and
16 you build in the adjustment for abdominal
17 pain, and say abdominal pain patients should
18 be there for "X" number of hours, it sort of
19 adjusts that into the system. And so, I would
20 not encourage that.
21 CO-CHAIR PITTS: Okay. There is
22 another? I'm sorry. Ellen?

1 MEMBER WEBER: I would like to
2 just reiterate again about the boarding thing
3 is really what the time target dealt with.
4 And so, we would not need to use any kind of
5 risk adjustment for a boarding time target.
6 That is the thing I agree with Brent, that
7 that would be a very good recommendation
8 because it is really what all of these targets
9 have been about. It is not about getting the
10 ED physicians to work faster, and they will
11 become that if we don't make it very clear as
12 to what part of the system we are really
13 doing. Yes, there is a lot of overuse, and we
14 need to work on that, but I am not sure that
15 is the issue we can address this way with a
16 time target.
17 CO-CHAIR PITTS: Okay. Oh, more?
18 Yes. Arjun?
19 MEMBER VENKATASH: I think one of
20 the challenges I have with this concept of
21 adjustment is, if it is meant to either
22 describe capacity on the preparedness side or

1 if it meant to drive a lot of improvements,
2 the problem with adjustment is you can improve
3 adjusted times, but those aren't real minutes.
4 So, it only helps, I think, with
5 an institution-to-institution comparison,
6 which I think is right now kind of, as I
7 alluded to, much more of interest from a
8 research perspective, understanding patterns
9 of utilization and care like that, but from a
10 perspective of, what do I do with those
11 numbers?
12 A patient certainly can't use an
13 adjusted time. I don't think even a
14 department itself knows what to do with our
15 adjusted length of stay is or our adjusted
16 boarding time is two hours and four minutes
17 versus our unadjusted time is two hours and 40
18 minutes. What does that mean?
19 What do you know is, if your
20 unadjusted time is two hours and 40 minutes,
21 you could put in place certain improvements or
22 try to understand how that changes with

1 certain improvements, but understanding how
2 adjusted time improves in the setting of
3 improvement I think is pretty useless at an
4 operational level right now.
5 So, I think from that perspective,
6 for all of these, leaving them unadjusted to
7 me just seems to make more sense for actually
8 being able to track this and make it
9 meaningful over time.
10 And I think the other thing I was
11 going to say is that this, to some degree,
12 kind of wraps into the discussion we were
13 having above. So, I don't know if maybe
14 combining the recommendations or putting them
15 somehow together just smooths it out. That
16 was Brendan's idea.
17 CO-CHAIR PITTS: Okay. Actually,
18 the adjustment bit, I mean, the way I have
19 encountered that problem is when my hospital
20 says, "Oh, we are at the bottom of this
21 ranking. We don't want to be here. It is
22 because we have sicker patients." I mean, I

1 am sure that UHC has that problem. That is
2 where we always are compared to other
3 hospitals within UHC. The answer to our
4 failures is always it wasn't properly
5 adjusted.
6 MEMBER VENKATASH: But even when
7 it is adjusted, you will still say it is not
8 properly adjusted.
9 (Laughter.)
10 CO-CHAIR PITTS: That's true.
11 Okay. Was there another? Okay.
12 Let's go on to the next one. That is measures
13 of central tendency, median versus et cetera.
14 We have already heard that the 90th percentile
15 was maybe a better choice.
16 Anybody have any comments about
17 that?
18 I will just have a pointy-headed
19 comment and apologize for making it. If you
20 are in a small ER like when we used to work at
21 Emory University Hospital, it was a tiny
22 place. It used to be called "treatment room".

1 And you know that you didn't sleep all night
2 or you would have a disastrous night.
3 So, if you have a very small
4 volume, your chances of getting that to the
5 90th percentile are higher than they are at
6 Grady, which is tons of patients and the 90th
7 percentile won't bother you at all.
8 So, there is a difference, that
9 P9-to-the-P50 ratio will vary depending on
10 your sample size. I don't know if that is
11 really important clinically, and I am not sure
12 it has been looked at. I don't think it has.
13 It is just one thought that came to mind as I
14 was looking at the data and thought maybe HCUP
15 could address that at some point. But that is
16 truly a pointy-headed comment. Sorry.
17 Any other comments about medians
18 versus geometric means versus any other
19 measure of central tendency?
20 MEMBER McCARTHY: Is that what you
21 mean, Steve --
22 CO-CHAIR PITTS: I am not sure

1 what I mean. I think that it is pretty
2 obvious why you shouldn't use the mean,
3 because of extreme values on the right side of
4 the distribution. So, the median would be
5 more reasonable.
6 But Brent was making the comment
7 that the place where you struggle might be
8 when you are really crowded. So, the P90
9 would be, the 90th percentile would be a more
10 useful value for you to report.
11 Did I get that right, Brent?
12 MR. PINES: Right. Sort of the
13 thinking is that just the median value. So,
14 meaning the hospital on their average day is
15 very different than this whole flexibility
16 issue; measuring the hospital on their worst
17 day, how do they perform?
18 MEMBER McCARTHY: And I think it
19 is true, Steve, that smaller hospitals have
20 less ability to absorb surge, because they are
21 smaller, than large hospitals do. That is
22 just kind of naturally -- that has been shown

1 statistically.

2 CO-CHAIR PITTS: Any other

3 thoughts about central tendencies?

4 (No response.)

5 Okay. I am sorry, I don't know

6 what the next point, Recommendation 9, exactly

7 means. Maybe, Jesse, you can talk about that.

8 MR. PINES: Sure. So, the

9 thinking behind Recommendation 9, there have

10 been some specific ways to structure the

11 emergency department that have been associated

12 with differences in length of stay.

13 For example, having a fast track,

14 physician in triage, there is a fair amount of

15 literature around that. And there are some

16 other things that some hospitals would call

17 best practices.

18 And our recommendation here would

19 be for those structural elements that have

20 been associated with differences in length of

21 stay or performance or quality, that those

22 could potentially serve as structural quality

1 measures for crowding.
2 MEMBER FIELDS: So, the concept
3 would be voluntary reporting if they are
4 participating in one of these alternatives?
5 MR. PINES: Right. So that, if
6 there could be some specific structural things
7 like having a full-capacity protocol in place
8 -- I think Anthony mentioned having some
9 protocol in place where, when you get to a
10 certain point, that your hospital actually
11 does something different. That could
12 potentially serve as a quality measure if in
13 multiple studies that has been associated with
14 differences in performance.
15 MEMBER ADIRIM: What are you
16 measuring?
17 MR. PINES: So, I guess the
18 easiest example would be the presence of,
19 let's say, a fast track. There is emerging
20 literature looking at different structural
21 elements in the emergency department and the
22 association with length of stay and other

1 outcomes.

2 The recommendation here is just to

3 say that those could be considered as

4 potential quality measures, as structural

5 measures.

6 CO-CHAIR PITTS: Emily? I'm

7 sorry.

8 MEMBER CARRIER: Maybe others here

9 are much more familiar with the literature in

10 this area than I am. Jesse, you said that

11 there is a lot of it.

12 The few studies that I have read

13 that have looked at things like that, I

14 wouldn't describe them as of sufficient

15 quality that I would say quality measure. It

16 is more like our center was motivated to do

17 this, and we did it, and our pre/post data

18 shows that things have improved.

19 MR. PINES: So, the literature on

20 this currently is pretty sparse, but,

21 essentially, this recommendation would be, if

22 in the future there is some sort of best

1 practice that is evidence-based, that that
2 could potentially be a structural measure for
3 crowding.
4 CO-CHAIR PITTS: Jay?
5 MEMBER SCHUUR: Sort of to follow
6 up Emily's comment, I would disagree with the
7 recommendation as written. I wouldn't want
8 structural measures that were associated with
9 improved flow. I would want structural
10 measures that were associated with improved
11 patient outcomes.
12 And I think about structural
13 measures as helpful if you don't have good
14 outcome measures or good process measures.
15 But we think we have pretty good process
16 measures for flow. So, why not just measure
17 the flow and people can implement whatever
18 strategies they want, unless the specific
19 strategies have been tied to outcomes?
20 CO-CHAIR PITTS: AnnMarie?
21 MEMBER PAPA: Yes, I would kind of
22 agree with that as well because it is not just

1 having the strategy. It is effectively
2 implementing it. Because many people have a
3 capacity management protocol, but how many
4 people, how many hospitals really utilize it,
5 and utilize it effectively every time?
6 And some people have a fast track,
7 but they can only get it staffed between these
8 hours and these hours. That may not go with
9 your flow. So, I don't know how we would tie
10 that in.
11 MEMBER FIELDS: I really want to
12 try to have some continuity with the morning
13 discussion because I think it was potentially
14 really powerful. I think the idea of looking
15 at populations and looking at regional
16 services, and those kinds of outcomes, is a
17 way we can lead.
18 And so, in that context, I think
19 if Recommendation 9 was strategies that are
20 deployed within a service area or across
21 hospital systems, I think that is really what
22 you would want to encourage. To the extent it

1 might help you with surge capacity or gray
2 squirrels, I think you would like to know if
3 they are doing it.
4 MR. PINES: And also, thinking
5 more broadly about structural measures, I know
6 that the literature on specific structural
7 measures in the ED and length of stay is not
8 particularly robust right now. But when you
9 think about structural measures, that could be
10 specific protocols in place. It could be
11 transfer agreements between hospitals.
12 Essentially, the purpose of having this Draft
13 Recommendation in there is just to say that
14 these should be considered, that structural
15 measures should also be considered.
16 CO-CHAIR PITTS: Mike?
17 MEMBER STOTO: Actually, my
18 comment follows up on that. I think the
19 reason that I like this one is because I think
20 that some of these measures will also help
21 with the preparedness aspect of things. Well,
22 particularly if they can be associated with

1 outcomes, but even if only with flow, I think
2 that would be the kind of thing that would be
3 useful for preparedness, too.
4 CO-CHAIR PITTS: Gregg?
5 MEMBER MARGOLIS: Actually, I was
6 waiting for my comment until after we got to
7 Recommendation 10, but looking at time and
8 following up on my colleagues here, what I
9 would really like to emphasize here is to make
10 the connection between our morning discussion
11 and this one.
12 That is really, while I think that
13 boarding and crowding measures at a facility
14 level are very important, also are boarding
15 and crowding measures at a regional level. It
16 gives us a sense of a communities emergency
17 department capacity overall.
18 And I would suggest that perhaps a
19 Recommendation No. 10, or I'm sorry, No. 11
20 might be something to the effect of figuring
21 out ways that facility boarding and crowding
22 variables could be aggregated in a way that is

1 meaningful to provide information as to the
2 capacity of emergency care in a given
3 community.
4 I am not sure whether that is a
5 regionalization question or a boarding and
6 crowding issue, but I wanted to make sure that
7 it was brought up in this context, especially
8 in the light of the Chairman's comments.
9 MR. PINES: Sure, and just to
10 comment on that, I think we are going to have
11 that discussion after the next section.
12 CO-CHAIR PITTS: Okay. All right.
13 Well, Recommendation 10 then. I'm sorry, one
14 more comment. Ellen, yes, go ahead.
15 MEMBER WEBER: This is kind of
16 related to both 9 and 10. I wrote in here
17 some notes to myself.
18 Should we have some kind of
19 recommendation about what the hospital does in
20 this planning thing about high ED census?
21 Because we are talking about very specific
22 implementations of certain things that people

1 are talking about, but it kind of was a little
2 bit like the JCAHO flow thing.
3 But since we are talking about
4 this this morning in terms of the surge,
5 should we specifically say a plan for daily
6 response to surges and capacity responses to
7 overcrowding per se as opposed to the
8 throughput measures? But what do you have in
9 place? What is kind of your early-warning
10 system and that sort of thing? And actually,
11 really make it very clear what the connection
12 is here between this and the continuum to a
13 disaster.
14 CO-CHAIR PITTS: Okay. Gregg, are
15 you still up for a question? Or no? Brent?
16 MEMBER ASPLIN: I would support
17 what Ellen just proposed if it was tied to a
18 boarding standard or some outcome measure
19 where we are actually going to do something
20 about it. If it is just a plan, I am not too
21 excited. But if we are going to couple that
22 together with you have to meet this standard,

1 so how are you going to plan to meet it, then
2 it would be I think more helpful.
3 CO-CHAIR PITTS: Jay? Wes?
4 MEMBER FIELDS: I am just going to
5 keep pounding this nail because it seems like
6 somebody gave me a hammer.
7 (Laughter.)
8 But I really do think, if there is
9 a way to serve communities and be able to
10 quantitize surge capacity, it is because we
11 can find a way to agree that on a regular
12 basis hospitals, individually and
13 collectively, have to actually have measurable
14 impact on ED crowding as their daily fire
15 drill that prepares them collectively for the
16 black swan.
17 You know, I really think there has
18 got to be a way for you to create a
19 measurement that demonstrates not that they
20 have strategy, but that they can implement it
21 and that they can do it in real time. I think
22 that is exactly why the JCAHO measure that

1 begins at four hours for boarding is
2 inadequate for this purpose. Because, as we
3 have heard I think three times I can remember
4 during the day, there have been a number of
5 very significant events for communities that
6 come and go like the tides or a tsunami in
7 four hours.
8 So, I think the metric needs to
9 put some level of accountability around the
10 ability of facilities within a region to
11 respond and for this to be viewed finally, and
12 hopefully forever, as something other than an
13 emergency department problem.
14 CO-CHAIR PITTS: Arjun?
15 MEMBER VENKATASH: I guess the
16 only thing I am thinking about when we think
17 about structural measures is I really agree
18 with what Jay said, which is when you have
19 process or certainly outcome measures, the
20 utility of the incremental value for that
21 process measure is very little.
22 So, when I think about structural

1 measures, I think about what are either areas
2 that we can't measure via the other
3 mechanisms, and so structural measures have
4 added value, or is it necessary to help
5 balance the measure, that you need to have the
6 process measure with the structural measure?
7 In this case, I think Emily
8 mentioned earlier about thinking about what we
9 have done in care coordination. I was
10 thinking about this during the break. There
11 was only one structural measure I have seen
12 recently go through an NQF process that was
13 sort of interesting. And that was the NCQA
14 measure to tier medical home levels as NCQA
15 Level 1, Level 2, Level 3 medical homes. That
16 was a massive structural measure, right? It
17 included a ton of structural elements with
18 some research that was done that looked at how
19 well that tied to qualitative assessments of
20 patients feeling that they were part of
21 medical homes.
22 And I think thinking of that model

1 as a way for some of these boarding/crowding
2 structures, as well as some of the
3 preparedness structures, to fit into a list of
4 multiple structures that, when done in
5 concert, could be associated with this
6 perception within a health system of either
7 preparedness or being able to manage flow, and
8 would allude to some of these ideas of, does
9 that system have for flex, may be a way of
10 doing it.
11 Because, in isolation, any one
12 structural measure is going to look really
13 weak, and it is going to be tremendous -- I
14 can never see it getting through a consensus-
15 development process. But, coupled together
16 with some qualitative assessment that says
17 that those structural measures in concert make
18 sense, I think it is good guidance for
19 developers, and that is probably the way we
20 would want them to develop it.
21 And then, it gets at a process,
22 again, like I was saying before, we are not

1 going to be able to measure outcomes, right,
2 for preparedness? So, maybe this fits later
3 in the discussion later the afternoon, but my
4 guess is that this structure map includes
5 boarding, crowding, traditional preparedness
6 processes all in one.
7 CO-CHAIR PITTS: Great. That is
8 actually interesting.
9 I'm sorry. Brent?
10 MEMBER ASPLIN: Well, what Arjun
11 just said triggered in my mind this might be
12 our opportunity to sunset the whole term "ED
13 crowding," to begin to sunset it, because that
14 was probably our biggest strategic mistake way
15 back whenever.
16 CO-CHAIR PITTS: Call it something
17 else?
18 (Laughter.)
19 MEMBER ASPLIN: Well, what we are
20 really talking about -- and this does combine
21 the two topics -- is system capacity and
22 response, right? From a regionalized

1 emergency care standpoint, we are looking at
2 system capacity and response, and forms of
3 that involve daily operations and how we
4 manage daily surge. That is where flow,
5 delays, targets around boarding become
6 important. And then, that morphs into the
7 larger capacity and response issues of
8 emergency preparedness. That might be a way
9 to kind of tie this together and stop talking
10 about crowding. Just a thought.
11 MEMBER PAPA: And just to dovetail
12 off that, the biggest mistake we ever made was
13 to put that first patient in the hallway many
14 years back when we were trying to fix things,
15 because no other unit does that.
16 Unfortunately, we are the victim of our own
17 success. I agree with you, it is not ED. It
18 is not an ED issue, and this will help move us
19 forward.
20 CO-CHAIR PITTS: Yes, we did a lot
21 of things for a lot of people in the old days.
22 (Laughter.)

1 All right. This is the last
2 recommendation before our break. So, then,
3 Recommendation 10, measures of ED -- we have
4 discussed this a bit -- measures of ED outflow
5 beyond boarding. For example, hospital length
6 of stay for specific conditions may be
7 considered by quality developers to impact ED
8 flow. I guess one question is, how easy would
9 it be to get this kind of information?
10 CO-CHAIR STONE-GRIFFITH: Well, I
11 will start off by saying we didn't think it
12 would be that easy to get the information out
13 of the emergency department once upon a time.
14 But I think if we don't contextually look at
15 it across the entire hospital continuum, then
16 we are really going to miss the other patients
17 that are being boarded elsewhere or not being
18 managed as effectively and as efficiently as
19 they can be. So, I would certainly support at
20 least some guidance around that entire
21 hospital experience.
22 CO-CHAIR PITTS: Brent, are you

1 up?

2 MEMBER ASPLIN: Yes. I like this

3 one. I think most hospital administrators

4 will know more about this than they will about

5 their ED length of stay. So, these data are

6 out there, and it kind of ties back into the

7 same concept of system capacity and response.

8 CO-CHAIR PITTS: Ellen?

9 MEMBER WEBER: Yes, actually, I am

10 going to steal this idea from Peter Marcello.

11 But one of the things that he mentioned at our

12 crowding interest group was something that you

13 could track was how long it takes to get an

14 order to put in for a needed study when a

15 patient is admitted or to get the neuro

16 consult for the patient who isn't going to get

17 the TPA.

18 Also, bed days, how efficient are

19 you with your beds? Of course, then you would

20 need some risk adjustment.

21 So, beyond just the length of stay

22 for specific conditions, there are probably

1 some other process measures of hospital
2 efficiency that ought to be being tracked, not
3 just for economic reasons.
4 CO-CHAIR PITTS: There is also
5 just a simple, how do you schedule your
6 surgery at this particular hospital?
7 AnnMarie?
8 MEMBER PAPA: Thank you.
9 The other thing you can look at is
10 your discharge time and your discharge order.
11 Your discharge order happens maybe at 11
12 o'clock. The patient doesn't leave until six
13 o'clock at night, and we all know that because
14 we feel it. You can't get a bed all day long,
15 and then, all of a sudden, at six or seven
16 o'clock at night you take a bolus of patients
17 upstairs. The upstairs nurses are
18 complaining. They can't take them all at the
19 same time.
20 So, what is that process from
21 beginning that discharge order being written
22 to the patient leaving? Because that is a

1 huge issue as well.
2 CO-CHAIR PITTS: Brendan?
3 MEMBER CARR: Yes, I guess I just
4 wanted to echo that I think this one is also
5 really important. It starts to get at the
6 systemness of this. I think it also sort of
7 builds on pillar -- we are trying to cut clean
8 lines between this session and the next couple
9 of sessions. But I think, in part, the point
10 is to not. This builds on the first pillar
11 that Marco was talking about earlier today:
12 is there a way to bake into here some
13 awareness about whether or not this person can
14 be reverse-triaged, should they need to be?
15 And I don't know that the
16 literature is going to support anything
17 getting through the process yet, but it does
18 seem like we could start to increase some sort
19 of awareness about our inpatient triage
20 system.
21 CO-CHAIR PITTS: Terry?
22 MEMBER ADIRIM: Yes, what I like

1 about this measure, I agree with my
2 colleagues, is that it is an integrative
3 measure. I think it puts accountability, just
4 so that everybody is concerned about it away
5 from the ER when it is not the ER's fault.
6 So, one of the recommendations I
7 would suggest or somehow put in here, that
8 measure developers should move towards
9 developing measures that are integrative.
10 Because each one of the issues that you have
11 brought up, you know, really not just at the
12 isolated ED part, the one thing that I have
13 always been concerned about is like, why are
14 we, the ED, always considered separate from
15 the rest of the healthcare system?
16 CO-CHAIR PITTS: Manish?
17 MEMBER SHAH: This may be a little
18 bit on a tangent to this, but one of the
19 things that always concerned me, and I think
20 is also a potential to measure how the region
21 is doing, is the EMS offload time. I mean,
22 that has been a big issue in our area, you

1 know, with EMS having to stay at the hospital
2 for an hour and a half trying to offload the
3 patients. And that is something that is
4 measured within them, so it can potentially
5 give a fair amount of information. And so,
6 that might be useful to somewhere integrate,
7 whether it is, whether it is expanding this
8 recommendation a little to include maybe input
9 for in-flow measures also.
10 CO-CHAIR PITTS: Arjun?
11 MEMBER VENKATASH: I was just
12 going to say, for the EMS offload time, I
13 think that is a good measure, and it is one
14 that in the previous phase of this project,
15 when we were speaking to David Cone, he spent
16 some time in Australia and did a lot of
17 assessment of their EMS systems. And that is
18 standardly reported in Australia. So, it
19 would be worth reconnecting with him in
20 thinking about that.
21 CO-CHAIR PITTS: Oh, I am sorry.
22 I didn't see you there.

1 MEMBER LEVINE: I just wanted to
2 add that I like this one as well, but this is
3 one that we could also add in, if we wanted to
4 or felt the need to have a risk-adjustment
5 piece in it to really get at the acuity of the
6 patients in the hospital, that there is a lot
7 of established risk-adjustment methodology
8 already out there versus the iffy-ness that we
9 had for the ED patients. So, that is an
10 opportunity to throw that in as we make this
11 more systemwide or hospital-based.
12 MR. PINES: Great. So, I do want
13 to take about a 15-minute break in a minute
14 here.
15 One of the things I did want to
16 have people think about is other
17 recommendations. We have 10 recommendations
18 here. So, maybe what we could do is, before
19 the next session starts on accountability and
20 regionalization, we can just do a quick around
21 the room and see if anyone has any other
22 recommendations that they want to bring up for

1 the crowding and boarding. Or if you came up
2 with something from this morning, please let
3 us know then.
4 So, let's reconvene here at 3:15.
5 (Whereupon, the foregoing matter
6 went off the record at 2:56 p.m. and went back
7 on the record at 3:18 p.m.)
8 CO-CHAIR PITTS: We are just
9 slightly out of sequence. No problem.
10 For this next step here, we will
11 talk about accountability and regionalization.
12 Since we have already touched on a lot of
13 issues on that topic -- and, subsequently,
14 recommendations, right?
15 MR. PINES: Yes, why don't we just
16 do a round robin of recommendations?
17 CO-CHAIR STONE-GRIFFITH: Are
18 there any other recommendations we should add?
19 CO-CHAIR PITTS: So, we are
20 thinking of round-robining that. I know Mike
21 has got some stuff to say. After that, we
22 will go on to Arjun's presentation.

1 MEMBER STOTO: So, I have got a
2 couple of suggestions about the preparedness
3 area. There is some text in the draft report,
4 but not made specifically into
5 recommendations.
6 Angela, did you get the email yet?
7 I did it on my iPad, so it may not look that
8 great when it comes up.
9 So, anyway, I thought there really
10 were three things that encapsulate some of the
11 discussion that we had this morning.
12 One is to identify some of the
13 capabilities that are important on a daily
14 basis in small-scale emergencies and large-
15 scale emergencies, basically across the whole
16 spectrum of things, and then find ways to
17 measure those things.
18 I am saying that because I think
19 that we don't have many opportunities to
20 measure in large-scale emergencies. But if we
21 can find capabilities that are useful across
22 the board, then as much as possible measure

1 that in these small-scale events, and so on.
2 The second one is to develop
3 approaches to measures these capabilities at
4 the regional and the system level for two
5 different opportunities. One is in actual
6 emergencies, and two is in exercises and
7 simulations. I think both of those cases, it
8 would involve developing -- it is the last one
9 on there -- a protocol and a measurement tool
10 like an instrument that would be used to do
11 this. And, of course, you would need to
12 assess its validity and reliability through
13 standard methods.
14 And the third one, which is not on
15 there yet for some reason, is to consider sets
16 of measures. I think that a lot of these
17 measures really don't work all that well by
18 themselves, but we really need to think about,
19 if we had a set of these things, we maybe
20 could get a good picture.
21 Typically, NQF endorses one
22 measure at a time. But I think we are really

1 talking to developers at this stage. If we
2 talk about developing a set of measures, they
3 could be put forward in a package, and that
4 would be useful.
5 MS. FRANKLIN: Yes, we do endorse
6 one measure at a time, but we do, also, look
7 at measures that are expected to be reported
8 together as well and composites.
9 MEMBER STOTO: Okay. That is the
10 concept I have in mind, yes. So, that is the
11 idea.
12 CO-CHAIR PITTS: You have,
13 hopefully, had a chance to think a little bit
14 about the topic. We are going to go around
15 the room, hoping that somebody will have an
16 idea on the topic of accountability and
17 regionalization.
18 MR. PINES: So, essentially, for
19 the next section, if we could just go around
20 the room, and if you have any recommendations
21 that we didn't think of that haven't been
22 mentioned, sort of other ideas that came to

1 your mind during a break or that you wanted to
2 mention that we could integrate into the
3 document as draft recommendations when we send
4 it back out to the group?
5 CO-CHAIR PITTS: Yes, go ahead,
6 Ellen. You are first.
7 MEMBER WEBER: I am going to throw
8 out three things. Just getting back to the
9 one that was the England experience, one of
10 the other measures they had was a maximum
11 length-of-stay measure. So, that might be
12 worth considering, where sort of all the roof
13 falls in on you, and the health minister comes
14 and sees you. They have what was called the
15 12-hour trolley wait. If you were admitted
16 for 12 hours and still in the department,
17 literally, that was like a failed institution.
18 (Laughter.)
19 So, it is kind of one of those
20 things where I would say most emergency
21 physicians would agree that 12 hours is beyond
22 the pale of what you really should be doing in

1 the ED. A lot of times that is a service
2 issue where no one will take the patient, and
3 so forth, or there is no bed. So, that might
4 be just another, when you are talking about
5 time targets, we are going into sort of the
6 semi-non-controversial.
7 The other thing, because we have
8 talked about this, actually, the experience of
9 the patient and the experience of the staff.
10 This is not my area, but just to think about
11 whether there ought to be measures of that
12 because so much of the crowding issue is a
13 stress issue, a burnout issue.
14 And then, depending on how it goes
15 for the patient and what your ED is like, do
16 they feel whatever -- you know, some
17 assessment of their experience in the ED I
18 think is important. That sort of goes beyond
19 "Was the doctor nice to you?"
20 CO-CHAIR PITTS: Do you want to
21 add anything, Mike?
22 MEMBER STOTO: Yes, I have a

1 comment, and I am not sure it is quite a
2 recommendation, about accountability. This is
3 something we are struggling with on this -- I
4 mentioned this National Health Security
5 Preparedness Index that I am working on.
6 The issue is this: when you look
7 at the Institute of Medicine model about
8 preparedness, it talks about what the whole
9 system, broadly defined, has to do together
10 for a community to be prepared.
11 On the other hand, CDC gives money
12 to health departments and ASPR gives money to
13 mostly state health departments or other
14 organizations at the state level. You really
15 can't hold those organizations who have
16 received the money accountable for what the
17 others do or don't do in the community.
18 So, although we really would like
19 to think about the contributions of all these
20 different organizations, I think, quite
21 appropriately, the groups that receive the
22 federal funds say, "Well, we can't be

1 accountable for them. We can only be
2 accountable for what we do."
3 Coming up with a way to deal with
4 that I think is a big challenge. So, maybe I
5 have articulated the challenge, as opposed to
6 solving it. But, hopefully, that is helpful.
7 CO-CHAIR PITTS: Wes, any
8 additional insights?
9 MEMBER FIELDS: I just want to
10 quickly reiterate the two things that I think
11 would be most valuable to the system. The
12 first is somewhere within the first three
13 recommendations. And it is just that, even if
14 it is reported as something which allows the
15 hospital to opt out of a door-to-admit time,
16 I think beginning to track what is happening
17 with observation services, both in the
18 emergency department and in the hospital, is
19 tremendously valuable in terms of its
20 potential to show how we could reduce both the
21 number of hospitalizations and have a positive
22 impact on length of stay. So, that is one.

1 And then, the other, which I
2 really think we probably are pretty close to
3 on nine, is this concept that, if you really
4 want to get to the population orientation of
5 responses at the community level, I think
6 Recommendation 9 looks more like structural
7 measures that demonstrate how hospitals and
8 hospital systems interact to improve the
9 capacity at the community level in terms of
10 potentially having a way to manage or predict
11 surge capacity for disaster response.
12 CO-CHAIR PITTS: Gregg, would you
13 like to contribute something?
14 MEMBER MARGOLIS: It is in a
15 different line. So, does anyone have any
16 response to the last comment?
17 (No response.)
18 I would like to ask the group to
19 think about, why is it accountability and
20 regionalization? Those two things are very
21 different to me, I think. So, I am just
22 curious if they make sense lumping them

1 together.

2 MEMBER STOTO: Can I just jump in

3 on that a minute? I don't think we need

4 measures of accountability. I think that

5 accountability is something we need to

6 consider as we develop all these measures.

7 So, I am uncomfortable with that phrasing as

8 well.

9 MR. PINES: So, the thinking

10 behind putting those together was based on

11 basically taking a lot of these measures and

12 actually aggregating them up higher levels.

13 So, for example, the hospital across town, you

14 would actually care if there length of stay

15 was long if you were being measured on how

16 they were doing. And essentially, you know,

17 the whole notion of competition, that we know

18 that places will continue to compete, but to

19 have some incentive to cooperate. So, that

20 was the thinking there. But if you wanted to

21 separate those out, we could certainly do

22 that.

1 MEMBER MARGOLIS: For the record,
2 I have no advocacy position on it. I am just
3 curious what everybody's thought is about it.
4 To me, that might be an issue of how do we
5 incentivize cooperation or "coopetition" in
6 regionalization and that sort of stuff as
7 opposed to who is accountable for it. But I
8 am just curious what everybody else's thought
9 is about the notion of accountability being
10 lumped together with regionalization, and I
11 have an open mind.
12 MEMBER STOTO: Jesse, hearing what
13 you said, it strikes me that that is just a
14 different way of articulating the point that
15 I made just a moment ago. Is that it? Okay.
16 CO-CHAIR PITTS: Manish, have you
17 got anything you would want to mention?
18 MEMBER SHAH: So, I will just
19 reiterate kind of the question I brought up
20 earlier, which is where EMS metrics and EMS
21 falls within this, whether it should be a
22 separate recommendation, talking about whether

1 it is offload timing at the regional level or
2 even potentially at the individual hospital
3 level. And are there other things, as much as
4 I hate attestation-type things, are there
5 cooperative-type protocols/policies in place
6 to address various levels of issues around
7 preparedness, around crowding?
8 I hate diversion. We have gotten
9 rid of it in our system. Is that something
10 that should be in that list of things we
11 consider?
12 And the other thing, over break,
13 just kind of we were talking about it a little
14 bit, I don't know where to go with this. But
15 sometimes within regions, however you define
16 that, or within groups, you are going to have
17 a wide variation, right? You are going to
18 have those hospitals that are massively
19 crowded, boarding, running at 110-percent
20 capacity, and then you have the other ones
21 that are running at 60-percent capacity or 70
22 percent and don't have boarding.

1 Somewhere around there, is it
2 worth thinking about that as a metric of how
3 the region is working together to optimize the
4 care of all the patients in the community? I
5 don't know where to go with that, but it was
6 just something that flew in, and maybe it
7 should just fly right back out.
8 CO-CHAIR PITTS: I think it is
9 really important. I am not sure how it fits
10 into the NQF measures, but there is a huge
11 difference that has not been investigated
12 scientifically because it is really almost
13 impossible to get ED-level information either
14 in HCUP or in NHAMCS. It is possible, but you
15 have to go through a bunch of steps. So, you
16 just don't see much research on that topic.
17 I think it is really important.
18 Brent?
19 MEMBER ASPLIN: Can I just
20 highlight things that I and others have
21 mentioned earlier? One is the rollup of
22 institutional-directed measures to a region.

1 I think that is an important concept that we
2 really should stress. And then, taking the
3 opportunity to move beyond crowding and really
4 just purposely call that we want to change the
5 nomenclature.
6 CO-CHAIR PITTS: Arjun, I'm sorry,
7 I skipped over you. Did you have something to
8 say?
9 MEMBER VENKATASH: I guess it is
10 another measure concept. I don't know where
11 that fits. Maybe it was just in the previous
12 concept.
13 But, as we were talking about
14 this, a lot of what we have talked about
15 considers surge on top of a system that is
16 already crowded as a problem. But I actually
17 think that if we want to get at some of the
18 issues we were discussing before, which is how
19 much flex the system has or knowing what a
20 high-performing system, perhaps the measure
21 should be surge recovery. Maybe the measure
22 is something along the lines of number of days

1 or number of hours of sustained boarding at
2 whatever -- I am not going obviously raise the
3 discussion of whether that is two hours, four
4 hours, or three hours.
5 But, to me, it seems like if we
6 want to understand how systems respond to
7 these types of things, then, actually, their
8 ability to recover in minor surge, be it the
9 bus or the day at 105 percent, the 106
10 percent, whatever it is. And whichever
11 systems -- and that could be hospital or
12 regionally measured -- recover the quickest
13 are probably high performance from a
14 perspective of preparedness. That is
15 something you could measure at the hospital
16 level and aggregate up at the regional level,
17 and get an idea for preparedness out of that.
18 CO-CHAIR PITTS: Brendan?
19 MEMBER CARR: I have two. The
20 first we touched on, but I just want to make
21 sure that it doesn't get lost. I think that
22 there is an ability to use that inpatient

1 triage measurement or to sort of make that a
2 firmer piece, both at the hospital level to
3 relieve boarding, but also at the aggregated
4 level to get a sense of what proportion of
5 patients, how many beds you could create,
6 given the inpatient -- I am using the words --
7 "inpatient triage". We have called it
8 reverse-triage, sending them home. I don't
9 know what the criteria are.
10 But if everybody was flagged in
11 some way, it strikes me that you would then
12 know something about the hospital's ability to
13 absorb a punch, and you also know, then,
14 something about the region's ability to absorb
15 one.
16 And the second piece is I think
17 that there is a lot of story that could be
18 told in transfers, because that speaks to how
19 efficiently you get people out. So, I don't
20 know what happens in boarding-speak when
21 someone gets transferred to another hospital.
22 Do we follow it? Do you know?

1 CO-CHAIR PITTS: Yes, I can tell
2 you that NHAMCS, which has time intervals,
3 does not consider psych transfers boarding.
4 You can try to get at that by identifying a
5 psych diagnosis and seeing whether they were
6 transferred or not. And you can actually do
7 interesting analysis that way. But census
8 field reps have not called that "boarding".
9 MEMBER CARR: And what about the
10 way that they get reported to CMS? What do we
11 do with them? We just throw them out?
12 Because they are the window, I think, to the
13 region or the regional-ness or to the
14 coalition-ness, I think, right? There is
15 something. The transfers are telling us the
16 story about how well I can offload my patients
17 I can't take care of.
18 CO-CHAIR STONE-GRIFFITH: Yes, in
19 the measure there are just strata, but if they
20 are transferred, I mean, they are essentially
21 a discharge.
22 MEMBER CARR: What happens in

1 hospital two, presuming they go to a floor?
2 I am not talking about psych. I am talking
3 about medical patients.
4 CO-CHAIR PITTS: Yes, but there is
5 no transfer criterion in the NQF criteria, I
6 don't think.
7 CO-CHAIR STONE-GRIFFITH: No, no.
8 CO-CHAIR PITTS: Transfer doesn't
9 come up.
10 CO-CHAIR STONE-GRIFFITH: Right.
11 MEMBER CARR: I am talking
12 specifically about boarding metrics that have
13 been accepted by CMS.
14 CO-CHAIR STONE-GRIFFITH: If you
15 are discharged from the hospital through a
16 transfer mechanism, you would not be in that
17 boarding --
18 MEMBER CARR: I understand.
19 Sorry. I get it now. Because you are not
20 considered admitted.
21 CO-CHAIR STONE-GRIFFITH: Correct.
22 MEMBER CARR: You are being sent

1 to my hospital to be admitted.

2 CO-CHAIR STONE-GRIFFITH: Whoever

3 receives them will likely admit them, but they

4 are not in that measure yet.

5 MEMBER CARR: So, yes, I don't

6 know what the metric is, but I do think that

7 that tells the story of how well-connected my

8 hospital is.

9 MR. PINES: So, just to clarify a

10 recommendation for measure developers, how

11 would you frame it for measure developers?

12 MEMBER CARR: I thought the "I

13 don't know" part was clear.

14 (Laughter.)

15 Yes, I will get back to you. I

16 will write something and email it to you.

17 CO-CHAIR PITTS: All right.

18 Manish, Brent; that leaves Terry.

19 MEMBER ADIRIM: Thank you.

20 I have three points that I wanted

21 to make, the first one with regard to any

22 recommendation that you have with regard to

1 regionalization. I would encourage you to
2 incorporate the concepts or actually just
3 straight-out within your recommendation to
4 measure developers to consider the capability
5 for special populations.
6 I am here because I am a
7 pediatrician, but my colleague, Dr. Shah,
8 points out that in Katrina most of the people
9 affected were elderly. But I think
10 considering those populations is a very
11 important capability to have. So, I would
12 like that to be included.
13 The second is that kind of goes to
14 what Jesse was talking about with structural
15 measures. I think any recommendation with
16 regard to structural measures that may at
17 least indirectly go to throughput would be
18 with regard to designation of the institution,
19 what type of trauma center designation,
20 whether it is pediatric designated. So, I
21 kind of thought that may be -- and I could be
22 wrong -- but that may be something to

1 consider, as well as the training of the
2 staff.
3 So, in some departments you have
4 to be a Board-certified general emergency
5 physician. If it is a pediatric institution,
6 you have to -- so, that kind of indirectly
7 goes to quality -- well, not indirectly; I
8 think directly -- but it may have an impact on
9 patient outcomes.
10 And No. 3, we were discussing
11 earlier amongst ourselves that we would
12 encourage measure developers to look at the
13 existing care-coordination measures, to look
14 to adapt them for applicability to ED. I
15 think it is already done; you already have
16 them. And you could either respecify them or
17 whatever you can do to them to make them
18 applicable to regionalization or any of the
19 other issues we have discussed, would be good.
20 CO-CHAIR PITTS: Emily?
21 MEMBER CARRIER: So, are these
22 only recommendations to measure developers or

1 can some of them be recommendations about a
2 research agenda or overall larger policy
3 changes that could facilitate measure
4 development?
5 I just wanted to say I feel like
6 talking about regionalization and
7 accountability, it is really important to note
8 that certainly currently, and even most likely
9 under future generations of Meaningful Use, as
10 I am aware of it, it may still be impossible
11 to track the clinical course of a patient from
12 EHR to EHR if they are transferred from one
13 hospital to another. So, you couldn't follow
14 the patient who arrives in the ED and is
15 transferred for cath, for example.
16 And in many markets, those
17 patients will stay within a hospital system
18 with a single EHR, a single shared EHR. So,
19 a unified record may be possible in those
20 cases. But not all markets are going to have
21 those systems.
22 Understanding regional dynamics,

1 like in some markets it gets really
2 complicated how a community works together
3 versus surge. Like in some of the market, in
4 one of the markets we study, it is quite
5 possible that one hospital's ED could be
6 overflowing and a neighboring hospital could
7 be accepting transfers from out of state for
8 a high-cost surgical procedure. And there are
9 a lot of other markets like that.
10 So, the more that we can really
11 follow individual patients from system to
12 system, I think that would help get a good
13 understanding, a better understanding of these
14 three quality measures.
15 CO-CHAIR PITTS: Great.
16 AnnMarie?
17 MEMBER PAPA: I will echo what
18 Terry said about the continuum in the care
19 coordination. We did have that conversation.
20 I think, to your point, Ellen,
21 with regard to the experience of the patient,
22 absolutely. But the experience of the

1 caregivers. And I know in ICU there is a lot
2 of work done with moral distress and futility
3 and things like that. So, I don't know if
4 there are other measures out there that would
5 be similar or transferrable for us as well.
6 CO-CHAIR PITTS: I am sorry. Is
7 it Emily? Kathy? Kathy, my apologies.
8 MEMBER ROBINSON: Thank you.
9 I just want to support some of the
10 comments that have been previously made about
11 there needing to be a recommendation in
12 regards to system evaluation. We have talked
13 a little bit about diversion and offload
14 times. But if there isn't any coordination
15 between hospitals and the individuals that you
16 expect to transport patients to other
17 locations, such as long-term care facilities,
18 such as rehab facilities, to move them from
19 one clinic to another, or whatever that is,
20 ambulance services don't have unlimited
21 resources. So, to staff up for that from a
22 vehicle or manpower standpoint is something

1 that they need to plan for.

2 So, I guess I would like to

3 advocate for that kind of consideration. When

4 you are talking about regionalization, it

5 doesn't just mean hospitals.

6 CO-CHAIR PITTS: Wes, did you want

7 to go back?

8 MEMBER FIELDS: I just want to

9 elaborate on what Brendan raised and what

10 others have sort of touched on. I really

11 think there are more and more reasons, as you

12 regionalize care, you should expect more

13 transfers. I think you need to begin to

14 measure the difference between a move inside

15 of a hospital system and a transfer across

16 hospital systems because I think both of those

17 things are likely to occur more and more.

18 And then, I just wanted to make

19 sure I qualified something I said about

20 observation services. I feel the same way

21 about what is increasingly understood to be a

22 transition of care. There, too, moving a

1 patient from independent living to assisted
2 living is just as significant a transaction or
3 a transfer as any other. And especially, that
4 is true in terms of population management and
5 trying to improve outcomes.
6 So, I just feel like, as we let go
7 of the idea that crowding is an emergency
8 department problem, I think we need to embrace
9 the idea that there are many transitions of
10 care and/or transfers which potentially can
11 add value to the system, improve the patient
12 experience, and reduce cost. But if we are
13 not finding ways to track them, we will lose
14 our ability to really understand them.
15 CO-CHAIR PITTS: Ryan?
16 MEMBER MUTTER: Just a few points.
17 First, to Emily's point about transfers moving
18 in and out of system and being lost,
19 administrative data like HCUP increasingly has
20 the capacity to track a patient across time
21 and settings with an encrypted unique patient
22 identifier. And that capacity has started to

1 be used and the development of some
2 experimental indicators. So, that could
3 potentially get at some of the issue that you
4 raised.
5 Second, just thinking about this
6 sort of "coopetition" and the incentives and
7 all that, I think it is potentially important
8 to think about. I don't quite know what the
9 solution is. On the one hand, developing,
10 say, coalition-level measures is interesting.
11 We could see variation. We could get sort of
12 a sense of capacity and capability and all
13 that. But what if you see bad performance?
14 Then, what? What do you do? Say, "Do
15 something about it."
16 You know, basically, we represent
17 Hospital A and Hospital B and we are
18 competitors, and our area looks bad. I mean,
19 our incentive is to say, "Do something about
20 it" to them, and theirs is the same thing.
21 And we have every little incentive to do
22 something that is going to make them look

1 better.

2 So, there is something to think

3 about. I don't know what the solution is.

4 But if we are going to invest in measure

5 development, we might want to be thinking

6 about, well, to what end and can we

7 incentivize improvement?

8 And then, I guess third and

9 finally, I think the observation services

10 angle is really interesting. I mean,

11 observation services is increasingly used,

12 although there is variation in its use and how

13 it is used.

14 In the event of a disaster, those

15 are beds. In some facilities, for example,

16 there are a lot of prolonged observation stays

17 which CMS seems increasingly concerned about.

18 That could be something potentially to

19 consider as something that is going on that is

20 sort of in daily operations, but could

21 potentially impact disaster preparedness.

22 So, I don't quite know what the

1 angle is, but it has sort of come up and it is
2 interesting to think about.
3 CO-CHAIR PITTS: AnnMarie?
4 MEMBER PAPA: There was one thing
5 that popped in my head as you were talking,
6 Ryan. What measures does the VA use? I mean,
7 they have that one system and there are things
8 that they may already have in place that we
9 might be able to piggyback off of. I think
10 Terry said you are working with them on some
11 things, right?
12 CO-CHAIR PITTS: Wes?
13 MEMBER FIELDS: Yes, I actually
14 forgot the most important one of all. This is
15 a joke, but it is that time of the day. Every
16 emergency department should have different
17 color of socks for the patients they discharge
18 home. This would allow you to get beyond the
19 Meaningful Use problem because you would be
20 able to know where the patient most recently
21 was treated by the color of their socks.
22 MEMBER ADIRIM: How do you measure

1 that?

2 (Laughter.)

3 CO-CHAIR PITTS: Ellen? I'm

4 sorry.

5 MEMBER WEBER: I just want to

6 reiterate what a couple of people have said.

7 I just want to make sure. To me, the more I

8 think about it, the diversion measure would be

9 really important, both in terms of crowding

10 and in terms of regionalization. Because,

11 basically, there has to be some level of

12 agreement. Well, I can't say that for sure.

13 But if there is no diversion in an area, that

14 generally suggests people have become

15 enlightened in some way, and perhaps there has

16 been some work around how do we avoid

17 overloading one hospital versus another

18 hospital. Is there better communication as a

19 result of it?

20 And time on diversion would be

21 sort of like a bad thing. So, that could be

22 another push towards either cooperation or at

1 least improving your flow.
2 So, I see it as kind of bridging
3 both of the areas. Actually, the more I think
4 about it, I think it is worth looking at.
5 CO-CHAIR PITTS: Is there any
6 formal diversion national-level sort of
7 criteria? I mean, I remember there used to be
8 in the old days certainly the nurse could
9 decide to go on diversion for the next five
10 patients and then go back. In some places,
11 diversion is a formal process involving
12 multiple layers of the hospital, and in others
13 it is sort of an ad-hoc kind of a decision.
14 I wonder if there is any standardization at
15 all. I am sort of not up on that.
16 No? The answer is no? Okay.
17 MEMBER WEBER: I thought there was
18 something I just read in here, that each
19 hospital is supposed to have a plan in place,
20 you know, criteria for going on diversion.
21 MR. PINES: Right. I think that
22 is part of the Joint Commission Flow Standard.

1 MEMBER WEBER: Yes.
2 MR. PINES: But I don't think
3 there is any like national criteria.
4 Essentially, the hospital has to have their
5 own criteria.
6 CO-CHAIR PITTS: Manish?
7 MEMBER SHAH: I was going to say,
8 I mean, I think diversion the way we are
9 talking about it, because you are crowded,
10 because you are boarding a lot of patients, or
11 whatever, my sense of at least the environment
12 is people are moving away from it in
13 Massachusetts, in San Diego, and we have done
14 it in Rochester.
15 Diversion because, you know, the
16 plane just crashed into your hospital is a
17 completely different thing. I think that is
18 usually what most of us write into our JCAHO
19 or the Joint Commission requirements, that
20 there are going to be instances where you have
21 to divert.
22 CO-CHAIR PITTS: Were you going to

1 say something, Brent?

2 MEMBER ASPLIN: Real quick, there

3 is no national standard, but some regions have

4 done pretty clear quantitative criteria before

5 you can go and divert. I don't know how much

6 enforcement there is.

7 CO-CHAIR PITTS: All right. Ryan,

8 are you still vertical? Okay.

9 I am sorry I haven't got to you

10 guys.

11 DR. HUNT: A couple of quick

12 observations from the discussion. The

13 discussion surrounding the gross measures

14 versus granular measures of crowding,

15 specifically around the admit order piece, a

16 long discussion about that. As I listened to

17 that, I flashed back to the discussions a long

18 time ago about an EMS measure of dispatch

19 time, and it took a long time to figure out

20 about how many calls there were to make that

21 happen, when the wheels of the ambulance

22 actually moved. I mean, there were a lot of

1 cuts to that.
2 And I thought about it and said,
3 well, you know, the system, the system itself,
4 that just needs a gross measure, but to really
5 do problem-solving, not just at a facility
6 level, not just at an EMS level, but also at
7 a system level, at some juncture this will
8 need to evolve to a much more granular level
9 than this sort of like gross measure. So, I
10 would encourage getting to the granularity
11 sooner than later.
12 I am really sensitive that, while
13 we don't have definitions around that, start
14 making marks in the sand. That would be my
15 encouragement about measure.
16 And then, the other one that I had
17 a sidebar conversation about, I was charged a
18 while back with being the Chair of the
19 Crowding and Surge Committee for the hospital.
20 The most surprising thing, the aha moment,
21 when we got down to granularity of data, it
22 wasn't discharge from the hospital orders

1 written; it was the time from discharge orders
2 written by the resident, and the nurse signed
3 off, to actually having the bed vacated,
4 cleaned, and staffed by staff. So, that
5 interval from discharge orders, hospital
6 discharge orders, to actually vacating the bed
7 and having it cleaned, et cetera, et cetera,
8 we were just stunned. That was the
9 bottleneck. It wasn't the discharge order
10 issue.
11 So, again, that is granular, but I
12 think at some juncture this is going to have
13 to move toward granularity to do the problem-
14 solving to improve it. That may mean you have
15 got to gross first, but you have got to go
16 granular to be able to do the problem-solving.
17 CO-CHAIR PITTS: Okay. Brendan?
18 MEMBER CARR: So, I wanted to
19 respond what Ryan said because I think that he
20 was asking about why people wouldn't cooperate
21 within a coalition, within a region. I mean,
22 I guess I am wondering if we need to be more

1 explicit in the report, then, to suggest that
2 the reason to develop metrics at that level is
3 to create incentives and/or the opposite of
4 incentives, so that people do cooperate. I
5 wonder if we need to be more explicit in the
6 report, if that is not clear. I mean, I think
7 that is the reason that we are having this
8 conversation, is to be able to benchmark my
9 region versus yours versus someone else's.
10 And then, with respect to the
11 transfer thing, I wanted to offer this: I
12 think that time from decision to transfer to
13 leaving the department might be an okay
14 benchmark, but decision to transfer is going
15 to be very difficult. I wonder if there isn't
16 some utility in just knowing time from
17 presentation to the emergency department or
18 triage or doc, or whatever you pick, to time
19 to be transferred for all transfer patients.
20 On some level, shouldn't there be
21 some awareness that we can't take care of this
22 patient? Right? Arjun sort of said to me,

1 maybe you pick a couple of diseases, and if it
2 is intracranial hemorrhage and you are
3 transferred to a neurosurgical service, it is
4 time from CT scan. So, it is essentially when
5 you got the diagnosis.
6 But, on some levels, I can't
7 manage this patient. How long should it take
8 me to figure out that I can't manage this
9 patient? Isn't just time from presentation to
10 time from leaving the door telling?
11 CO-CHAIR PITTS: I think it is
12 telling. It certainly is telling with respect
13 to behavioral problems. That time clearly
14 distinguishes psych illness from other
15 illness.
16 So, you are saying that maybe we
17 could limit ourselves to time-in versus time-
18 out plus a marker for transfer or not
19 transfer, essentially.
20 MEMBER CARR: Not as a marker.
21 Just within transferred patients, for
22 transferred patients.

1 CO-CHAIR PITTS: So, if you can
2 identify who is transferred, all you are going
3 to do is time-in and time-out, basically, if
4 I understand you.
5 MEMBER CARR: You do understand
6 me, and I think those are going to be short
7 numbers in places that have a game plan ahead
8 of time and long numbers in places that have
9 a hard time offloading patients, either
10 because their neighbors are overwhelmed or
11 because they didn't belong to a coalition or
12 they didn't participate in something.
13 CO-CHAIR PITTS: AnnMarie?
14 MEMBER PAPA: But to that point,
15 Brendan, what about the extenuating
16 circumstances? Suppose you are a small
17 hospital on an island, a critical-access
18 hospital on an island, and the only way you
19 get a patient off is by boat or by helicopter,
20 and you can't fly and you can't get the boat
21 out. I mean, that is going to affect your
22 transfer time. So, there are things that have

1 to go into play when you are looking at that,
2 I think.
3 In our area, in Philadelphia, it
4 shouldn't be a big issue. But, you know,
5 sometimes we can't fly them by PennSTAR. So,
6 we have to go by land. You can't go by land
7 on some of these places. So, just something
8 to consider. I mean, I am not saying that it
9 is a bad measure. I just think it is
10 something we have to consider.
11 CO-CHAIR PITTS: Kathy?
12 MEMBER ROBINSON: The comments
13 that Dr. Hunt made really resounded with me
14 from the standpoint that we have been talking
15 about crowding and boarding and preparedness,
16 and the need to perhaps consider some of the
17 greater detail in that regard.
18 And I just think of the example of
19 EMS and fire agencies that might be charged to
20 evacuate a community at the same time that a
21 hospital is implementing their plan to
22 discharge patients, and those personnel, those

1 resources can't be in two places at the same
2 time.
3 Without those sorts of discussions
4 ahead of time, or someone suggesting to them
5 that that might be a consideration, that is
6 going to get lost.
7 CO-CHAIR PITTS: Jay, do you have
8 something to say?
9 MEMBER SCHUUR: Sure, around
10 transfers. One thing comes to mind around
11 that idea, which is there is an NQF measure in
12 the chest pain set around time to transfer for
13 patients with ACS. And so, that might be a
14 good model for the sort of disease-specific
15 measures.
16 And I think it probably is worth,
17 if we are going to really hold people
18 accountable for times, thinking about diseases
19 where there is a clear time-to-outcomes
20 relationship, whether it is sepsis, ACS, or
21 something like that.
22 I think there is also a role for

1 transfer measures in the capacity piece,
2 looking at what institutions are transferring.
3 Because one aspect is the sick patient you
4 can't care for. The other type of transfer is
5 the patient that you should be able to
6 transfer, the hand injury, but you are
7 transferring them because your orthopedist
8 won't come in after hours, insurance issues,
9 this, that, or the other thing. That also is
10 a measure of system capacity resilience. I
11 would recommend exploring that also.
12 CO-CHAIR PITTS: I guess, Arjun,
13 you are next. Nothing to add? Okay.
14 Jay, do you want to say anything
15 more general that you have been thinking
16 about? Okay.
17 David? You're good?
18 Linda? No?
19 Emily? No?
20 Melissa?
21 MEMBER McCARTHY: Just that I love
22 the idea of the sunsetting with crowding.

1 (Laughter.)
2 It is brilliant, Brent.
3 And the idea, too, of just daily
4 operations kind of at a facility level or a
5 healthcare system level to me is very
6 different from a regional level. Because if
7 we just even take maybe length of stay, I
8 mean, it works at the facility level or maybe
9 even within a healthcare system. But what
10 does it mean at a regional level? You have
11 eight different hospitals. So, their average
12 either length of stay or their median or their
13 90th, or whatever, is so variable within those
14 eight hospitals. I don't know what we get
15 from a summary.
16 But once you start thinking about
17 them as separate concepts, what are measures
18 of regional systems of care, then I think they
19 have to be thought of differently? So, that
20 is one recommendation I would make.
21 CO-CHAIR PITTS: Anthony?
22 MEMBER MacINTYRE: Yes, I would

1 just echo that. I am still struggling with
2 the conversation this morning about whether
3 this is really two ends of the spectrum or two
4 different things with interrelated components.
5 I am still in the camp of two different
6 things.
7 Two specific comments. Some of
8 the recommendations that are very specific
9 under the crowding piece really seemed to
10 arise from the facilities-specific world. I
11 don't know what the validity is when they are
12 suddenly scaled-up to a regional level.
13 Now, if their intent is to compare
14 facilities within a region, maybe there is
15 something there. But, as Melissa said, at a
16 regional level, I don't know what we are
17 looking at with some of those numbers.
18 The second comment with respect to
19 the preparedness side, I like where Mike was
20 headed. He is trying to give you some
21 specificity to the recommendations there.
22 I would just reiterate two points.

1 One is preparedness and response are two
2 different beasts. If you are going to have
3 measures, you are going to have measures for
4 both.
5 And the second is that surge does
6 not exist in isolation. I mean, that is an
7 antiquated thought that many clinicians,
8 primarily, still hang their hat on. Surge
9 exists within the construct of how you manage
10 your organization during a time of duress.
11 And those management systems apply whether it
12 is surge, a resiliency issue, or a safety and
13 security issue.
14 The way in which I communicate
15 with my staff during a surge event, an
16 evacuation event, an active shooter in my
17 hospital should be very similar. And if they
18 are not, then you are missing the boat with
19 all-hazards emergency preparedness and
20 response.
21 So, I think examining surge in
22 isolation is a bit shortsighted.

1 CO-CHAIR PITTS: Emily?
2 MEMBER CARRIER: I am sorry, I did
3 remember one thing. I think it would be
4 great, I guess going back to what you are
5 saying about examining surgeon isolation, it
6 would be great not to examine what we no
7 longer call crowding in isolation.
8 (Laughter.)
9 It would be great to see suites of
10 measures that look not only at performance in
11 length of stay or meeting time targets, but
12 also paired them with things like rates of 72-
13 hour revisits, rates of discharge within 24
14 hours from inpatient admission, to get a whole
15 picture of how the system is functioning, and
16 not just how this one track is doing.
17 CO-CHAIR PITTS: So, Melissa, what
18 are we going to call the crowding interest
19 group? I thought about operations maybe.
20 (Laughter.)
21 Suzanne?
22 CO-CHAIR STONE-GRIFFITH: Well, as

1 I have been listening to several of the
2 comments, one of the things that has resonated
3 with me suddenly is sort of, what about
4 freestanding emergency departments? When you
5 brought up the movement transfer in both the
6 context of transfers and in the context of
7 movements from one department to another, and
8 the proliferation of freestanding emergency
9 departments that is occurring in our
10 communities, what role do they play in terms
11 of -- I don't know -- just the population that
12 they serve, the surge, the EMS? They become
13 part of it.
14 I think whether that is a strata
15 or a way to look at those in aggregate or
16 separated, I would like to sort of put that
17 one in the mix.
18 CO-CHAIR PITTS: Okay. Helen, did
19 you want to say anything in particular about
20 this whole business? No?
21 All right. Jesse?
22 MR. PINES: So, I just also wanted

1 to make sure that I think we have had a pretty
2 robust discussion about regionalization and
3 accountability, but I wanted to make sure that
4 if there are any other comments on that topic.
5 Essentially, the way it is going to be framed
6 in the report is, basically, what we talked
7 about before, which essentially is taking
8 these current measures and essentially
9 aggregating them to different levels, regional
10 levels, hospital and coalition level.
11 Is there any other discussion
12 around that or other comments that we should
13 get into that section of the paper?
14 CO-CHAIR PITTS: I'm sorry? Yes?
15 Peggy?
16 MS. SPARR: One that hasn't really
17 been discussed very much, but it would seem
18 appropriate if you are talking about it at a
19 regional level, is just revenue. I think that
20 it is unrealistic just to take the numbers
21 from individual facilities and work their way
22 up. I think there has to be, at least from

1 our experience in big disasters, there has to
2 be some way to make sure that people are made
3 whole by cooperating with each other and by
4 doing what they need to do.
5 I think that within some sort of a
6 context that that can be done. I don't know
7 that it can all be done under existing
8 authorities, under CMS, or different insurer
9 plans, or whatever. But, unless there is some
10 way to make sure that people are made whole,
11 it is a lot less likelihood that they are
12 going to be working together.
13 Whereas, I think people are very
14 motivated during disasters and during
15 emergency events, but they also need to know
16 that, when they do this, at the end of it all
17 there is going to be some way that things will
18 go back to normal, and they are going to start
19 working their way back down to normal amounts
20 of delivery of care.
21 It is not something that has been
22 really said very much. And yet, I think it

1 does affect the ability of these measures to
2 actually work or not.
3 CO-CHAIR PITTS: Sure, Terry?
4 MEMBER ADIRIM: Yes, I just wanted
5 to ask a question, to go to what Jesse was
6 saying about kind of tying up this section.
7 It may just be the time of day, but did you
8 clearly hone-in on what you are going to write
9 about accountability?
10 MR. PINES: So, we do have a draft
11 of that section in the report. We can take a
12 look at that. But, essentially, what is
13 currently in there is that the measures are
14 going to be aggregated at different levels.
15 So, essentially, a lot of these crowding
16 measures and preparedness measures would be
17 basically taken from the facility level to the
18 regional level or to the hospital/coalition
19 level to promote the "coopetition".
20 So, next, we are going to go ahead
21 and move to the discussion of the NQF
22 criteria. Arjun Venkatash had a short

1 presentation he was going to give for us.
2 MEMBER VENKATASH: It is not as
3 much of a presentation, I think, as it is a
4 valuable exercise for this process, which is
5 that a good handful of people in the room have
6 served on NQF Steering Committees in the past
7 through a consensus-development process, but
8 some haven't as well. I think there is
9 probably value for those who have not served
10 to look at the NQF measure evaluation criteria
11 when thinking about these concepts, because
12 that helps set the bar of understanding what
13 it would take for any of these concepts to
14 actually turn into something that would be
15 endorsed.
16 And for those who have been
17 through the process before, I think it would
18 be valuable to add those insights to this
19 discussion, because the criteria have not
20 necessarily evolved over time, but have been
21 specified over time. And I think probably the
22 two things that happened, most importantly,

1 were two reports about a year ago on the
2 evidence expectations regarding measure
3 evaluation, and then the second being around
4 testing.
5 I think probably the easiest thing
6 to do is -- oh, you have got them right there?
7 Good.
8 Helen presented this morning the
9 four general categories by which measures are
10 evaluated. I think where this group can
11 provide some value here in terms of what the
12 final report looks like is thinking about
13 places where you think either an exception
14 needs to be made to the current NQF measure
15 evaluation criteria in order for a measure
16 around crowding, boarding, and preparedness to
17 make it through the process or, secondly,
18 places where there are clear inadequacies that
19 measure developers need to be aware of before
20 they go through the measure development
21 process.
22 So, if we start at the very top of

1 the measure evaluation process, No. 1 is a
2 must-past criteria that is the importance of
3 the measure.
4 Angela, do you have that other
5 table?
6 So, for the purposes of this, I
7 don't know what everybody here thinks, but my
8 idea was, if we use the IBA measure that we
9 alluded to this morning as kind of a frame of
10 reference to the back of our head, I think it
11 will be valuable because it is a preparedness
12 measure. I think it is the preparedness
13 measures really that are going to have the
14 most trouble when you look at the way
15 measurement evaluation criteria are set up and
16 the degree to which they are outcome- and
17 patient-measurement-focused. So, I think if
18 we think of that measure in the back of our
19 head, and then go through these criteria, that
20 is probably the most valuable.
21 So, we will start with importance.
22 I don't have it in front of me, either, I

1 don't think.

2 Within importance, if you think of

3 that IBA measure as it currently stands, I

4 think that a lot of the preparedness measures,

5 importance is kind of subdivided by

6 categories. That IBA measure would be able to

7 -- one of the first criteria is, does this

8 fall within a national strategy around quality

9 or improvement? I think that the preparedness

10 concepts will often fall within national

11 strategies, either by fiat or whatever it is.

12 But that part wouldn't be very challenging.

13 The second step of that would

14 often be, is there an evidence base to suggest

15 that there is a performance gap, would come

16 under importance. So, I guess a question for

17 the group is, what does performance gap data

18 look like? What does variation data look like

19 for a proposed measure, be it at the hospital

20 level or regional level, around preparedness?

21 Because if the outcome is rare, we may not

22 have that type of gap data.

1 MEMBER CARRIER: May I ask a
2 question?
3 MEMBER VENKATASH: Yes.
4 MEMBER CARRIER: When you are
5 talking about importance, is it enough to say
6 that in a disaster it is important that
7 hospitals be able to move beds? Or do we have
8 to say in a disaster we have demonstrated that
9 it is important that hospitals be able to move
10 20 percent of their acute beds within four
11 hours, which are two different questions I
12 think?
13 MEMBER VENKATASH: So, I mean, the
14 latter. But we are almost even a step up from
15 that, in the sense that that would get more at
16 the focus of measurement and the actual
17 specifications of a measure. But you were to
18 be a measure developer and make a measure
19 around IBA, part one of importance would be
20 that it is high impact. So, we would argue
21 that preparedness in the setting of either
22 surge or large-scale massive disaster is

1 important to the National Quality Strategy,
2 things like that.
3 And then, when you describe the
4 opportunity for improvement in the current
5 performance gap, you would have to show data
6 that says, okay, in the setting of disasters,
7 currently, there is variation amongst
8 hospitals, and 50 percent of hospitals are
9 unable to create 20-percent capacity.
10 So, the question I would have is,
11 if we think about this in terms of the IBA
12 measure, right, the IBA measure asks, can you
13 increase capacity by 20 percent in four hours?
14 What data would a measure developer have to
15 show you for that measure for you to believe
16 that there is a performance gap, that right
17 now, at either the hospital level or the
18 regional level, that there is currently a gap
19 between being able to do that or not?
20 DR. BURSTIN: Just one
21 clarification. Actually, it doesn't have to
22 be a gap in care. It could also be variation

1 across providers or across entities, whatever
2 the case may be. But that would be adequate
3 as well.
4 CO-CHAIR PITTS: Mike, you have
5 got something to say?
6 MEMBER STOTO: Yes. I think that
7 that criteria is a really important one. But,
8 given the state of development of this field,
9 where no one has any data at all about this,
10 we just can't do that right now.
11 So, I think that in this case the
12 importance argument has to rely on the kind of
13 arguments that Dave was making this morning
14 about, if you can't do this, you can't do
15 anything else, is basically what it comes down
16 to.
17 I think that, given the state of
18 development, we just have to think about that
19 differently now.
20 MEMBER ADIRIM: You could say it
21 has face validity.
22 MEMBER STOTO: I'm sorry?

1 MEMBER ADIRIM: You could say it
2 has face validity.
3 CO-CHAIR PITTS: Face validity.
4 MEMBER STOTO: Yes, that's right.
5 Right. And I think of that in terms of a
6 logic model that you really think through how
7 is this going to lead to the outcomes that we
8 want. It really is on the order of face
9 validity and kind of logical thinking, as
10 opposed to data, at this stage.
11 MR. PINES: Right. Right. So,
12 essentially, what we are trying to do here is
13 basically take the objective criteria, NQF
14 criteria, that are applied to all measures,
15 and given the unique nature of preparedness
16 data/evidence, basically, modify those
17 standards a little bit. And we don't want to
18 say "reduce the standards," but modify those
19 standards, so that measures that are important
20 can potentially get through.
21 MEMBER VENKATASH: I guess a
22 related question here is, traditionally, when

1 thinking about the performance gap, right, it
2 helps us identify those areas which require
3 performance improvement. So, in the case of
4 preparedness, part of this is justifying that
5 this is worth measuring and that it needs
6 improvement.
7 So, does it need simulated
8 exercise to demonstrate performance is
9 inadequate? Or is this kind of face concept
10 that we believe in general consensus that
11 current performance with respect to that
12 measure is inadequate? I think that is
13 probably a question that this group can
14 provide guidance on because, if that is not
15 enough, if we are going to dedicate a lot of
16 resources to the improvement, should the
17 standard be that at least simulated exercise
18 has demonstrated that current performance is
19 inadequate before you continue through the
20 rest of measure development?
21 CO-CHAIR PITTS: Is there not any
22 empirical data on performance being inadequate

1 in response to some disaster? There must be.
2 You hear about disasters, and this and this
3 was done, but was it adequate?
4 MEMBER CARR: What sources do they
5 use? Do they need peer-reviewed literature?
6 Does anybody know this?
7 MEMBER STOTO: I don't think that
8 people have looked at this in a systematic
9 way. I think people have looked at one
10 disaster after another and have said, "Oh,
11 gee, we didn't have enough capacity in the
12 hospital to do this." And that is the kind of
13 reasoning that this is based on, but I don't
14 think it is the kind of statistical analysis
15 that we often see in NQF.
16 MEMBER CARR: But does anybody
17 know the threshold? I mean, does that work?
18 There is a series of six disasters, right? We
19 just heard that Aurora's emergency department
20 was crowded before they got 20-some-odd --
21 DR. BURSTIN: For the performance
22 gap, yes. For the evidence for the measure

1 focus, no. Those are different. So, you
2 could certainly use, I think, the cumulative
3 experience to assess that there are issues.
4 I think the question that is
5 raised up here on the top one is really
6 evidence of measure focus. And again, I think
7 there is going to be plenty of data, I would
8 think, to suggest that better-organized --
9 that the availability of beds makes a
10 difference. No? Okay.
11 MEMBER STOTO: But, you know, I
12 think that we have to -- I want to be careful
13 about not saying we lower standards, but just
14 think about it differently. Because the state
15 of this field is just very early. The fact
16 that we don't have evidence doesn't mean that
17 it is not important.
18 DR. BURSTIN: So, two things to
19 add to that, the first of which is, if it is
20 an outcome -- and I guess the question is, is
21 this an outcome? I am not sure this really
22 is. No, I guess it is a process measure. So,

1 that doesn't really count.

2 But we actually do have an

3 exception as well which we put in there

4 specifically for areas that just aren't as

5 further along in terms of evidence, which is

6 that if there is no empirical evidence, expert

7 opinion is systematically assessed with

8 agreement that the benefits to patients

9 greatly outweigh potential harms. I mean, to

10 me, this seems like a logical area for where

11 the exception could potentially be invoked.

12 But I think it is important to note that it

13 probably will need to be invoked for these

14 kinds of measures.

15 CO-CHAIR PITTS: So, I am speaking

16 for Suzanne here, who wonders if there is not

17 data internationally in places where they have

18 disasters every couple of weeks, Israel or

19 someplace like that.

20 MEMBER STOTO: You know, there is

21 another issue here, too. Where did the 20

22 percent come from? It may be that 20-percent

1 increase in capacity doesn't do you any good
2 at all in most kind of exercises. Maybe you
3 need to double or triple your capacity in this
4 regard. But that, to me, is a bigger
5 challenge than the idea that you need to
6 increase it.
7 CO-CHAIR PITTS: Wes?
8 MEMBER FIELDS: Well, I may be
9 missing something here, but it seems to me
10 that this provides the best rationale for
11 fusing these two areas of activity. Because
12 I think if you go back to sort of the calculus
13 of this, there is lots and lots of peer-
14 reviewed evidence that crowding translates
15 into bad patient outcomes. If you aggregate
16 all that, I think it provides a compelling
17 case for why, if we are having this much
18 trouble managing low- to mid-range surges in
19 demand, then we can reasonably conclude that,
20 whether it is 20 percent or 40 percent above
21 the highest level of the tide in the nation's
22 EDs, that additional capacity needs to be

1 created.

2 So, I actually think that is the

3 reason why we are all here. It is ironic that

4 crowding data that has been peer-reviewed can

5 make the case for achieving a fairly high-

6 level national strategy around surge capacity.

7 CO-CHAIR PITTS: Peggy? Yes,

8 sorry.

9 MS. SPARR: I'm sorry. I am new

10 to ASPR. As I have been aware, this standard

11 of 20 percent, even for individual hospitals,

12 it has been above their normal daily operating

13 ability, not for IBA going 20 percent below

14 it.

15 But it is tied, also, to the

16 ability of when a community will essentially

17 say, "We need help." So, if you can do that,

18 somebody has come up with the number, and it

19 predates me, but it is tied to at what point

20 you are going to ask the state to come in to

21 offer resources, and then the state to ask the

22 feds to come in for resources. So, it is not

1 just a number; it is a number tied to how many
2 days that you can hold off, how many hours you
3 can hold off on your own without anybody else
4 coming in.
5 MR. PINES: And also, just to
6 clarify the discussion here, essentially, we
7 are talking about the specific criteria under
8 impact. I don't see a major issue with a lot
9 of preparedness measures being able to show,
10 certainly, a national impact here.
11 But, specifically, under
12 performance gap and evidence, where there may
13 be issues specifically tying specific
14 interventions to outcomes -- so, for example,
15 IBA is an idea right now. It is not something
16 that has been necessarily tested. How do we
17 modify our criteria for acceptance of
18 performance measures where there may not be a
19 lot of data on performance gap? And what
20 Helen had said we could potentially do is have
21 expert consensus.
22 And then, basically, for evidence,

1 in a lot of the preparedness literature there
2 is not really any sort of tie to outcomes, for
3 the reasons that Mike mentioned earlier. No
4 counterfactual; you know, you don't really
5 have a control group, and other issues. You
6 don't really know what would have happened had
7 you not done what you did.
8 So, essentially, how do we modify
9 that language to make sure that measures like
10 IBA can actually get through?
11 MEMBER STOTO: Well, you know,
12 actually, in a way, I don't think we do,
13 thinking about it that way, because this is a
14 major feature of the HPP capacities and the
15 PHEP capacities. Just the way that we would
16 say that the Preventive Services Task Force
17 recommends this, I think that has similar
18 standing.
19 CO-CHAIR PITTS: Brent?
20 MEMBER ASPLIN: I think we could
21 do that, but I thought that was the whole
22 point of this meeting. You know what I mean?

1 So, if we were going to do that, why have this
2 second phase of the whole process? We could
3 have just been doing the measures today?
4 I am not suggesting that you are
5 saying that is your preferred outcome. I
6 would really like to avoid it, if we can,
7 though, because, ultimately, I think it serves
8 this body of work best if we meet the same
9 standards for the whole consensus-development
10 process as the other measures that go through
11 NQF. I think it will help the body of work
12 better.
13 MR. PINES: I think the issue that
14 we are going to run into, especially with
15 taking a look at the measures from the
16 environmental scan and other measures that
17 Mike has brought up, essentially, we would
18 systematically make it very difficult for any
19 measure to get through if we use the current
20 NQF criteria. And essentially, not for
21 crowding measures, but specifically for a lot
22 of the preparedness measures that are HPP.

1 MEMBER VENKATASH: The last part I
2 think that is worth a quick discussion within
3 evidence is the consistency standard,
4 especially because, as more measures have been
5 getting reviewed recently, that has been one
6 where there has been a lot more, I think,
7 within Steering Committees discussion.
8 What that basically expects is
9 that, for things that have been studied in
10 multiple contexts -- and I can imagine the
11 situation here being that, if we look at
12 historical examples, achieving consistency is
13 going to be difficult. It would be easy for
14 somebody to say, "Well, that experience is a
15 little different than this one," right there.
16 That shooting in Aurora was different than
17 that flood there.
18 And so, coming to some agreement
19 around what evidence consistency means here
20 for the measure focus I think is actually
21 going to be something that would be fairly
22 challenging. Since I don't know this

1 literature at all -- and maybe, Mike, this is
2 looking to you and others in the room -- the
3 idea around, how well agreed-upon is the idea
4 that what we have known from historical
5 examples, if that is what we are going to use
6 to get at this idea of importance, how
7 consistent is that across different examples?
8 MEMBER STOTO: This is a good
9 question. I mean, I think that consistency in
10 this context is also basically used the same
11 way it is used in a systematic review. I
12 mean, do you see not only that there is a
13 strong effect in a meta-analysis, but there is
14 relatively-little heterogeneity. So, we just
15 don't know that because this kind of study
16 hasn't been done.
17 But I do think, though, that if
18 you think about it logically, there are some,
19 I guess there are likely to be some kinds of
20 emergencies where having surge capacity is
21 important; some where it is not that
22 important.

1 Now does that mean that we
2 shouldn't have a measure of it, because it is
3 only important in some situations but not in
4 others? I don't think so.
5 What I would say is that we
6 interpret this in terms of heterogeneity in a
7 meta-analysis, and it just doesn't apply here.
8 I don't want to seem like an apologist for
9 this, but I think that the process, we need to
10 really think carefully about how to apply the
11 process to a very different situation for the
12 situations we used before.
13 MEMBER VENKATASH: I mean, if that
14 is the recognition that is made from the
15 group, that is a big deal because right now
16 consistency is a must-pass criteria. So, if
17 there was a measure developer out there
18 developing a measure --
19 MEMBER STOTO: I am not saying
20 that it shouldn't apply. I am just saying
21 that it doesn't -- we just don't know. We are
22 not in a position to assess it because we

1 don't have the kind of statistical studies
2 that you would in others.
3 MR. PINES: But, also thinking
4 about consistency in a broader way, you know,
5 are there ways to measure consistency or other
6 potential standards that we could either
7 replace that with, that would kind of seem
8 like a similar bar for preparedness measures?
9 Because, essentially, I think what we don't
10 want is what seems like sort of measures that
11 are sort of experiments, that are sort of put
12 out there, saying that this is what we think
13 we should do. So, this is your measure of
14 performance.
15 So, essentially, that we do have
16 at least some sort of an expert panel, expert
17 consensus, some rigorous methodology that was
18 used. I know that for HPP there was a lot of
19 rigorous methodology, a lot of expert panels
20 that have gone into develop those measures.
21 That could potentially be used for this.
22 MEMBER STOTO: And maybe this is

1 the place where the simulation studies you
2 mentioned, you suggested, might come into
3 play, is that you can sort of do it, look at
4 it over a range of different kinds of
5 situations; does this consistently make a
6 difference?
7 CO-CHAIR PITTS: Okay. Brendan?
8 And then, Emily.
9 MEMBER CARR: I also wonder if
10 there is room to lean on crisis standards-of-
11 care document to talk about the fact that
12 there are times -- I don't know. I am
13 sensitive to Brent saying he doesn't want the
14 rules to be different. But, at the same time,
15 you know, we are being asked to play by
16 evidence-based rules in a world that doesn't
17 use evidence-based decisionmaking. This is
18 the intersection of public health and
19 healthcare, and it is tricky to do that.
20 So, I don't know. I wonder if we
21 sort of go through the crisis standards-of-
22 care conceptual framework and try to apply it

1 here, if we feel less conflicted, given that
2 central entities have said it is okay.
3 MEMBER ASPLIN: Keep in mind I am
4 coming at it from the crowding side more than
5 -- so, I am spending more time in that world.
6 So, I probably feel more strongly about that,
7 those measures, than I would from
8 preparedness.
9 MEMBER CARR: Sure. Sure. Yes.
10 DR. BURSTIN: I think it is
11 actually quite different on the emergency
12 preparedness side, where there just isn't a
13 robust literature to draw on. We wouldn't,
14 for example, let a lot of the care-
15 coordination measures go forward, even though
16 there is systems research that clearly showed
17 evidence that was applicable.
18 In this case, again, I think we
19 did this for some of our palliative care
20 measures, a new, emerging field as well.
21 There aren't a lot of studies on the benefits
22 of spirituality for patients undergoing end-

1 of-life, but, boy, you would sure note, you
2 know, there is a lot of expert consensus that
3 says it is important. So, we are not going to
4 hold back a measure that is going to have
5 benefits to the nation just because it doesn't
6 emerge from that same level of database.
7 CO-CHAIR PITTS: So, Emily, and
8 then Rick.
9 MEMBER CARRIER: I was just
10 wondering if there was any benefit to thinking
11 about the frame of measures around never
12 events, particularly for the disaster
13 preparedness. I don't know much about how
14 those measures are developed, but no one is
15 going to do an RCT of wrong-side surgery
16 certainly. And yet, we are able to build a
17 measure that this should never happen.
18 Are there things in preparedness
19 or in crowding that are never events?
20 MEMBER ASPLIN: Apparently not in
21 crowding.
22 (Laughter.)

1 CO-CHAIR PITTS: Rick?
2 DR. HUNT: I am not sure if we
3 have resolved the performance gap piece, but
4 I want to get really concrete, really
5 specific, and really practical for just a
6 second.
7 Performance gap. After four days
8 at the Madrid hospital that saw the majority
9 of the patients, they said, "We did not
10 perform very well. We performed very badly."
11 They saw 272 patients in 2.5
12 hours. For the ER docs like me around the
13 room, that ought to make you really
14 tachycardic and lose bodily functions. Okay?
15 Two hundred and seventy-two, 2.5 hours. "We
16 performed very badly." That is what he said.
17 That was the surgeon in charge of the hospital
18 that day. They performed badly in terms of
19 they had a long list of these are the things
20 we did not -- it was a long list.
21 And so, when you think about where
22 there is a performance gap, I kept going,

1 well, how in the world did they do this at
2 all? It was a 1600-bed hospital. Blocks were
3 1600 beds. And by the way, we got lucky
4 because it was switch of shift. So, they had
5 staffing for 3200 patients.
6 So, if there is a performance gap
7 -- and that is real, that really happened. It
8 is not theoretical. So, in terms of are there
9 lists of kinds of events -- and people can do
10 Auroras. The gaps definitely exist.
11 So, I am hopeful that that one we
12 can get beyond.
13 CO-CHAIR PITTS: Anthony?
14 MEMBER MacINTYRE: Just the
15 literature, the medical literature is scant
16 and mainly anecdotal. There are recurring
17 patterns of process issues that are repeated.
18 But I wonder how looking at other bodies of
19 literature might be approached, not to
20 increase your workload, Jesse. But there is
21 a tremendous amount of emergency management
22 literature. There is a good body of business

1 crisis continuity literature. There is a
2 whole lot of DoD literature out there,
3 consultant-generated and otherwise. If you
4 really want to look at organizational
5 management, there could be some good pieces
6 out there.
7 Just as a specific example, you
8 know, DoD has spent a lot of time looking at
9 how to develop competencies for individuals to
10 perform in unusual situations, and how do they
11 maintain those skills, knowledge, and ability.
12 I think there are some parallels there.
13 Obviously, you are not going to develop a
14 whole new NQF standard based on one article,
15 but it might be worth looking at some of these
16 other bodies of literature. We tend to stay
17 siloed sometimes in our own realm.
18 DR. BURSTIN: And NQF has
19 experience doing this with our safe practices,
20 for example, where it is perfectly reasonable
21 to invoke other industries where safety has
22 been so far ahead of us for quite some time.

1 So, that is very fair game, a great
2 suggestion, Anthony.
3 CO-CHAIR PITTS: Jay?
4 MEMBER SCHUUR: I really like
5 Emily's idea around the never events. I think
6 that that is an interesting frame.
7 Maybe you guys can remind me.
8 When the Patient Safety Committee sort of went
9 through never events again, as I remember,
10 ACEP put one in which was death in the waiting
11 room, as an idea of a boarding never event.
12 And from what I remember of the form, there
13 was a different sort of standard. It wasn't
14 the typical full measure form. It was a
15 shorter form.
16 And has that now changed with the
17 new evidence development process? Or is there
18 a different process that that goes through?
19 DR. BURSTIN: It is a different
20 process for both serious reportable events and
21 safe practices. But I think the example that
22 was raised by Emily was the wrong-side

1 surgery. That actually is also in our Quality
2 Indicator. So, I mean, sometimes they are
3 measures and sometimes they are practices or
4 serious reportable events. And I think you
5 can go either way.
6 CO-CHAIR PITTS: Mike?
7 MEMBER STOTO: I could think of
8 lots of potential issues, preparedness issues,
9 and measures for which there is no good
10 evidence, and people don't really agree. But
11 does anybody really think that it doesn't
12 matter whether you can increase the capacity
13 of your healthcare system during an emergency?
14 I mean, that just seems so obviously true,
15 right?
16 MR. PINES: Well, I think the
17 question would come particularly if a measure
18 was submitted for IBA and the 20-percent
19 number was used. We would, hopefully, want to
20 see some sort of rigor around that 20-percent
21 number or at least some expert consensus or at
22 least some sort of a methodology that would

1 demonstrate that that number was vetted.

2 MEMBER STOTO: Yes. No, I agree

3 about the 20 percent. But about the concept

4 of being able to increase your capacity to

5 treat acute cases, it is hard to imagine that

6 not being true.

7 MR. PINES: Right. Right, and I

8 think that would come under the importance to

9 measure and report.

10 MEMBER MacINTYRE: You also need

11 to have assumptions, though, with that. And

12 the assumptions are that the sky is blue,

13 Metro is running, the bridges haven't been

14 closed for the Inauguration, on and on.

15 Because, unfortunately, most disasters do

16 occur with those other issues, and that

17 impacts your ability to surge 20 percent. So,

18 having some assumptions in there is pretty

19 important, even if you do scope out the number

20 well.

21 I mean, around here, Hurricane

22 Isabelle, Metro shuts down; there goes your 20

1 percent.

2 CO-CHAIR PITTS: Did you cancel

3 your comment? Okay.

4 All right. Arjun, do you want to

5 continue on?

6 MEMBER VENKATASH: I think it is

7 probably, given how much time we have, worth

8 going on to scientific acceptability.

9 MEMBER STOTO: I haven't heard

10 actually how it is defined, this measure.

11 MEMBER VENKATASH: Well, it is not

12 specified. Right now, it really sits at a

13 measure concept level. So, that is why I say

14 think of it as, if that were the concept, what

15 would your expectations be at each of these

16 junctures? Especially that applies primarily

17 to Category 1, importance, and Category 2.

18 MEMBER STOTO: Well, I mean, how

19 can we talk about validity and reliability if

20 we haven't defined it?

21 MEMBER VENKATASH: That is a good

22 question. I think in some of the sub-

1 questions, though, within validity and
2 reliability, we can get it without even the
3 definition. And that is that scientific
4 acceptability as a whole contains two
5 categories: first, validity, and then, second
6 is reliability.
7 Part of this does get at how
8 specific, how well it is specified, but a lot
9 of the validity question actually gets to how
10 well the specifications are supported by
11 evidence.
12 So, now, with a lot of the
13 preparedness measures, for the same reason
14 that we may not have evidence around the
15 measure focus above, it would be the same
16 reason why we wouldn't have evidence,
17 potentially around specific measure
18 specifications.
19 And the classic example I like to
20 use here is denominator exclusions within
21 this. And that is thinking about, when you
22 apply this measure and we think about who is

1 in and who is out, which hospitals you
2 measure, which hospitals you don't measure,
3 which patients within a hospital within a
4 region would be measured, which ones wouldn't,
5 the expectation is often that, if the patient
6 is going to be excluded, that is based on an
7 evidence base that lives below that.
8 It may be that for these measures
9 this doesn't become a huge issue because we
10 say everybody is in, which I think is probably
11 the clear concept and gets to some of what we
12 were saying before.
13 But if there are going to be
14 exclusions, there is not going to be evidence
15 base around any of that. I don't know if that
16 applies well, but it is certainly worth a
17 little discussion.
18 MR. PINES: I think that that kind
19 of gets too deep into the weeds. We can't
20 even think about that.
21 So, I am thinking there are a
22 couple of ways I can imagine of assessing

1 this. One is you can go around to whatever
2 these regions are and say, "Can you bump up
3 your capacity in four hours by 20 percent?"
4 And they say, "Oh, yeah, yeah, we can do
5 that." I mean, I wouldn't regard that as
6 evidence that is valid and reliable.
7 Well, then, I might say, "Well,
8 how about if you did it in an exercise where
9 you actually called the people in and did it
10 and moved them around, and so on?" Well,
11 then, I would think a lot more highly of that.
12 And maybe you guys have thought
13 this already, but I think until we hear
14 whether it is that, one or the other or
15 something else, we can't even begin to think
16 about these other issues.
17 MR. PINES: And I think we are
18 also thinking about the reliability and
19 validity in the context of what instrument is
20 used to actually measure what you are trying
21 to measure. I think there are a lot of ways
22 to do that.

1 I know that for emergency
2 preparedness, particularly preparedness, on
3 the preparedness side there are tons of
4 instruments out there with variable
5 reliability and validity, some with a lot more
6 testing than others. That could potentially
7 go into the NQF submission. You know, really
8 linking preparedness to actually may be a
9 little bit more tenuous.
10 And essentially, one of the only
11 things we may have in that part of the
12 application would be the reliability and
13 validity of the instrument itself.
14 MEMBER STOTO: But this is a
15 particular measure we are talking about, your
16 ability to increase your capacity for acute
17 cases by 20 percent in four hours. And so,
18 the validity or reliability of some other
19 issue is not relevant here. This is a
20 specific thing for which you can actually get
21 some evidence on this specific thing. But you
22 have to specify what you mean and how you are

1 going to measure it first, before you can even
2 think about this.
3 MR. PINES: Right, right. So, I
4 mean, it could be done through a tabletop
5 exercise. And essentially, you would
6 basically do repeated tabletop exercise to
7 demonstrate. I mean, that may be what we are
8 talking about.
9 CO-CHAIR PITTS: Oh, I'm sorry, go
10 ahead, Peggy.
11 MS. SPARR: I just wanted to make
12 sure because I am not clear. I don't think I
13 heard Marco say that this morning. So, I just
14 want to make sure, when people think about
15 IBA, that we are not talking about surge
16 above; we are talking actual offloading of
17 people within four hours. I just want to make
18 that within four hours you will have beds
19 available already versus having to pull them
20 out of your storage area, call in more staff,
21 because they are already there. And that is
22 his novel concept.

1 CO-CHAIR PITTS: Okay. Okay,
2 Arjun, go ahead.
3 MEMBER VENKATASH: So, I guess
4 within some of this reliability and within the
5 validity question, then, I guess, a reasonable
6 question for guidance is, would an attestation
7 measure be something that would be considered
8 for endorsement? Or is the general group
9 consensus that, listen, that bar is way too
10 low?
11 To demonstrate that this is worth
12 measuring, not worth measuring, but that this
13 is valid, at least there has to be some data
14 that suggests that it is done via exercise or
15 something else. Is that reasonable?
16 MEMBER STOTO: To me, it is.
17 MEMBER ADIRIM: There is a
18 systematic way of assessing.
19 MR. PINES: Yes, I think that is
20 what we are looking for, is basically to see
21 how much the group really agrees with this
22 language. You know, we will certainly send

1 this draft document out to the group. But,
2 essentially, to make sure that in the context
3 of the NQF standards that it does not appear
4 like we are going to basically modify the
5 standard so that, in order to get measures
6 through these campy ideas, there has to be
7 some scientific basis behind them.
8 CO-CHAIR PITTS: It sounds like we
9 all agrees attestation is not good enough.
10 Okay.
11 MEMBER VENKATASH: I think it is
12 sort of related in some way, you know, in the
13 specified measure, but the usability and
14 feasibility side of this. If a measure is
15 developed in this space, I think on the
16 crowding side this seems much clearer because
17 a lot of these things you can take a group of
18 hospitals, you can see what it took to measure
19 it, and then demonstrate how understandable
20 those findings are to various people, right,
21 be it boarding time, waiting time, any of
22 those? That kind of makes sense to us.

1 On the preparedness side, what is
2 a demonstration of usability? Does a measure
3 developer have to demonstrate that this
4 information is meaningful at the policy level,
5 patient level? How do you demonstrate that
6 the findings from this are meaningful, outside
7 of saying that we really wanted to measure
8 preparedness, I guess?
9 MEMBER STOTO: Oh, in the public
10 health preparedness world, what it usually
11 comes down to is these are one of the things
12 that CDC has required that we have been
13 reporting, and people have been looking at it
14 to make judgments, and so on.
15 DR. BURSTIN: I think the read of
16 what we have under usability and use fits the
17 extent to which potential audiences, which in
18 this case could be ASPR, CDC, and others, are
19 using or could use the performance results for
20 both accountability and performance
21 improvement. I think that is actually a
22 pretty easy fit on this one. Arjun, I am not

1 too worried.

2 MEMBER VENKATASH: And then, if

3 you look down at feasibility, about the same

4 general consensus, that if somebody has

5 collected some of this data in order to be

6 able to apply and demonstrate it, that that is

7 kind of the demonstration of feasibility?

8 CO-CHAIR PITTS: Yes, Wes?

9 MEMBER FIELDS: I think where we

10 may have to demonstrate feasibility is if we

11 really get to the point of demonstrating how

12 hospital systems cooperate and collaborate in

13 this mode. And again, that might be a little

14 challenging, but I think the concept of

15 scalability has come up several times and it

16 makes sense to me. But whether or not that

17 will meet the test for a standard measure, you

18 guys will have to tell me.

19 MEMBER VENKATASH: That is

20 actually a good question. If a measure is

21 developed and the level of measurement is

22 specified as coalition or region, should data

1 already be present at that level? Or is
2 hospital-level data from multiple different
3 regions but not all within one existing
4 coalition sufficient?
5 DR. BURSTIN: It depends on the
6 level of analysis. So, I think it will work
7 either way.
8 MEMBER CARR: You think it will
9 work, even though we don't know what the
10 region is or what a coalition looks like?
11 DR. BURSTIN: I think you have to
12 have preciseness --
13 MEMBER CARR: Okay. Yes, right.
14 It does strike me that the geographic unit
15 here --
16 DR. BURSTIN: Yes.
17 MEMBER CARR: -- is a really big
18 gap. I mean, we all could sum the data, but
19 we do have to know what we are summing it to.
20 So, will they say, "We are not letting
21 anything through until you tell us what the
22 unit is?" or will they allow us to have a

1 nebulous unit?
2 DR. BURSTIN: I mean, one of the
3 most important issues here is precision of
4 specifications. You have got to be able to
5 compare apples to apples. So, that is the
6 goal. So, the precision is important, but we
7 do require measure testing at the level of
8 analysis in which it is intended. So, in some
9 ways, having a regional measure makes it
10 easier because it is a whole lot easier to be
11 potentially, with data already collected, to
12 do some of the signal-to-noise analysis at a
13 higher level of analysis than it is to take
14 the deeper dive on the reliability of the
15 provider-level data aggregated up.
16 So, there are different approaches
17 here. I think both of them are workable.
18 MEMBER STOTO: I think that might
19 be true for this particular measure about
20 capacity, because this really is summing up,
21 I think. But some of the other preparedness
22 measures we want to do really have to do with

1 how the different parts of the system work
2 together. And that is very different from
3 summing up and that would be a different kind
4 of situation.
5 CO-CHAIR PITTS: Jesse? Did you
6 have something? Oh, I'm sorry.
7 MEMBER VENKATASH: Actually,
8 Brendan just raised a good question, which is,
9 I mean, currently, as measures would be
10 specified, you would have to specify, if you
11 say this is a regional measure, what the
12 region is.
13 DR. BURSTIN: You have to define
14 what a region is, right.
15 MEMBER VENKATASH: That probably
16 needs big, red underlining in terms of
17 expectations of developers.
18 DR. BURSTIN: And I think there
19 are some good examples. I mean, for example,
20 if you look at the AHRQ Prevention Quality
21 Indicators, which are defined at a community-
22 level, a population-level, those are examples.

1 You recently endorsed a measure in population
2 health, one of the only, looking at late-stage
3 presentation for HIV, again, at a more
4 regional approach. So, there are some
5 examples.
6 There are plenty of HRSA regions
7 and HHS regions and lots of ways to cut and
8 paste these things, as appropriate.
9 MEMBER ADIRIM: Does it have to be
10 so specific that it is saying that it is a
11 state being a region versus just coming up
12 with a definition, so that there is
13 flexibility for local communities? So that,
14 for example, a region could be multiple states
15 versus a local community. Tiered. I mean, I
16 could see various ways to define a region.
17 MEMBER VENKATASH: Would it raise
18 a harmonization issue? If you have multiple
19 measures with differently-specified regions,
20 then if you endorsed multiple measures, the
21 same agents are functioning within
22 preparedness under different collaboratives or

1 different collections of what a region is.

2 MEMBER ADIRIM: Yes, but for

3 preparedness you would have the same elements

4 within a region. The capabilities would be

5 similar, right? So, you could compare a local

6 region -- I may be hallucinating -- but can

7 compare a local region, because it would have

8 certain elements that you would need to handle

9 disaster versus a multi-state region maybe?

10 I don't know.

11 CO-CHAIR PITTS: Go ahead, Gregg.

12 MEMBER MARGOLIS: Well, I don't

13 know if I have the answer, but we have

14 certainly had a lot of conversations about

15 this, and more questions than answers, I am

16 sure.

17 First of all, I think at least in

18 terms of the regions, there is some element of

19 geopolitical borders here that probably do

20 make sense, although we know that patients

21 don't necessarily follow those geopolitical

22 borders in terms of referral patterns. But

1 there are elected officials, whether at a
2 county level or a municipal level, that bear
3 certain responsibility and interest in some of
4 these variables for the communities in which
5 they have been elected to serve.
6 So, there probably is, at least in
7 terms of preparedness and some of these other
8 variables, some value in being able to make a
9 comment to elected officials that the
10 preparedness of your county or city or state
11 is this. And that kind of gets a little bit
12 to the accountability piece that was brought
13 up a little bit earlier.
14 But I don't think that that is the
15 whole piece of it. One of the things that we
16 have been talking about and kicking around a
17 little bit is what might some of the Dartmouth
18 Atlas work in terms of geographic variations
19 in care be able to offer to some of this
20 conversation? And we were just having a
21 little watercooler conversation. You know,
22 what might be the analog of the hospital

1 referral regions for emergency care? Is it
2 possible -- and Ryan might be able to help us
3 with this -- to define that people that have
4 emergency care issues within this geographic
5 area have a 90-percent or 95-percent
6 probability of staying within the healthcare
7 resources of this area and, therefore, helping
8 to define maybe not health or hospital
9 referral regions, but maybe emergency care
10 referral region? And do those, in fact, line
11 up with some of these other ways to look at
12 geographic variations in care, such as the
13 Dartmouth Atlas?
14 CO-CHAIR PITTS: So, Ryan?
15 MEMBER MUTTER: So, yes, there
16 have been a lot of these sort of
17 conversations. We have kicked around a lot of
18 ideas and at this point probably generated
19 more heat than light.
20 But there are a few ideas that
21 sort of come to mind. One is sort of what I
22 will regard of as a positive approach, which

1 is we sort of come up with some kind of
2 construct and sort of empirically build a
3 region.
4 The other is sort of what I regard
5 as a bit of a negative/testing approach, which
6 is to look at an existing construct, whether
7 it is a geopolitical boundary, say a county,
8 or something like that, or sort of more of a
9 scientifically-based measure, an HRR, or
10 something, and then look at unplanned critical
11 illness and what is going on there.
12 So, there is an idea that it is
13 sort of from the economics literature. It is
14 Elzinga and Hogarty. Some of you all have
15 talked to me about this. You have heard me
16 talk about them.
17 And they came up with a measure
18 basically for alcohol. What they did is they
19 looked at an area and said, okay, so there are
20 people in this area and there are breweries in
21 this area. What we are interested in is how
22 much beer is coming into this area to be

1 consumed by these people and how much of the
2 locally-produced beer is going out.
3 Okay. So, let's do the analog for
4 healthcare, for unplanned critical illness.
5 Let's look at a region and there are hospitals
6 in there, and there are injured patients in
7 there and all around. So, what percent of the
8 injury or the unplanned critical illnesses in
9 the HRR, let's say, are being treated in
10 there? What percent are going out? And if
11 that is a high number, then that suggests that
12 maybe HRRs aren't so good for this. And what
13 percent of unplanned critical illness is
14 outside the HRR flowing into it? If that
15 number is high, if that percent is high, maybe
16 these things aren't so good.
17 So, basically, it is sort of an
18 assessment. We could do an assessment of this
19 sort for different constructs, be it HRRs,
20 HSAs, counties, whatever. So, that is one
21 sort of aspect of it.
22 The other aspect of it is to look

1 at variation in some quality-of-care metrics.
2 And there are a few that we could use within
3 these entities, HRRs, HSAs, whatever, and sort
4 of see, is there variation across these
5 entities in these quality measures that we are
6 interested in? And if so, if there is
7 variation in quality, well, that suggests
8 there is an opportunity for improvement.
9 Maybe these things are interesting.
10 And so, anyway, those are some of
11 the concepts that in various conversations,
12 and whatnot, we have sort of kicked around,
13 because this is like a very big issue. It is,
14 what is this area that we want to assess? Is
15 it connected to the idea of coalition-
16 building? Is it exactly the same as the
17 coalition? Is it related? So, there is sort
18 of the definition for coalition-building
19 purposes, and then there is sort of the
20 definition of area for sort of quality
21 measurement purposes. And there may be an
22 extent to which those two are related.

1 CO-CHAIR PITTS: Brendan?
2 MEMBER CARR: So, yes, Ryan and I
3 spoke, and Gregg, about this at length. But,
4 then, the last piece is, if we are going to
5 talk about incentivizing geographies, regions,
6 coalitions to do something, to cooperate, what
7 happens to all the shared space? I mean,
8 these are not going to be crystal-clear lines
9 in the sand. There is going to be, you know,
10 as you get further and further away from one
11 coalition, you are going to bleed into the
12 other coalitions. So, there is going to be
13 lots and lots of -- I talked this morning
14 about white space, Marco, because I worry
15 about white space all the time, people that
16 aren't part of the team.
17 And sort of going back to my
18 trauma system roots, people that are not part
19 of an inclusive system, they are sort of on
20 their own, but I also worry about the shared
21 space and the redundancies because we don't
22 know which coalition. We don't know how to

1 share credit or responsibility or blame for
2 poor outcomes for those places that are shared
3 by multiple coalitions. You can imagine how
4 miserable this becomes in urban areas where
5 there is a lot of overlap.
6 CO-CHAIR PITTS: Jesse?
7 MR. PINES: Just a quick comment.
8 I just want to make sure, you know, I think
9 this is a really important discussion. I
10 think we are going to be integrating a lot of
11 the sort of need to empirically define
12 regional boundaries as a recommendation.
13 But I also just want, just sort of
14 getting back to this specific question about
15 the precision of specification, regardless of
16 whatever region it is, whether it is HRR or
17 whether it is these newly-defined empirical
18 regions, it has got to be precise when it is
19 submitted to NQF.
20 CO-CHAIR PITTS: Mike?
21 MEMBER STOTO: You know, I think
22 that this is a critically-important issue for

1 ASPR in implementing this approach. But I
2 don't think it is so much a measurement issue
3 or a harmonization issue. I think the real
4 critical issue is how do you define these
5 regions.
6 We did some work here in this
7 region that we are sitting in at this moment
8 now. We came up with five different views of
9 what the region was. I heard two different
10 ones, in addition, already just in the last
11 few minutes.
12 So, I think coming up with regions
13 that make sense is really hard, but that is
14 the hard part. It is not a measurement issue.
15 MEMBER MARGOLIS: If I could
16 actually just respond to that, they are not
17 regionally-exclusive, either. I mean, it is
18 entirely possible that you might want to be
19 able to, for different purposes, if you are an
20 elected official, you are only concerned about
21 the entities within the borders of your
22 community.

1 But if you want to look at it
2 differently, I think it would be really cool
3 if you are able to define the regions in
4 different ways based on different needs.
5 MEMBER STOTO: Cool, but hard.
6 And the other dimension is that in this region
7 here we cross state boundaries, maybe as many
8 as five, depending on how you call it. You
9 know, the Governor of Virginia doesn't care
10 much about Maryland.
11 CO-CHAIR PITTS: Wes?
12 MEMBER FIELDS: Yes, actually, I
13 think this sounds an awful lot like a
14 management problem. I think if we assume
15 that, from now on, it is a mutual problem,
16 then, to me, what that means is that the usual
17 chain of command that hospitals respond to are
18 the ones that are going to make the most sense
19 because of the improvement opportunities won't
20 happen from disaster to disaster. They will
21 happen from, you know, micro-event to micro-
22 event.

1 So, I think, especially if the
2 launch point is metrics and measures, which in
3 theory changes the way providers behave and
4 how hospitals deliver services, to me, what
5 that implies is you may need the geographical
6 management scheme for the big blowoff, but to
7 actually make the hospitals work better, and
8 for them to cooperate more across systems, you
9 are going to have to use fairly familiar-
10 looking management structures that aren't
11 geopolitical, and they are much more about how
12 the money flows.
13 CO-CHAIR PITTS: Arjun, are you
14 still proceeding onward or are we done?
15 MEMBER VENKATASH: We can be done.
16 CO-CHAIR PITTS: Okay.
17 MR. PINES: So, one thing I did, I
18 know we are sort of ending our time in the
19 next couple of minutes here. I did want to
20 just have a very brief discussion with the
21 broader group. Essentially, we were asked to
22 set up a runway for measure development, and

1 I just wanted to have a quick discussion about
2 the who and how, and to do a little
3 brainstorming about who are the measure
4 developers for this, how do we communicate
5 with them now to let them know that there may
6 be a consensus-development process in the
7 coming years, and what sort of tools do they
8 need? And what sort of mechanisms can we use
9 to make the highest likelihood of good
10 performance measures in this area?
11 MEMBER MUTTER: So, I will mention
12 that AHRQ has an IDIQ mechanism that we use to
13 facilitate measure development. That is the
14 means by which we are doing our current
15 emergency department Quality Indicator work
16 that we are just beginning right now.
17 Other agencies who want to use
18 this mechanism, basically, through an IAA, can
19 do so. For example, the current work we are
20 doing, as I mentioned before, has got a mental
21 health component to it that is funded by
22 SAMHSA. So, if there were other agencies that

1 wanted to support this kind of work, our IDIQ
2 is a possibility to get that done.
3 CO-CHAIR PITTS: Does HCUP -- what
4 kind of identifiers or at what level do you
5 identify these types of data, all the way down
6 to the hospital, the region, the address?
7 What is available?
8 MEMBER MUTTER: So, I mean, I
9 think some of that sort of depends on the
10 scope of work that is envisioned. I mean, a
11 lot of AHRQ's Quality Indicator work has been
12 built around data that is coded like HCUP
13 because we have HCUP data.
14 That doesn't mean that measure
15 development work has to be done on HCUP-
16 looking data. Basically, the IDIQ is a
17 mechanism. If someone were to want to come in
18 and do work on a different type of data, I
19 mean I think that is a conversation. It is
20 certainly not by nature limited to admin data
21 that looks like HCUP.
22 CO-CHAIR PITTS: Arjun?

1 MEMBER VENKATASH: I think one
2 obvious potential operator is the Joint
3 Commission, right? They have already got flow
4 standards. They already have a lot of
5 standards around preparedness to some degree,
6 and they have experience in the measure
7 development space.
8 CO-CHAIR PITTS: AnnMarie?
9 MEMBER PAPA: I don't know, but
10 what about IHI? They have a lot of measures
11 and they do a lot of -- I don't know if they
12 actually develop the measures or they use
13 other people's measures. So, I can't answer
14 that. But just something to think about.
15 MR. PINES: Jay, any thoughts on
16 ACEP potentially being a measure developer in
17 this area?
18 MEMBER SCHUUR: I think probably
19 saying that the organization is going to be
20 discussing over the next six months, but at
21 this point I would say, no, I think not by
22 themselves, but in collaboration with other

1 entities, whether governmental or academic
2 groups.
3 DR. BURSTIN: There is actually a
4 nice example in the world of stroke
5 measurement, where it is a combination of the
6 American Stroke Association, the Joint
7 Commission, the CDC, who actually came
8 together as a coalition to develop a set of
9 guidelines that everybody is comfortable with,
10 and then the Get with the Guidelines folks are
11 involved as well.
12 So, one thought might be kind of
13 thinking about how are the right people at the
14 table and seeing if there is a way to kind of
15 have some collaborative development, so you
16 don't wind up with measures in different
17 spaces that are really conflicting with each
18 other.
19 MEMBER CARR: For the less-
20 initiated, could we get like the 90-second
21 primer on how you go and who goes to engage
22 them? I mean, does NQF do advocacy in that

1 realm, to build coalitions? Is that something
2 that feds usually do? Or we just hope for the
3 best after we put the paper out?
4 DR. BURSTIN: It happens in a
5 whole variety of ways. I think in many of the
6 clinical areas those coalitions sort of
7 already exist. They are sort of more natural.
8 I think the question is if we
9 could help play any matchmaking role here. It
10 sounds like some of this is just who is ready
11 around the table. It might be a good, logical
12 place to start here.
13 But we do put out the measurement
14 gaps. So, a lot of what this report will
15 indicate is where the gaps or where measures
16 need to be developed.
17 And frankly, just to be honest,
18 measurement development costs money. So, the
19 other question is, if there are dollars on the
20 table, that people can put on the table to say
21 here are the defined gaps that ASPR and others
22 find to be the three-four most important

1 measures we need developed in the next year,
2 I don't think it would be that hard between
3 AHRQ and us and others to find the right
4 people to help you with that.
5 CO-CHAIR PITTS: Wes?
6 MEMBER FIELDS: That just takes me
7 back to my first response this morning to the
8 pitch. If you have $350 million funded, it
9 makes a lot more sense to me to use it to do
10 the focused measure development we have been
11 talking about rather than trying to pile it on
12 an ACO for disasters.
13 MR. PINES: So, any final comments
14 for the group? We have a few administrative
15 things before we end, but any other final
16 comments?
17 (No response.)
18 Angela is going to be taking us
19 through the timeline, but, basically, we have
20 to get this done this fall. So, we will be on
21 a very tight timeline.
22 But I just wanted to go ahead and

1 thank everyone for all their attention today.
2 I know today was a very long day. There were
3 a lot of really great comments, and this is
4 very helpful as we develop this document.
5 MS. FRANKLIN: Okay. And before
6 we wrap up, Arnika, I wanted to check to see
7 if there is public comment out there.
8 THE OPERATOR: Once again, to ask
9 a question, please press *1.
10 (Pause.)
11 There are no questions at this
12 time.
13 MS. FRANKLIN: Is there any member
14 of the public in the room who wants to make a
15 comment?
16 (No response.)
17 There's none? None here. We are
18 good.
19 Actually, what I would say, I will
20 turn it over to Adeela. But we will be
21 getting back with you to set up a call in the
22 next two to three weeks to go over all of the

1 changes that we want to aggregate into the
2 document, based on your comments. Please
3 don't hesitate to email us comments and
4 suggestions as well in the interim. But you
5 will be getting a poll from NQF as to your
6 availability for a call to get together to
7 walk through the new document.
8 MR. PINES: And one thing I
9 forgot, I just wanted to thank our Co-Chairs,
10 Suzanne and Steve, for leading this meeting
11 and, also, for all the folks who put together
12 extra stuff for this meeting, extra
13 presentations: Mike Stoto, Dave Marcozzi, and
14 Arjun Venkatash.
15 MS. FRANKLIN: If there is nothing
16 else, I think we are adjourned.
17 (Whereupon, at 5:02 p.m., the
18 meeting was adjourned.)
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A

abandon 141:15
abandoned 268:5
abdominal 230:9 276:16 285:11 293:16,17
ability 46:20 52:2,9 52:19 53:5 54:5 54:13,14,20 55:2 57:7,15 58:21 59:3,4 62:8 63:11 64:6,20 66:4 68:4 69:20 71:16 72:2 79:11 81:2,3 83:12 101:16 104:3 114:7 146:15,19 159:4 167:8 168:6 201:22 204:15 233:22 299:20 310:10 336:8,22 337:12,14 347:14 370:1 384:13,16 397:11 400:17 405:16
able 32:7 35:21 37:11 53:6 54:3,4 63:2 65:6 66:1,18 70:4 76:10 81:7 83:15 84:1 95:17 121:18 123:14 127:7 152:21 174:7 179:9 180:20 236:18 250:9 256:20 267:5,16 270:12 271:11 296:8 309:9 312:7 313:1 350:9,20 356:16 357:8 362:5 374:6 375:7,9 376:19 385:9 394:16 400:4 410:6 412:4 416:8,19 417:2 423:19 424:3
abnormal 132:20
abs 285:21
absence 201:1
absolute 135:9
absolutely 180:21 232:21 253:2 288:3 344:22
absorb 299:20 337:13,14
absorbed 117:1
abstraction 200:12
AC 16:13
academic 18:8 21:12 23:16 149:11 242:9 429:1
accept 52:9,19 53:6 57:8 68:3,5 73:19 109:12 211:11
acceptability 34:10 401:8 402:4
acceptable 161:10
acceptance 162:5 385:17
accepted 160:22 161:6 339:13
accepting 221:20 344:7
access 136:6 174:17 207:19,21 207:22 218:22 247:7
accident 140:18
accomplish 61:10 78:1 83:9 151:6,7 151:20 152:4 250:4
accomplished 84:5 84:6
accomplishing 252:6
account 30:4 141:9 248:13
accountability 7:6 35:5 40:2,20 81:6 91:13 92:1 105:3 106:19 154:3 177:3 196:10 262:12 263:13,22 310:9 319:3 321:19 322:11 325:16 328:2 330:19 331:4,5 332:9 343:7 368:3 370:9 409:20 416:12
accountable 49:6 165:9 167:16,16 174:16 328:16 329:1,2 332:7 361:18
accreditation 111:12
accurate 293:6
ACEP 19:3 20:16 20:18 115:21 398:10 428:16
achievable 58:4
achieve 58:12 66:13 97:7 98:18 99:6
achieving 384:5 388:12
acknowledge 114:13 136:3
ACO 59:10 219:15 431:12
ACOs 49:9 60:13
ACS 361:13,20
Act 49:6 82:12,18 82:21
action 101:3
actions 225:20
activate 149:16
active 201:8,10,14 292:17 365:16
actively 292:7
activities 26:10 45:20
activity 383:11
actual 102:20 105:11 109:14 199:20 202:13 213:9 226:15 243:10 244:13 324:5 375:16 406:16
acuity 6:16 52:9,20 54:6,21 56:4,17 59:2,2 73:20 104:3 109:3 128:10,17 141:8 142:2 244:16 245:19 286:21 287:6 291:11 321:5
acute 74:9,13 81:14 134:13 135:2 136:2 146:6 166:2 167:17,18 273:5 273:16,22 276:5 280:8,12 282:6 283:2 375:10 400:5 405:16
ad 39:16 54:9,9 55:18 107:6
adapt 342:14
adaptability 81:6
adapted 150:19 176:17
adapts 50:13
add 67:7 112:16 155:20 196:22 203:11 236:18 321:2,3 322:18 327:21 347:11 362:13 371:18 381:19
added 6:15 286:20 311:4
adding 123:19
addition 97:9 423:10
additional 7:4 36:6 71:18 128:22 232:13 275:21 276:1 329:8 383:22
address 65:10 68:1 74:16 106:20 153:6,14 294:15 298:15 333:6 427:6
addressed 239:11 285:4
Adeela 3:16 8:15 195:5 432:20
adequate 69:8 236:15 377:2 380:3
adequately 148:20
adherence 227:10
Adirim 2:4 18:5,6 60:15 84:12 150:1 151:14 152:11 170:2,5 188:7 197:7 198:22 212:4 213:21 301:15 318:22 340:19 350:22 370:4 377:20 378:1 407:17 414:9 415:2
Adirim's 186:20
adjourned 433:16 433:18
adjunct 15:6
adjust 257:14 258:19,21 262:1,2 262:14,15
adjusted 6:12 242:15,16 249:4 253:10 256:15 258:4 261:10 266:15 268:3 295:3,13,15,15 296:2 297:5,7,8
adjusting 243:9 253:11 258:7,14
adjustment 233:8 240:22 242:18 248:12 249:7 251:20 253:22 254:2,4,18 287:12 292:12 293:16 294:5,21 295:2 296:18 316:20
adjustments 6:8 240:18
adjusts 293:19

admin 201:18,22 202:7,20 218:19 220:1 228:13 427:20
administration 18:11 19:15 45:11 76:12 240:2
administrative 7:19 182:10 224:17 253:1 270:8 347:19 431:14
administrators 316:3
admission 176:5,13 181:3 216:2 217:5 221:17 229:6 232:1,7 235:21 245:15 251:6 273:17,18,19,22 275:22 276:13 278:12,13,16 285:1 366:14
admissions 270:9 277:13
admit 175:8,11 176:1 180:3 193:22 194:3,7 203:13 206:17 208:6 209:6 211:9 221:17 223:3,6,17 224:16,20 225:10 225:14,19,21 250:22 259:15 283:7 340:3 354:15
admitted 55:19 131:20 203:3 208:9,9 214:20 216:6 228:18,19 232:4 233:3 269:9 270:13,15 275:15 282:22 283:1,2 316:15 326:15 339:20 340:1
admitting 235:17 237:20 259:10
adopted 40:1
adults 17:12 240:6
advance 9:12
adverse 53:7 231:8
adversely 265:3
advice 44:18 83:4
advisory 87:7
advocacy 16:12 332:2 429:22
advocate 346:3
ad-hoc 352:13
AED 166:6
Affairs 18:10 24:11
affect 64:20,21 66:4,18 73:5 83:19 162:18 171:22 264:20 359:21 370:1
Affordable 49:5
afternoon 148:6 185:19 186:12 313:3
age 35:9
agencies 79:15 89:8 97:8 114:19 360:19 426:17,22
Agency 25:20
agenda 107:13 343:2
agents 414:21
aggravates 236:17
aggregate 336:16 367:15 383:15 433:1
aggregated 27:5 306:22 337:3 370:14 412:15
aggregating 196:8 331:12 368:9
aggressive 281:1
ago 10:13 92:15 120:14 149:2 173:21 219:19 227:9 237:16 241:2 256:4,17 332:15 354:18 372:1
agree 115:2 126:9 150:3 153:19 154:13 155:9 161:15 180:18 181:9 203:18 207:11 238:11 247:18 256:8 262:7 265:19 266:17 284:6 286:8 288:2 289:12 294:6 303:22 309:11 310:17 314:17 319:1 326:21 399:10 400:2
agreed-upon 389:3
agreement 164:15 226:14 351:12 382:8 388:18
agreements 159:4 305:11
agrees 407:21 408:9
aha 355:20
ahead 8:11 44:9 81:20 108:6 188:3 188:5 195:3,5 197:6 249:9 264:13 307:14 326:5 359:7 361:4 370:20 397:22 406:10 407:2 415:11 431:22
AHRQ 2:14 17:13 20:7 23:4 24:15 30:18 174:11 182:9,14 190:15 195:14 413:20 426:12 431:3
AHRQ's 181:20 182:1 427:11
AHRQ-funded 14:11
alcohol 418:18
algorithm 222:16 286:3
Aligning 41:9
alignment 79:15
Alliance 14:3,15
allow 31:13 32:5 37:5 50:19 83:18 99:2 109:17 179:10 231:5 238:6 271:10 350:18 411:22
allowed 48:7 50:10 84:3 221:8
allowing 83:20
allows 32:6 83:17 98:14 254:19 329:14
allude 312:8
alluded 126:7 158:18 260:14 295:7 373:9
all-comers 52:13 52:16
all-hazards 365:19
already-existing 199:2
alternative 86:11 102:19 202:19 219:17 238:14
alternatively 242:19 287:12
alternatives 285:1 301:4
altogether 282:3
amazing 119:19 183:8
ambulance 218:7 345:20 354:21
ambulatory 13:22 22:5 182:5
America 2:8
American 2:19 11:16 21:4 180:11 280:18 429:6
amount 160:6 213:1 218:7 229:5 234:3 250:3 277:8 300:14 320:5 396:21
amounts 261:19 369:19
analog 416:22 419:3
analogy 113:17 137:7 175:14
analyses 105:14
analysis 104:20 119:4 173:18 174:2 176:20 231:20 264:2,4 338:7 380:14 411:6 412:8,12,13
Analyst 8:16
anchor 34:1
ancillary 280:3
and/or 36:13 347:10 357:3
anecdotal 396:16
Angela 3:13 4:4,18 8:13 189:10 323:6 373:4 431:18
angle 349:10 350:1
animal 140:20 253:9 254:10
animals 123:11
ankle 56:19
Ann 3:14 4:14 10:1 10:6 26:8
Annals 241:2 256:17
AnnMarie 2:15 18:16 71:10 210:15 245:11 288:1 303:20 317:7 344:16 350:3 359:13 428:8
anomaly 231:22
answer 45:14 117:6 127:1 145:20 149:6 215:20 220:8 239:19 240:3,10 251:15 297:3 352:16 415:13 428:13
answers 415:15
Anthony 2:10 23:9

74:19 87:6 92:10 93:20 112:11 120:22 147:12 150:4 184:19 301:8 363:21 396:13 398:2
Anthrax 142:3
antibiotics 39:11
anticipate 181:13
anticipating 152:14
antiquated 365:7
anti-labs 285:20
anybody 11:18 55:4 108:3 124:17 129:17 221:6 276:11 277:9 297:16 380:6,16 385:3 399:11
anymore 36:20 240:16 266:6
anytime 275:3
anyway 272:19 286:15 289:21 323:9 420:10
apologies 345:7
apologist 390:8
apologize 9:11 125:20 297:19
apparently 251:4,7 394:20
appear 183:7 408:3
appeared 187:9
apples 253:16,16 254:20,20 267:6,6 412:5,5
applicability 342:14
applicable 150:18 342:18 393:17
application 40:2 200:6 201:20 263:18 405:12
applications 263:13,16,22
applied 75:9 182:8 246:20 378:14
applies 125:16 257:15 263:4 401:16 403:16
apply 45:13 81:16 91:6 126:6,13 143:22 365:11 390:7,10,20 392:22 402:22 410:6
applying 152:1
appreciate 19:6 44:11
approach 31:9 50:20 62:12 63:8 77:1 98:20 106:12 107:7 111:20 126:10 142:13 151:10 251:17 414:4 417:22 418:5 423:1
approached 396:19
approaches 38:9 106:2 107:21 324:3 412:16
appropriate 38:12 56:4 57:17 64:3 226:18 236:9 263:12,20,21 281:3 368:18 414:8
appropriately 83:19 146:9 328:21
appropriateness 216:2
approximately 50:5 53:12,16 202:2
arc 231:14
area 26:16 31:6 34:4 37:20 69:21 78:12,19 79:12,20 85:6 89:18 91:8 100:15 104:19 114:10 120:17 125:15 128:20 152:19 172:15,16 172:17,19 181:20 236:20 302:10 304:20 319:22 323:3 327:10 348:18 351:13 360:3 382:10 406:20 417:5,7 418:19,20,21,22 420:14,20 426:10 428:17
areas 26:20,20 34:3 35:14 43:10 68:16 136:11 142:10 165:6 311:1 352:3 379:2 382:4 383:11 422:4 430:6
argue 375:20
argument 238:1 280:17 377:12
arguments 377:13
Arjun 2:23 7:10 20:11 68:10 71:14 78:20 158:14 163:6 199:17 201:3 260:11 262:8 265:20 294:18 310:14 313:10 320:10 335:6 357:22 362:12 370:22 401:4 407:2 409:22 425:13 427:22 433:14
Arjun's 322:22
arms 69:12
Arnika 42:17 189:5 432:6
arrival 207:14 213:4
arrive 128:14
arrived 128:4 158:5
arrives 343:14
article 53:4 397:14
articulate 75:18
articulated 75:10 329:5
articulating 332:14
artificial 215:6
aside 28:22 231:20
asked 88:5 153:11 153:15 170:6 202:6 392:15 425:21
asking 68:13 85:10 86:10 103:14 112:14 132:13 136:7 205:2 356:20
asks 376:12
asleep 117:16
aspect 249:13,13 285:3 305:21 362:3 419:21,22
Asplin 17:15,16 125:19 160:18 162:9,12 201:3,6 208:4,12,15 218:16 228:12 231:1 247:14 274:8 284:17 285:12 308:16 313:10,19 316:2 334:19 354:2 386:20 393:3 394:20
ASPR 2:11,12 13:6 20:3 24:16 42:13 44:14,15,16 46:8 226:19 328:12 384:10 409:18 423:1 430:21
assess 32:5 54:6,20 182:20 324:12 381:3 390:22 420:14
assessed 281:20 382:7
assessing 54:12 91:16 106:7 403:22 407:18
assessment 33:10 91:7 94:17 96:15 97:10 103:8 106:1 106:12 185:12,15 273:17,19,20,21 282:6 283:2 312:16 320:17 327:17 419:18,18
assessments 36:2 96:8,21 311:19
Assistant 2:7 17:1 24:12 25:17 42:12 83:3
assisted 235:3 347:1
Associate 17:6
associated 165:12 172:2 192:20 222:16 241:9 300:11,20 301:13 303:8,10 305:22 312:5
association 2:18 18:22 19:9,11 28:9 192:16 301:22 429:6
assume 176:19 286:21 424:14
assumptions 147:19 148:13 400:11,12,18
assurance 106:19
asterisk 98:5
as-lean-as-it-can-... 51:19
Atlanta 9:6 119:16
Atlas 416:18 417:13
attaches 263:3
attack 88:3
attending 158:8
attention 432:1
attestation 110:6 111:18 407:6 408:9
attestation-type 333:4
attractive 79:14
audience 166:13
audiences 34:21

409:17
Aurora 115:17 116:1 134:7 138:13 140:18 148:7 163:17 388:16
Auroras 396:10
Aurora's 380:19
Australia 217:2 223:12 289:8 320:16,18
author 137:9
authorities 369:8
availability 52:7,8 61:8 210:8 381:9 433:6
available 26:18 102:15 113:9 270:14 293:9 406:19 427:7
average 53:10,12 53:15 65:4 214:20 215:2 290:5 299:14 363:11
avoid 38:18 277:11 277:12 351:16 387:6
avoidable 174:8,9 174:10
awaiting 51:17 57:1
awarded 182:15 183:13
awardee 59:17,17
awardees 48:16 50:17 60:5,6,7 62:13 64:22 65:9 65:13 74:14 78:4 78:5
awardee's 70:21
aware 343:10 372:19 384:10
awareness 318:13 318:19 357:21
awful 148:22 237:11 424:13
axes 141:13
axis 142:1
A-F-T-E-R-N-O-... 189:1
A-plus 78:6
a.m 1:21 8:2 122:7 122:8 188:20

B

B 348:17
babe 72:15
back 42:4 44:13 56:9 68:12 84:2 85:17 91:18 92:4 96:4 104:1 106:4 108:21 118:8 119:16 122:8 123:13 124:7 135:1 150:9 161:22 169:16 175:19 176:4 178:7 188:21 190:10 212:5,12 221:10 232:16 235:9 259:14 260:15 274:10 282:19 285:22 288:7 313:15 314:14 316:6 322:6 326:4,8 334:7 340:15 346:7 352:10 354:17 355:18 366:4 369:18,19 373:10,18 383:12 394:4 421:17 422:14 431:7 432:21
backdrop 31:17 32:21
background 15:16 28:5 95:7 268:21
backgrounds 43:10
backs 265:4
backup 153:1
backwards 151:8
bad 130:19 136:5 163:19 171:18 180:7 229:7,16 238:4 239:7,8 270:6 348:13,18 351:21 360:9 383:15
badly 395:10,16,18
bailiwick 121:9
bake 293:12,13 318:12
balance 106:21 311:5
balancing 107:1
balloon 156:16
Baltimore 90:15
bar 33:4 371:12 391:8 407:9
barriers 27:1
bars 82:15
base 53:2,9 54:16 88:8 200:14 374:14 403:7,15
based 7:8 13:17 26:4 40:11 119:5 176:12 182:10 214:16 231:20 243:11 257:9 280:15 331:10 380:13 397:14 403:6 424:4 433:2
basic 111:13 186:10
basically 29:7,13 89:18 132:2 133:11 134:5 135:3 182:2,20,22 190:7 191:19 192:1 193:5 195:8 241:2 242:1,2,13 248:4 250:2 254:19 257:6,20 258:22 260:4 263:10 272:18 276:6,11 278:3 284:4 287:6 291:4 323:15 331:11 348:16 351:11 359:3 368:6 370:17 377:15 378:13,16 385:22 388:8 389:10 406:6 407:20 408:4 418:18 419:17 426:18 427:16 431:19
basis 162:21 175:3 309:12 323:14 408:7
bathroom 107:15
bear 49:19 135:18 416:2
bearing 131:7 178:18
beasts 147:18 365:2
beauty 228:14
bed 52:6 54:9 61:8 168:22 169:3,10 202:7 203:14,15 204:2 205:5 206:18 208:10,16 208:19 212:13 213:13,13,20 216:22 217:5,10 220:6,22 221:4,16 221:21 222:1 223:3,4,9 224:17 228:22 234:20 253:8 259:16 316:18 317:14 327:3 356:3,6
beds 57:9 58:6 72:10 74:5,8,9,11 74:13 81:12 104:3 109:4 112:19 113:6,7 180:8 214:7 221:7 267:12,12 269:8 270:16 279:3,10 316:19 337:5 349:15 375:7,10 381:9 396:3 406:18
bed-ordering 221:3
beer 418:22 419:2
beginning 31:19 46:10 108:18 172:9 238:9 270:21 280:21 317:21 329:16 426:16
begins 310:1
begrudgingly 202:11
begun 182:14
behave 425:3
behavioral 231:19 236:4 358:13
believe 20:15 144:11 154:6 181:11 203:1 252:2 376:15 379:10
belong 359:11
benchmark 14:3 14:15 357:8,14
benchmarking 21:15
benchtop 114:11
bend 147:20 149:18 154:20
bending 161:2
beneficiary 234:20
benefit 141:17 260:7 266:11 272:7 292:4,15 394:10
benefits 382:8 393:21 394:5
bent 148:8
Berwick 40:14
best 17:18 79:2 84:14 92:3 98:17 99:4 105:6 125:8 145:15 193:3 204:12 211:19,21 220:7 224:3 279:20 300:17 302:22 383:10 387:8 430:3
bets 141:14
better 47:9 48:3,6

49:14 63:13 68:2 104:22 105:17 136:20 137:3 151:4 152:2 166:21 172:21,21 172:22 174:22 203:8 205:20,20 215:16 223:21 245:21 259:9,22 267:5,8 288:18 297:15 344:13 349:1 351:18 387:12 425:7
better-organized 381:8
between-hospital 291:4
beyond 6:24 41:14 77:22 119:4 207:8 241:6 264:18 275:8 281:12 315:5 316:21 326:21 327:18 335:3 350:18 396:12
bias 124:13 245:1
Biddinger 103:2
big 107:9 115:9,12 117:22 137:19 138:21 149:15 184:5 199:11 235:5 242:8,11 257:10 283:3 319:22 329:4 360:4 369:1 390:15 411:17 413:16 420:13 425:6
bigger 88:20 127:11 264:9 383:4
biggest 313:14 314:12
bill 204:22 205:6 277:16,18
billboard 145:15
billing 245:18
277:5
bills 182:10
biological 45:17
biosurveillance 100:15 101:20
bit 9:18 10:11 30:7 31:17 37:3 41:1 58:16 61:22 68:12 86:2,6 89:13,21 92:12 107:14 108:8 122:1,17 123:13 126:4 132:8 137:14 139:15 150:9 169:19 183:11,11 190:4,9 196:10,12 198:18,18 210:13 225:1,2 240:21 247:9 259:14 271:16 273:9 278:11 280:19 281:12 288:19 290:11 296:18 308:2 315:4 319:18 325:13 333:14 345:13 365:22 378:17 405:9 416:11,13 416:17 418:5
bits 169:22
black 126:16 134:17 136:13 137:7,10,10,12,14 137:18 138:1,5,9 147:8 248:18 309:16
blame 422:1
blank 11:17
blanket 71:2
bleed 421:11
blend 49:8 60:13 82:2
blind 215:18
blocking 180:8
Blocks 396:2
blowoff 425:6
blue 400:12
blunt 239:14 247:9 272:3
board 18:12 93:7 162:5 171:18 323:22
boarded 230:10 315:17
boarding 5:17,23 6:3,12,24 26:19 64:4,9 67:3,5 72:21 80:15 116:21 129:15,18 131:8 145:6 159:21 160:2,6,22 161:3,18 171:8,15 175:13 176:2 181:11 186:13,15 190:5 191:15 193:8 194:12,15 196:21 207:21 209:20 210:11 214:15 215:1,3 218:4,22 219:8,21 225:2,5,6 227:4 229:1,5,6,15,21 230:17 232:8 234:4 237:3,5,6 237:13 238:3,3 239:8 240:20 253:1 261:4,10,20 266:21 267:11 268:4 284:19 286:6,9 294:2,5 295:16 306:13,14 306:21 307:5 308:18 310:1 313:5 314:5 315:5 322:1 333:19,22 336:1 337:3 338:3 338:8 339:12,17 353:10 360:15 372:16 398:11 408:21
boarding-speak 337:20
boarding/crowdi... 312:1
Board-certified 342:4
boat 117:12 359:19 359:20 365:18
bodies 121:8 396:18 397:16
bodily 395:14
body 387:8,11 396:22
boil 59:19 154:14
boiled 154:17
bolus 72:22 73:1 83:21 317:16
bombing 119:15
bond 275:14
borders 415:19,22 423:21
Boston 112:13
bother 298:7
bottleneck 206:19 356:9
bottom 296:20
boundaries 422:12 424:7
boundary 418:7
bow 206:12 221:8
box 110:7
boy 394:1
brainstorming 426:3
Brave 266:7
breadth 66:17
break 44:19 69:14 80:2 107:15 119:21 121:18,20 134:11 188:3 311:10 315:2 321:13 326:1 333:12
breaking 169:18
breakpoint 169:6
breaks 134:16
Brendan 2:5 19:20 63:15 67:20 68:13 80:11 128:19 132:17 143:7 146:2,21 150:10
153:7 158:19 205:12 210:18 212:7 252:18 318:2 336:18 346:9 356:17 359:15 392:7 413:8 421:1
Brendan's 157:8 259:4 296:16
Brent 17:16 129:9 160:17 161:15 165:8,10 199:18 200:18 203:11 212:6,12 218:15 228:11 230:19 236:5 247:13 274:7 284:16 294:6 299:6,11 308:15 313:9 315:22 334:18 340:18 354:1 363:2 386:19 392:13
Brent's 171:7 183:4 190:13 195:4
breweries 418:20
bridge 67:12 127:17
bridges 400:13
bridging 352:2
brief 118:14,14 181:19 184:3 278:14 425:20
briefly 37:2 38:22
Brigham 20:22
brilliant 363:2
bring 28:20 49:19 74:22 75:5 86:4 118:7 120:6 132:11 135:18 144:19 165:18 173:17 175:3 321:22
bringing 176:22
brings 132:22
broad 164:15

broaden 153:2
broadened 210:9
broader 193:7 196:22 203:14 215:10 253:13 391:4 425:21
broadly 173:16 176:16 195:22 257:16 283:20 305:5 328:9
broken 62:14
brought 27:15 44:16 60:19 150:11 307:7 319:11 332:19 367:5 387:17 416:12
bucket 219:11
budget 65:4
build 52:21 99:21 137:21 141:19 175:22 270:19 293:16 394:16 418:2 430:1
building 90:3 95:1 95:2 117:8 141:18 420:16
builds 318:7,10
built 111:15 427:12
bulk 190:21
bullet 39:1
bump 104:8 404:2
bunch 168:14 226:13 334:15
bundler 16:14
bunk 72:10
Bupa 15:1
burden 35:8
bureaucratic 217:19
burnout 327:13
Burstin 3:12 4:23 30:9,11,22 173:11 177:6,10 198:17 206:15 208:6,14 222:11,14 226:16 227:5 232:10 263:6,9 376:20 380:21 381:18 393:10 397:18 398:19 409:15 411:5,11,16 412:2 413:13,18 429:3 430:4
bus 56:18 57:3 128:4 134:6 140:17 149:15 153:4 336:9
buses 128:13
business 9:10 19:17 48:8 117:20 125:3 134:15 367:20 396:22
businesses 89:10
busy 133:9,16 168:6,7
button 56:14 243:2
bypassing 282:15

C

calculated 185:12 246:13
calculating 245:9
calculations 227:9
calculus 136:8 383:12
California 2:23 14:7 101:14 111:22 205:1 235:15
call 4:4 24:21 39:16 52:6 141:7 187:13 187:14 195:17,20 205:14 208:17 221:11 249:16 274:12 280:7,8 282:9,13 300:16 313:16 335:4 366:7,18 406:20 424:8 432:21 433:6
called 15:20 263:17 272:17 273:5,17 273:19 297:22 326:14 337:7 338:8 404:9
calls 29:1 43:13 287:5 354:20
camp 147:17 157:12 168:3 229:17 364:5
campy 408:6
Canada 241:21,21 242:1 260:3 284:11 292:6
Canadian 287:5
cancel 401:2
cancer 145:15
capabilities 45:12 45:13,21 46:4,5,7 46:9,11,14,18 47:3 50:20 51:3 66:5 77:7 78:1 93:11,17,19 94:5 94:7 95:15,19 97:21,21 98:2,12 99:6,13 100:1,3,8 100:14 101:21 102:2,7,21 106:20 108:22 109:2 127:2,10 162:20 188:15 323:13,21 324:3 415:4
capability 46:21,22 47:2,14,15 70:19 92:15 94:3,14 95:4 98:18 100:16 101:15 108:17 119:8 341:4,11 348:12
capability-based 45:7,8
capable 235:3
capacities 93:10,17 93:19,22 94:6 95:14,21 99:21 101:22 102:1 106:20 386:14,15
capacity 50:6 67:9 78:19 94:13 95:2 96:7,8,15,21 97:10 98:20 111:3 114:18 119:7 129:5,14 131:1 135:4 144:20 158:1 181:4 204:13 209:5,16 234:2 261:5 262:6 272:12,21 294:22 304:3 305:1 306:17 307:2 308:6 309:10 313:21 314:2,7 316:7 330:9,11 333:20,21 347:20 347:22 348:12 362:1,10 376:9,13 380:11 383:1,3,22 384:6 389:20 399:12 400:4 404:3 405:16 412:20
capped 211:15
capture 35:9 37:11 41:6 69:6 111:5 158:11 214:9 239:7,13 244:7 262:4
capturing 207:22
cardiac 246:4,5
cardiologists 179:13
cardiovascular 35:14
care 1:5 8:5 13:6 13:22 17:11,12 20:6 22:5 23:6 28:10 31:10 35:14 35:19 37:20 41:3 48:18,18 49:5,6 52:8 56:5 57:12 57:13,16,18,19 58:22 59:2 60:1,2 61:1 63:11 69:5 74:1,4,10,13 81:12 83:20 85:13 86:8 90:2 102:7 109:8 117:1 129:1 130:6 132:15,16 133:13,16 136:2 143:15 144:3,17 145:16 146:10,16 146:19 150:17 151:1,17 154:21 157:15 164:2 165:10,14 166:2,2 166:15 167:16,17 167:17,18 168:12 169:7,8 170:11,18 170:22 171:17,17 172:15,19 179:7 180:20 182:5,20 183:19,19 190:17 194:17 207:19,20 210:18,21 230:5 235:6 236:9 237:21 240:5,8 242:9,11 245:19 250:10 252:1 260:19 265:1,9 271:6 273:5 276:5 276:6 280:8,11,12 280:14 292:7 295:9 307:2 311:9 314:1 331:14 334:4 338:17 344:18 345:17 346:12,22 347:10 357:21 362:4 363:18 369:20 376:22 392:11,22 393:14,19 416:19 417:1,4,9,12 424:9
career 9:4 23:3,16
careers 19:12
careful 60:10 381:12
carefully 75:10 103:17 194:12 390:10
caregivers 345:1
care-coordination 342:13
care/general

173:13
care/primary 280:11
Carr 2:5 19:18,20 63:16 67:1,6 129:3,19 143:8 153:8 205:13 206:6,8 207:11 208:20,22 252:19 254:3 255:2 318:3 336:19 338:9,22 339:11,18,22 340:5,12 356:18 358:20 359:5 380:4,16 392:9 393:9 411:8,13,17 421:2 429:19
Carrier 2:6 22:7,8 108:7 110:6,10,13 110:17 141:2 143:1 200:17 201:5 239:2 255:21 257:2,11 258:10 275:12 276:18 302:8 342:21 366:2 375:1,4 394:9
carrots 172:1
carry 275:22
cars 118:8,9
cart 62:13
cascade 35:21
cascading 126:7
case 40:5,15 113:4 141:13 145:8 213:2 241:7 244:8 244:15 245:4 248:21 254:14 257:8 258:7,15 265:16 311:7 377:2,11 379:3 383:17 384:5 393:18 409:18
caseload 259:20
cases 109:15 127:7 178:1 212:22 213:15 254:16 324:7 343:20 400:5 405:17
case-mix 258:16
casualties 121:8
CAT 152:21,22
categories 231:19 244:4 372:9 374:6 402:5
categorizing 95:13
category 236:11 244:12 279:21 280:4 401:17,17
cath 146:17 156:18 210:2 230:16 291:15 343:15
caught 229:22
causally 149:5
causing 39:14
cautious 163:13
caveat 52:16
CDC 2:12 17:13 20:7 22:13 44:16 46:5 87:2 97:19 100:14 105:9 328:11 409:12,18 429:7
CDC's 97:20
CDC-funded 15:9
CDU 276:12
CDUs 286:12
cellulitis 269:4 286:1
census 192:17 212:19 307:20 338:7
censuses 192:19
center 2:6,11,20,22 2:24 9:9 13:9 18:19 22:3,10 46:20 87:3 105:10 144:7 242:9,11 302:16 341:19
Centers 2:16 15:11 15:12
central 6:18 297:13 298:19 300:3 393:2
CEO 109:5 252:17
CEP 2:8
certain 103:13 156:4 229:5 257:3 276:9 277:8 288:20 295:21 296:1 301:10 307:22 415:8 416:3
certainly 33:4 44:16 45:15 47:4 48:22 49:5 54:16 62:20 83:22 162:18 166:20 233:22 251:11 267:3 280:14,15 295:12 310:19 315:19 331:21 343:8 352:8 358:12 381:2 385:10 394:16 403:16 407:22 415:14 427:20
cetera 25:12 175:19 218:22 285:2 297:13 356:7,7
chain 90:17 424:17
chains 51:13 90:11
chair 15:20 18:2 21:3 24:6 355:18
Chairman's 307:8
Chairs 12:21
challenge 61:4,15 100:9 102:2 169:12 205:10 329:4,5 383:5
challenged 72:20 166:1
challenges 47:6 87:17 108:20 294:20
challenging 158:22 159:14 374:12 388:22 410:14
chance 325:13
chances 298:4
change 2:7 22:11 45:9 75:21 85:21 132:2 153:15 156:1 168:9,10 169:8 227:6 335:4
changed 12:9 39:17 50:7 140:12,15 198:15,19 209:18 216:1 398:16
changes 50:12 107:3 119:5 163:10 171:22 227:7 295:22 343:3 425:3 433:1
changing 65:1 132:15 216:19 284:20
characteristics 247:10 262:2
charge 44:14 156:7 237:10,13,17,22 275:21 276:1,4 279:2 395:17
charged 355:17 360:19
charging 269:22
chart 200:7,20 223:15,16,16
charters 48:8
charts 199:21 223:20
check 42:19 110:7 189:4,5 432:6
checklists 103:18
chemical 45:16 139:18
chest 131:19 224:18 269:4 273:11 291:13 361:12
chest-pain 57:1
chewed 229:14
Chicago 163:18
child 31:2
children 188:11
Children's 116:2
choice 297:15
Chris 92:14
Cipro 142:5
circumstance 118:20
circumstances 105:18 287:1 359:16
cite 54:16 76:2
cited 15:16 91:3
city 60:10 69:15,16 89:14 142:2,3 144:2,7 155:3,4 416:10
claims 37:7 200:10
clarification 120:21 376:21
clarify 120:22 224:6 244:1 247:21 266:13 275:4 283:11 340:9 385:6
clarifying 91:12
clarity 61:22 237:9 238:8
class 236:13
classes 236:8 257:3 260:6
classic 402:19
Classically 50:3
classification 143:5 242:22 245:8 257:9 289:19 292:16
classifications 248:3
classify 276:7
clean 318:7
cleaned 356:4,7
clear 39:12 109:19 172:10 208:11 216:4 224:15 237:7 251:3,4 294:11 308:11 340:13 354:4 357:6 361:19 372:18 403:11 406:12

408:16
clearly 75:14 76:8 89:21 97:10 284:10 358:13 370:8 393:16
clear-cut 269:3
click 99:19
clinic 345:19
clinical 16:8 18:17 20:13 22:8 130:17 239:10 269:1,5 272:17 273:9 275:15,20 343:11 430:6
clinically 9:5 13:2 14:8 298:11
clinician 85:7 86:4
clinicians 86:16 168:14 365:7
clinics 81:13
clock 269:6
close 36:16 56:6 66:20 166:6,20 167:2 330:2
closed 73:2 116:9 400:14
closest 83:21 146:17 202:12
closing 175:16
Clotting 20:17
CMI 245:8,13,14 246:2,4,10 247:6
CMS 202:5 206:4 214:15 216:2 225:18 246:8,9 251:1,7,12 263:3 338:10 339:13 349:17 369:8
coalescing 97:22
coalition 24:8 46:19 47:15 48:22 52:18 54:22 55:15 55:16 56:2 57:17 58:7 59:1 60:8,9 60:12 63:22 64:10 65:22 66:3,14 68:20 69:2,7,13 69:15 70:6,19,20 70:21 72:8 74:4,8 74:9 75:7,11 77:9 77:20,21 78:22 110:18 112:12 121:4,14 135:16 141:17 143:14 356:21 359:11 368:10 410:22 411:4,10 420:15 420:17 421:11,22 429:8
coalitions 48:7,12 48:16,17 49:3,4 54:3 58:5,6 59:8 59:15 60:5 62:17 65:13,15 67:8 68:17 70:16 77:11 77:17,19 78:4 421:6,12 422:3 430:1,6
coalition-building 420:18
coalition-level 348:10
coalition-ness 338:14
coauthor 24:2 199:19
code 116:11 245:17 246:16,18,22
coded 427:12
codes 246:15
cognizant 164:3 214:6
cohort 247:15
cohorts 247:16
collaborate 410:12
collaboration 428:22
collaborative 98:9 159:19 429:15
collaboratives 22:15 414:22
collaborators 127:20
colleague 103:3 341:7
colleagues 73:7 87:2 150:4 306:8 319:2
collect 37:12 167:8
collected 41:2 410:5 412:11
collection 110:3,20 111:5
collections 415:1
collectively 79:21 266:1 309:13,15
College 2:19 21:5
color 350:17,21
column 99:22 183:18
combination 115:11 211:19 429:5
combinations 103:12
combine 10:9 313:20
combining 142:7 296:14
come 16:3 29:2,12 47:18 49:14,18 55:19 62:14 70:12 83:1 85:3 86:17 86:22 90:22 92:4 106:5 107:19 145:16 164:5,9 178:6 184:10 192:6 202:11 224:7 227:3 228:1 242:6 248:11 251:15 258:1 310:6 339:9 350:1 362:8 374:15 382:22 384:18,20 384:22 392:2 399:17 400:8 410:15 417:21 418:1 427:17
comes 68:20 90:3,8 94:2,9 105:1 123:16 154:2 157:17 188:14 226:4 269:21 281:4 282:1 323:8 326:13 361:10 377:15 409:11
comfortable 429:9
coming 14:12 28:14 29:15 57:4 66:18 71:7,8 72:7 88:3 104:1 152:4 163:22 170:11 192:5 194:18 274:17 281:17 329:3 385:4 388:18 393:4 414:11 418:22 423:12 426:7
command 424:17
comment 5:15 7:22 84:8 123:13 125:1 155:8,8 164:8 170:6 173:14 181:17 187:11 201:16 226:2 243:6,14 260:2 262:9 264:12 297:19 298:16 299:6 303:6 305:18 306:6 307:10,14 328:1 330:16 364:18 401:3 416:9 422:7 432:7,15
comments 5:10,12 5:20,24 6:7,9,14 6:17,20,23,26 7:12 62:3 107:17 108:4 164:17 169:17 184:4 186:10,18,20 187:15 233:17 297:16 298:17 307:8 345:10 360:12 364:7 367:2 368:4,12 431:13,16 432:3 433:2,3
commiserate 23:11
commission 62:21 96:12 111:11 194:16 221:9 225:8 230:2 237:16 251:13 352:22 353:19 428:3 429:7
committee 7:4 10:19 11:1,5,13 11:21 12:12 13:7 17:19 18:3 20:17 21:4 24:7 25:5,11 25:14 37:17 149:4 227:12 355:19 398:8
committees 19:2 22:1 32:19 263:11 371:6 388:7
common 95:6 105:15 118:12 124:12 127:2 129:10 248:2
commonly 287:15
communicate 96:21 365:14 426:4
communicating 100:6
communication 118:5 351:18
communications 112:18
communities 92:16 137:4 234:1 306:16 309:9 310:5 367:10 414:13 416:4
community 35:2 47:15 49:18 114:10 118:14 135:17 146:8,8 154:9 174:3,21 182:17 183:21 194:18 234:2,18 235:2 261:7,18,20 280:16 307:3

328:10,17 330:5,9 334:4 344:2 360:20 384:16 413:21 414:15 423:22
community-level 174:12,17
comorbidities 254:5
comorbidity 236:12
company 222:4
comparability 38:17
comparable 32:6 99:6 290:6
compare 32:7 202:19 215:13 241:14 254:20 267:6 289:20 364:13 412:5 415:5,7
compared 128:8 253:14 254:21,22 297:2
comparing 199:20 215:12 256:5,9 290:22
comparison 200:10 295:5
comparisons 34:15
compass 132:2
compelling 383:16
compete 331:18
competencies 397:9
competency 77:13
competing 35:17 210:10
competition 331:17
competitive 145:13
competitor 172:20 172:22
competitors 118:3 172:18 348:18
compile 187:20
complained 38:5
complaining 317:18
complete 81:5 221:18
completed 181:22 182:11
completely 117:12 120:7 123:11 124:6 140:13,17 147:21 181:9 265:7 353:17
complex 38:4 85:5 88:11 94:21 107:17 236:15 276:8,8,12 286:12 286:14
complexity 259:7
compliance 213:19
compliant 289:10
complicated 145:7 276:15 344:2
complication 90:8 90:19
comply 148:14
component 426:21
components 126:11 166:14 234:15 364:4
composites 325:8
concept 90:1 130:21 146:3 148:19 150:20 262:3 294:20 301:2 316:7 325:10 330:3 335:1,10,12 379:9 400:3 401:13,14 403:11 406:22 410:14
concepts 5:4,18 6:4 7:8 26:18 27:9 60:19 61:2 84:16 91:14 92:7 134:3 164:22 186:7 341:2 363:17 371:11,13 374:10 420:11
conceptual 195:9 392:22
conceptually 37:19 134:1
concern 34:13 271:2 292:20
concerned 78:20 137:17 171:13 228:19 269:14 293:10 319:4,13 319:19 349:17 423:20
concerns 55:7
concert 312:5,17
conclude 383:19
concrete 29:9 58:20 395:4
condition 231:2 240:14 273:13
conditions 315:6 316:22
Cone 320:15
conference 1:19 20:5 43:13 195:17 195:20 219:19 249:16
confidence 135:9 203:7
confident 218:19
confines 153:10
conflict 11:10 12:5 12:9 14:19 18:13 23:3 86:12
conflicted 393:1
conflicting 429:17
conflicts 12:3 17:3 18:4 20:15 21:3 21:14 24:2
confused 113:8
confusing 75:2 279:7
congestion 219:5
conjunction 48:9
connect 81:2,3 113:21 114:16 204:14 250:5
connected 420:15
connection 306:10 308:11
connects 95:1
connotate 229:16
cons 228:5 268:4,8
consensus 13:21 92:13 94:15 100:7 224:7,8 226:4 312:14 379:10 385:21 391:17 394:2 399:21 407:9 410:4
consensus-develo... 371:7 387:9 426:6
consensus-driven 46:8
consequence 212:21 230:12 259:13 262:21
consequences 39:9 40:4 93:1,6 162:17 230:4 283:14
consider 6:11 119:12 138:13 170:9 268:1 288:6 324:15 331:6 333:11 338:3 341:4 342:1 349:19 360:8,10 360:16
consideration 232:3 288:14 346:3 361:5
considerations 264:7
considered 244:13 302:3 305:14,15 315:7 319:14 339:20 407:7
considering 65:1 326:12 341:10
considers 335:15
consistency 33:14 33:15 388:3,12,19 389:9 390:16 391:4,5
consistent 57:10 97:11 389:7
consistently 133:10 246:19 392:5
consolidating 65:9 66:6
Consortium 2:10 21:12
constant 56:9
construct 53:10 70:12 365:9 418:2 418:6
constructed 126:14
construction 116:9
constructs 68:7 419:19
construed 24:1
consult 316:16
consultant 4:20 5:6 5:19 8:17 217:4 276:16 282:13,19
consultant-gener... 397:3
consumed 419:1
consumers 249:3 265:15
contact 88:19 280:11
contagious 93:4
contain 139:5,6
contains 402:4
context 23:21 113:20 118:11 164:21 172:7 185:18 191:4,11 203:21 304:18 307:7 367:6,6 369:6 389:10 404:19 408:2
contexts 388:10
contextually 315:14
Continental 13:16
contingency 57:14 57:16
continue 120:12 122:14 143:9

186:11,21 187:4 199:14 331:18 379:19 401:5
Continued 5:2 6:2 6:4 7:2
continuity 76:19 77:1 109:9 304:12 397:1
continuous 56:12
continuously 58:22
continuum 203:22 204:5 280:12 308:12 315:15 344:18
contract 13:5 29:17 182:15 183:12 276:5
contrary 85:11
contribute 106:14 330:13
contributing 257:17
contribution 17:18
contributions 328:19
control 140:5 185:10 248:14 252:3 282:17 386:5
controversial 225:4
convened 224:9
conventional 57:13 168:12
conversation 73:3 76:7 152:15 153:3 168:16 202:10 257:12 344:19 355:17 357:8 364:2 416:20,21 427:19
conversations 81:9 87:5 415:14 417:17 420:11
conversions 98:7
cool 142:20,21 424:2,5
cooperate 145:14 266:21 331:19 356:20 357:4 410:12 421:6 425:8
cooperating 369:3
cooperation 332:5 351:22
cooperative-type 333:5
coopetition 332:5 348:6 370:19
coordinate 72:1,4 211:5,20
coordinating 13:6 90:16 210:21
coordination 144:12 150:17 170:18,22 210:17 311:9 344:19 345:14 393:15
coordination-of-... 170:20
Coordinator 175:15
core 45:12,21 48:20 127:10,14
cornerstone 33:11
corollaries 78:15
corporations 125:4
Correct 339:21
correlate 291:12
cost 156:22 236:2 240:14 281:1 293:11 347:12
costly 155:20
costs 430:18
cost-effective 279:19
couch 44:22
couching 131:5,5
Counsel 4:14 10:7
count 47:18 382:1
counter 88:14
counterfactual 185:9 386:4
counterproductive 251:21
counties 419:20
counting 47:22 48:1
country 16:8 63:20 89:19 161:1 242:3 275:3 287:18
county 17:9 69:9 89:14 152:19 416:2,10 418:7
couple 18:20 31:8 61:18 74:6 78:9 84:11 101:5 107:16 119:20 122:14,17 128:13 128:21 150:11 169:17 171:6 219:19 226:11 237:18 241:1 249:6,11 256:17 308:21 318:8 323:2 351:6 354:11 358:1 382:18 403:22 425:19
coupled 312:15
course 61:16 211:22 252:7 316:19 324:11 343:11
cover 66:16 70:20 70:22 71:2
coverage 69:8 136:6
covered 68:17 70:13
covering 66:10
Co-Chair 2:3,4 4:9 4:11 8:21 9:15 13:1,13 58:15,19 68:10 71:10 74:19 78:7 80:1 81:19 84:10,22 86:18 107:12 113:15 115:14 119:14 122:5,9,13 124:14 126:15 127:19 129:17 131:14 137:5 138:6,12,18 139:2,20 142:19 143:4 145:18 147:11,13 149:22 151:11 153:7 155:6 157:1 158:14 160:17 161:13,14 162:11 163:1 164:6 165:1 169:15 170:4 172:4 173:10 177:4,9,12 178:22 181:16 184:1 187:6,10 188:5,17 189:20 198:20 199:14 200:16 203:10 204:9 205:12 206:3,7,12 208:21 209:11 210:14 212:1,15 214:11 215:17 216:14 217:21 218:13 220:9 221:2 222:7,13,19 225:15 226:22 228:4 230:1 231:17 233:6,10 233:21 237:1 239:1,15 240:17 243:1 244:10 245:4,11 246:7,12 246:17 247:4,12 249:9 251:18 252:18 255:17 258:18 260:11 263:1,8 264:13 265:11 267:17 272:8 273:4 274:7 275:11 277:22 278:20 279:3,9 281:14 284:16 285:6 286:6,18 288:1 289:7 290:9 291:9 292:19 293:21 294:17 296:17 297:10 298:22 300:2 302:6 303:4,20 305:16 306:4 307:12 308:14 309:3 310:14 313:7,16 314:20 315:10,22 316:8 317:4 318:2,21 319:16 320:10,21 322:8,17,19 325:12 326:5 327:20 329:7 330:12 332:16 334:8 335:6 336:18 338:1,18 339:4,7,8,10,14 339:21 340:2,17 342:20 344:15 345:6 346:6 347:15 350:3,12 351:3 352:5 353:6 353:22 354:7 356:17 358:11 359:1,13 360:11 361:7 362:12 363:21 366:1,17 366:22 367:18 368:14 370:3 377:4 378:3 379:21 382:15 383:7 384:7 386:19 392:7 394:7 395:1 396:13 398:3 399:6 401:2 406:9 407:1 408:8 410:8 413:5 415:11 417:14 421:1 422:6,20 424:11 425:13,16 427:3 427:22 428:8 431:5
Co-Chairs 1:22 8:11,19 27:20 433:9
co-PI 15:9
cranny 210:4
crash 134:6 149:15

crashed 353:16
crawl 62:12
crazy 217:1 256:10
create 16:14 21:18 79:10 170:13 219:17 244:2 247:22 256:18 271:15 309:18 337:5 357:3 376:9
created 269:1 272:9 384:1
creates 83:12
creating 141:20 266:20
creation 142:16
creatively 141:21
creativity 125:14
credit 422:1
crisis 57:12,14,19 154:21 392:10,21 397:1
criteria 27:3 32:18 33:2 91:19 122:3 197:17 231:18 235:18 242:1 243:15 337:9 339:5 352:7,20 353:3,5 354:4 370:22 371:10,19 372:15 373:2,15 373:19 374:7 377:7 378:13,14 385:7,17 387:20 390:16
criterion 33:9 339:5
critical 98:1,1 99:14 101:15 106:4 127:16 144:13 172:14 207:12 247:7 418:10 419:4,8,13 423:4
critically 158:3
critically-import... 422:22
critical-access 359:17
critical-care 73:7
cross 108:8 424:7
crosswalk 279:16
crowded 31:14 192:8 250:6 270:17 299:8 333:19 335:16 353:9 380:20
crowding 5:13,17 5:23 6:3,12,22 9:11 14:1,16,22 19:3 22:1 23:5 26:18 27:10 28:9 28:18,21 29:5 30:3 43:17 67:19 67:22 68:1,5,7 80:15 81:16 114:1 114:2,17 120:11 128:15 132:12 135:21 147:15 151:16 154:19 159:10,21 160:2 163:15 164:13 165:15 167:20,21 184:21 185:16,17 185:20 186:1,13 186:15 190:5 191:15,19 192:2 193:1 196:21 204:12 205:14,19 205:20 206:9,10 206:11 218:4 234:15 236:17 266:22 268:3 272:1 301:1 303:3 306:13,15,21 307:6 309:14 313:5,13 314:10 316:12 322:1 327:12 333:7 335:3 347:7 351:9 354:14 355:19 360:15 362:22 364:9 366:7,18 370:15 372:16 383:14 384:4 387:21 393:4 394:19,21 408:16
crowding-specific 197:19
crowding/boardi... 143:11
crutches 56:21
crystal-clear 421:8
CT 285:7,9,11,18 293:15 358:4
CTAS 241:22 242:2 260:4,7 290:15
culture 85:20 86:13
cumulative 381:2
curious 330:22 332:3,8
current 22:9,13 106:10 186:3 190:8 191:1 224:4 224:6 225:18 241:14 242:14 255:9,13 266:14 368:8 372:14 376:4 379:11,18 387:19 426:14,19
currently 13:2 14:9 18:9 20:12 24:3 53:11 77:17 235:16 302:20 343:8 370:13 374:3 376:7,18 413:9
curve 231:3
cut 80:6 318:7 414:7
cutoff 269:21
cuts 355:1
CV 10:20
cycle 50:15 91:11
cycles 24:4
cynical 180:9
C-O-N-T-E-N-T-S 4:2 5:2 6:2 7:2

D

daily 5:13 63:4 81:3 120:11 122:11,19,21 123:15 124:1,9 125:12 147:15 148:16 149:13 160:21 161:11 162:13,20 308:5 309:14 314:3,4 323:13 349:20 363:3 384:12
Dark 115:21
Dartmouth 416:17 417:13
dashboard 269:17
data 5:23 34:17 35:10 37:7,8,9 38:15,18,19 41:1 41:6,13 66:18 108:14 109:15,17 110:3,19 111:5 121:12 124:18 154:2 166:16,19 166:22 167:3,8,12 167:13 182:8,8,10 196:20 199:9,11 199:12,20 200:4,5 200:11,20 203:8 207:8 213:11 214:17 220:12 231:12 240:22 241:4,13,16,20,21 242:15,16 243:8 243:19 247:16 248:1 249:4 256:2 256:13 258:11 265:8,16 266:16 267:3 270:8 274:14,15 291:14 298:14 302:17 316:5 347:19 355:21 374:17,18 374:22 376:5,14 377:9 378:10 379:22 381:7 382:17 384:4 385:19 407:13 410:5,22 411:2,18 412:11,15 427:5 427:12,13,16,18 427:20
database 212:16,22 213:1 394:6
datasets 244:17 293:8
data/evidence 378:16
date 221:19
Dave 25:15 43:20 74:22 90:4 93:18 97:19 99:1 104:1 154:13 178:2 377:13 433:13
Dave's 88:19
David 2:9,11 5:8 21:8 75:6 145:21 163:1 165:1 320:15 362:17
Davids 163:2
day 12:18 16:6 18:16 20:2 21:9 22:9 34:9 35:9 51:12 53:16 61:17 114:2 117:19 127:2 128:12 129:8 130:14 132:20 151:19 154:16 157:20,21 168:6,7 181:4 186:22 232:15 278:19 299:14,17 310:4 317:14 336:9 350:15 370:7 395:18 432:2
days 53:13 128:2,4 128:8,8 132:16 133:4,9,16,19 314:21 316:18 335:22 352:8 385:2 395:7
day-to 129:7
day-to-day 115:12 117:5 118:1 127:22 131:11

137:21 148:1,2 154:18,19 162:5 163:8 174:20
DC 112:11
dead 158:4
deal 80:21 100:14 116:11 140:1,4,9 180:1,4 203:12 235:5 249:19,20 329:3 390:15
dealing 180:14
deals 103:1
dealt 22:1 294:3
death 398:10
debate 280:11
debrief 116:1 118:14
decade 96:5
decide 209:10 223:3 237:19 352:9
decided 130:18 213:12
decision 175:9,11 193:22 194:7 201:18,22 202:7 202:14,21 203:14 204:2 206:17 207:13 208:8 209:4 211:3,9,10 212:8 218:20 220:1 224:16 225:10,13,19 228:14 235:11 250:21 259:17 269:1,6 272:17 273:9 275:16,20 352:13 357:12,14
decisionmaking 392:17
decisions 86:12 214:6 225:20
declare 82:8,10,11
declaring 83:2,14
decrease 161:21
dedicate 379:15
deemed 56:3,16
163:16 263:11
deep 32:18 105:16 119:4 403:19
deeper 213:1 412:14
define 6:5 48:21 50:18 69:9 147:22 220:15 250:21 333:15 413:13 414:16 417:3,8 422:11 423:4 424:3
defined 48:17 49:1 59:9,13 70:6 152:7 177:21 213:20 222:8 328:9 401:10,20 413:21 430:21
defining 59:8 60:8 60:11 220:21
definitely 23:4 141:12 142:7 163:18 171:21 262:14 396:10
definition 59:14 99:14 194:14,19 225:9 238:2 402:3 414:12 420:18,20
definitional 251:17
definitions 14:4 100:13 224:13 225:8,22 226:21 227:9,11 355:13
definitive 31:11
degree 160:9 236:12 260:16 261:1,13 271:17 296:11 373:16 428:5
delay 85:16 215:8 253:1
delays 136:4 314:5
delighted 9:18 226:19
deliver 17:13 146:9 146:15 425:4
deliverable 51:5
deliverables 59:21
delivery 51:20 57:13 63:5 85:13 89:9 90:6,11 146:19 168:12 369:20
delta 208:16
deluge 62:12
demand 114:6,22 383:19
Deming 172:8
demonstrate 330:7 379:8 400:1 406:7 407:11 408:19 409:3,5 410:6,10
demonstrated 375:8 379:18
demonstrates 135:22 309:19
demonstrating 410:11
demonstration 409:2 410:7
denominator 402:20
denominators 64:4
Denver 13:17
depart 208:18
department 2:15 9:5 13:4 14:2,22 21:21 24:11 25:16 35:22 71:20 72:11 73:22 74:18 88:4 88:21 114:22 127:8 130:6,8 133:5,13 136:17 157:16 158:8 162:7,22 170:17 179:20 180:3 192:3,11 205:11 209:21 210:19 230:5 236:20 241:8 242:7 245:20 246:16 253:14,15 268:13 269:19,22 281:18 282:16,21 283:1
291:19 295:14 300:11 301:21 306:17 310:13 315:13 326:16 329:18 347:8 350:16 357:13,17 367:7 380:19 426:15
departments 30:15 39:15 97:1 98:16 105:12 114:19 171:16 266:12 269:1 271:16,19 272:15 328:12,13 342:3 367:4,9
departure 9:18 194:4,7 201:19 207:15 208:13 213:5
depend 231:15
dependent 64:7 292:1
depending 71:5 126:13 229:13 245:14 286:22 298:9 327:14 424:8
depends 236:10,13 411:5 427:9
deployed 304:20
depth 57:17
Deputy 24:12 42:12
derived 200:11
describe 34:5 49:15 50:1 294:22 302:14 376:3
described 125:7 253:2
describing 49:16 49:17 52:1 61:5 69:13,14,18 130:11
deserve 265:18
deserves 169:9
Design 15:20
designated 341:20
designation 341:18 341:19
desk 41:16
detail 37:3 95:22 360:17
detailed 232:21
detail-specific 106:21
determines 234:3
determining 150:21 202:20
develop 29:22 64:3 76:3 84:17 85:4 103:4 105:11 106:1 110:2 166:17 191:16 197:8 240:3 312:20 324:2 331:6 357:2 391:20 397:9,13 428:12 429:8 432:4
developed 77:10,11 85:12 92:14 103:17 160:15 188:10 200:6,7 241:19 255:14 394:14 408:15 410:21 430:16 431:1
developer 200:14 284:5 375:18 376:14 390:17 409:3 428:16
developers 5:22 6:5 6:10 28:17 29:10 29:14,21 44:7 108:12 120:15 164:11,20 165:5 166:19 172:11 191:4,17 194:11 196:19 197:3 199:1 200:2 220:15 226:6,12 268:1 275:10 312:19 315:7 319:8 325:1

340:10,11 341:4 342:12,22 372:19 413:17 426:4
developing 28:18 61:14 91:15 107:8 113:13 178:8 190:18 195:15 255:22 319:9 324:8 325:2 348:9 390:18
development 7:15 16:11 23:3 26:15 27:15 29:8,18 46:19 47:16 48:8 49:4 91:11 110:20 120:17 171:11 174:11 182:17 193:15 200:5 242:17 279:14 312:15 343:4 348:1 349:5 372:20 377:8,18 379:20 398:17 425:22 426:13 427:15 428:7 429:15 430:18 431:10
deviant 161:6
diabetes 35:15
diagnoses 280:5
diagnosis 231:16 338:5 358:5
diagnosis-specific 240:14
diagnostic 219:20 220:5 236:11 252:22 269:3 279:21 284:21
diagram 126:3 135:8 165:11 167:22
died 158:4
Diego 353:13
difference 34:5 39:3 75:19 138:7 163:8 232:4,9 256:7,14 278:12 298:8 334:11 346:14 381:10 392:6
differences 192:21 291:4 300:12,20 301:14
different 35:19 38:18 41:13 43:9 43:10 45:18 48:9 54:17 60:4,9 74:14 75:14 79:3 79:6 87:20 89:18 90:22 91:21 95:11 95:12 98:14,14,15 99:2 101:13 103:6 103:9 104:10 107:20,22 113:6 116:4 118:17,19 118:20 120:7 122:20 123:11,12 123:14,21 124:6 125:4,13,15 126:5 126:10 129:8,9 137:12 138:1 140:20 142:14 143:18 145:6,17 147:17,21 148:21 149:8,17 154:20 155:2,14 156:20 157:14 158:12 161:5,9 165:6 170:13 178:5 181:10 184:22 185:1 186:5 188:16 192:1,19 192:20 194:16 201:19 205:5 206:4 223:13 226:10 227:11 231:3 242:3 253:9 253:19 254:9 257:1,17,18,18 261:3 273:9 276:10,20 278:17 282:3 283:17 299:15 301:11,20 324:5 328:20 330:15,21 332:14 350:16 353:17 363:6,11 364:4,5 365:2 368:9 369:8 370:14 375:11 381:1 388:15,16 389:7 390:11 392:4,14 393:11 398:13,18,19 411:2 412:16 413:1,2,3 414:22 415:1 419:19 423:8,9,19 424:4 424:4 427:18 429:16
differently 104:21 132:3 150:8 363:19 377:19 381:14 424:2
differently-specif... 414:19
difficult 41:20 57:9 76:2 168:15 192:13 213:6 225:22 242:12 243:13 357:15 387:18 388:13
difficulty 283:5
diffuse 71:3
diffusely 64:19
dimension 424:6
dimensions 143:6
dipped 9:10
direct 263:7
direction 107:22 159:8,11,15 160:13
directionality 158:22
directive 45:5,6 202:6,18
directly 17:14 88:2 102:9 174:15 241:9 282:19 283:7 342:8
director 4:5,18 8:14 16:6,21 18:9 18:17 21:11,22
Directors 17:9
disadvantage 266:5
disagree 303:6
disagreement 224:14
disaster 5:14 52:13 55:3 56:3 78:10 80:18 81:4 82:9 116:4 117:22 120:11 122:11,20 123:1 124:5 130:2 130:4 132:1,4 133:19 136:22 142:6 143:5 147:3 147:6,16,22 149:13 151:12,18 154:19 163:9 164:5 168:7 180:19,22 184:18 206:11 308:13 330:11 349:14,21 375:6,8,22 380:1 380:10 394:12 415:9 424:20,20
disasters 61:17 63:14 118:1 123:3 123:22 124:3 133:18 136:10 141:3,12 148:20 160:20,21 161:2 161:12 369:1,14 376:6 380:2,18 382:18 400:15 431:12
disastrous 298:2
discharge 53:10,16 56:17 169:5 278:3 278:10 317:10,10 317:11,21 338:21 350:17 355:22 356:1,5,6,9 360:22 366:13
discharged 57:2 131:18 169:8 339:15
disclose 10:17 11:8 11:9 12:2,8,15,20 17:3 18:4 19:17 22:6 24:1,17 25:10
disclosing 11:3
disclosure 11:11
disclosures 4:12 10:3,8,10 20:9 25:8,18,21 26:1,4
discount 265:7
discovered 104:15
discuss 8:8 12:13 26:3 46:15 122:15 149:5
discussed 85:8 122:17 315:4 342:19 368:17
discussing 260:21 335:18 342:10 428:20
discussion 5:4,17 6:3 7:4,15 43:8 44:18,20 49:22 64:12 65:7 67:12 74:3 116:8 120:12 123:9 146:3 164:18 166:1 167:5 169:12 184:8 185:21 186:11 187:5 190:13 191:5 194:14 196:13 202:2 204:15 218:5 225:1 233:15 240:19 250:20 266:18 296:12 304:13 306:10 307:11 313:3 323:11 336:3 354:12,13 354:16 368:2,11 370:21 371:19 385:6 388:2,7 403:17 422:9 425:20 426:1
discussions 66:9 67:19 73:6 354:17

361:3
disease 93:5 101:1 127:6 140:10 145:17 236:12 244:16
diseases 358:1 361:18
disease-specific 361:14
disguise 250:2
disorders 231:22 232:5,6
dispatch 354:18
dispersal 82:14 83:18
dispositioned 214:5
dispositions 235:1 236:1
distal 36:17
distinct 168:4
distinction 129:5 158:16 181:15 237:7 252:20
distinctly 152:6
distinguishes 358:14
distress 345:2
distribution 299:4
dive 32:18 412:14
diverse 141:4
diversion 117:5 218:7 333:8 345:13 351:8,13 351:20 352:6,9,11 352:20 353:8,15
divert 116:16 353:21 354:5
Division 13:16 16:21
doable 79:17
doc 72:18 131:15 132:5 169:4 357:18
docs 395:12
doctor 9:4 13:11 214:4 223:22,22 237:20 282:17
327:19
doctors 223:21
document 24:3 46:9 49:1 95:7 100:4,5,6 188:9 196:15 227:21 326:3 392:11 408:1 432:4 433:2 433:7
documentation 223:21 225:12 235:20
documenting 223:13
documents 13:19 225:11 228:1,3 251:7
DoD 397:2,8
doing 10:15 15:15 16:11 25:7 30:15 36:6 49:9 55:12 65:1 87:1,9 107:5 110:14 112:13,17 113:12 115:12 117:6 123:18 139:14 155:18 156:13,15 174:22 183:7,20 201:11 217:9 222:20 236:19 267:5 272:19 281:13 284:21 286:15 293:14,15 294:13 305:3 312:10 319:21 326:22 331:16 366:16 369:4 387:3 397:19 426:14,20
dollars 179:20 430:19
dominated 76:8
Don 40:13
door 52:14 57:4 72:20 281:16 291:13 358:10
doors 73:2
door-to 156:15
door-to-admit 329:15
door-to-balloon 50:22 159:6
door-to-doc 162:3 163:11
dots 114:17 204:14
double 383:3
dovetail 71:13 314:11
downside 271:5
downstream 230:11 264:17
dozen 90:13
Dr 8:11 30:9,22 42:8 44:9,15 54:18 84:13 173:11 177:6,10 186:20 189:6,9 198:17 206:15 208:6,14 222:11 222:14 226:16 227:5 232:10 263:6,9 288:9,10 341:7 354:11 360:13 376:20 380:21 381:18 393:10 395:2 397:18 398:19 409:15 411:5,11 411:16 412:2 413:13,18 429:3 430:4
draft 91:3 183:5 191:1 305:12 323:3 326:3 370:10 408:1
dramatic 114:1
dramatically 198:15
draw 393:13
draws 89:4 97:18
drill 112:17 165:19 166:10,12 309:15
drills 62:22 130:4
drive 34:8 40:19 63:7 121:22 219:4
229:19 264:10 295:1
driven 239:10 240:15
driving 39:4
drove 248:4
dumb 215:20
duress 365:10
dynamically 205:4
dynamics 343:22
dysfunctional 283:9
D.C 1:21 24:7 90:18 165:21

E

earlier 27:18 43:13 80:11 126:8 130:11 157:21 193:17 211:1 260:14 286:11 311:8 318:11 332:20 334:21 342:11 386:3 416:13
early 96:19 111:20 221:12 381:15
early-warning 308:9
easier 10:12 110:14 146:22 267:10 412:10,10
easiest 153:22 301:18 372:5
easiest-case 139:16
easily 41:2
easy 94:11 99:7 222:6 272:5 315:8 315:12 388:13 409:22
echo 146:1 163:5 165:10 252:21 318:4 344:17 364:1
echos 50:22
economic 148:3 317:3
economically 64:16
economics 418:13
economist's 290:2
Ed 5:23 6:12,24 14:15 26:18 39:9 42:11 85:13 116:10,22 117:9 128:12 148:11 162:15 163:22 174:8,10 175:1,1 175:5,8 176:5,10 176:13 182:8,8,18 182:20,21 183:1,2 192:5,8 196:20 199:21 203:2,16 204:6 206:20,22 207:14,14,20 208:1,18 209:13 210:1,10 211:13 216:12 217:3,17 218:9 230:10 239:9 241:6 245:15 246:6 248:21 254:13 257:7 258:7,17 264:18 267:12 268:3 275:18 277:4 278:12,17 281:21 282:1,2 283:8 284:8 286:17 292:13,18 293:8 294:10 305:7 307:20 309:14 313:12 314:17,18 315:3,4 315:7 316:5 319:12,14 321:9 327:1,15,17 342:14 343:14 344:5
EDBA 224:11 228:1 244:3 257:22
eDocs 204:19 205:2
EDs 35:3 41:4 270:16 286:13 293:1 383:22

education 89:10
EDWARD 2:7
ED-based 205:8
ED-level 334:13
ED-oriented 279:22 281:2
ED-run 273:1
effect 49:14,19 63:8 65:10 66:6 128:21 173:8 264:17 272:2 306:20 389:13
effective 88:10 93:7 142:13
effectively 64:8 117:1 204:16 304:1,5 315:18
efficiency 157:22 317:2
efficient 87:15 134:12 280:19 316:18
efficiently 239:11 315:18 337:19
effort 47:11 73:4 94:4 110:20 113:12 247:15 251:15
efforts 35:15 49:8 49:10 82:2 111:6
egg 59:18,19 154:14,17
EHR 23:12 41:4,15 343:12,12,18,18
EHRs 23:14
eight 46:11,18 47:3 287:8 288:11 363:11,14
Einstein 172:8
either 34:17 37:6 40:10 84:7 143:22 151:18 189:15 243:18 262:11 270:18 276:7 287:11 294:21 311:1 312:6 334:13 342:16 351:22 359:9 363:12 372:13 373:22 374:11 375:21 376:17 391:6 399:5 411:7 423:17
EKG 291:14,20
elaborate 346:9
elderly 341:9
elected 416:1,5,9 423:20
electronic 35:10,11 200:8 201:12
elegantly 148:4
element 6:15 34:17 37:9,10 286:20 415:18
elements 41:1 99:15,18 218:12 300:19 301:21 311:17 415:3,8
eliminating 36:21
Ellen 2:23 14:5 80:5,5 126:7 162:16 177:17 179:2 216:14 220:3 237:1 251:18 252:21 267:21 275:13 281:14 293:22 307:14 308:17 316:8 326:6 344:20 351:3
Ellen's 113:17
else's 332:8 357:9
Elzinga 418:14
email 323:6 340:16 433:3
embedded 89:16 91:20
embrace 347:8
eMeasures 41:12
emerge 394:6
emergencies 87:22 137:17 178:14,19 323:14,15,20 324:6 389:20
emergency 1:4 2:19 5:4 8:5 9:5 9:11 13:3,6,15,21 14:2,6,16,21 15:10 16:7 17:6,8 18:1,7,17,22 19:10,12,22 20:6 20:13 21:1,5,9,16 21:21 22:8 23:1,5 23:10,17 24:6,7 24:14 26:19 28:5 30:14,19 31:10 35:22 39:15 46:19 48:19 61:1 71:19 72:11 73:22 74:18 82:10,17,21 83:2 83:15 87:18 88:4 88:21 90:2 91:8 92:20 93:12 95:3 97:20 103:22 106:15 114:18 115:6 121:6 127:3 127:13 129:1 130:6,8 133:5,12 134:22 135:1,13 135:14 136:16 143:15 157:16 158:8 160:20 162:7,21 165:15 170:10,17 171:15 179:8,19 180:2 192:3,10 194:17 209:2,21 210:19 230:5 236:19 241:8 242:7 245:20 246:15 253:14,15 260:19 266:12 268:13,15 268:22 271:6,18 273:10 281:18 282:16,20,22 300:11 301:21 306:16 307:2 310:13 314:1,8 315:13 326:20 329:18 342:4 347:7 350:16 357:17 365:19 367:4,8 369:15 380:19 393:11 396:21 399:13 405:1 417:1,4,9 426:15
emerging 125:6,9 301:19 393:20
Emily 2:6 22:7 120:13 150:4 200:16 239:1 240:11 255:20 275:11 302:6 311:7 342:20 345:7 362:19 366:1 392:8 394:7 398:22
Emily's 303:6 347:17 398:5
Emory 9:6 13:2 297:21
emphasize 157:10 306:9
empirical 379:22 382:6 422:17
empirically 133:2 418:2 422:11
employer 11:19
employers 89:10
empty 163:21
EMS 2:18 13:15 17:9 18:9 19:9,12 48:18 79:15 89:22 114:19 118:6,7 166:7,7,9 167:4 218:8 319:21 320:1,12,17 332:20,20 354:18 355:6 360:19 367:12
EMTALA 78:17 79:6 82:7,14 83:20
EMTALA's 82:6
ENA 14:1 19:4 115:22 224:10 227:22
encapsulate 323:10
encompasses 218:11
encountered 296:19
encourage 76:10 170:15 188:8 221:4 293:20 304:22 341:1 342:12 355:10
encouragement 355:15
encouraging 234:22
encrypted 347:21
endorse 325:5
endorsed 175:7 190:11 193:10 205:17 232:12 263:10 264:3 371:15 414:1,20
endorsement 26:13 26:15 31:22 32:11 407:8
endorses 324:21
ends 147:15 364:3
energy 202:9
enforcement 166:5 354:6
engage 31:5 429:21
engaged 65:18 166:8
engagement 79:4
England 14:21 179:18 235:9 286:13 326:9
enjoyed 30:15
enlightened 351:15
ensure 5:22 34:20 36:12 69:7 196:19 197:11
entertaining 204:21
entire 32:15 71:4 73:5 204:6 222:16 231:22 253:4 265:4 315:15,20

entirely 168:1,2 423:18
entirety 74:7
entities 48:10,11,13 109:7 377:1 393:2 420:3,5 423:21 429:1
entrepreneurial 235:14
entry 282:8
environment 167:9 227:7 353:11
environmental 387:16
envisioned 427:10
EOP 149:16
epi 100:17
equally 148:15
equation 261:12
equity 136:1
ER 9:3 72:18,22 131:15 161:8 168:7,22 169:2 212:19 213:9 278:2,9 279:3 297:20 319:5 395:12
error 201:10
ERs 213:10
ER's 319:5
ESI 130:17 287:14 287:20 290:2,19 290:22 291:2,5
especially 114:2 164:3 188:14 307:7 347:3 387:14 388:4 401:16 425:1
essence 51:1 55:12 63:11 64:21 69:18 168:17
essentially 28:14 29:18 30:1 31:4 34:13 43:7,18 79:5 121:5,18 122:2 132:10,13 132:19 133:7,9,17 158:4 164:11 186:10 190:2,7 191:2 192:18 195:2 196:17 214:21 224:12 225:18 242:12 243:17 244:5 248:18 254:12,18 255:6,11,14 257:19 258:2,3,13 292:5 302:21 305:12 325:18 331:16 338:20 353:4 358:4,19 368:5,7,8 370:12 370:15 378:12 384:16 385:6 386:8 387:17,20 391:9,15 405:10 406:5 408:2 425:21
establish 45:12 47:11,21 50:18 54:3,4 68:9 69:19
established 48:6 60:5 205:3 321:7
establishing 58:9
et 25:12 175:19 218:22 285:2 297:13 356:7,7
evacuate 360:20
evacuation 365:16
evaluate 103:15 112:15 216:21
evaluated 372:10
evaluates 31:18
evaluating 112:11 115:11
evaluation 32:17 44:15 286:16 345:12 371:10 372:3,15 373:1,15
evaluators 103:16
event 45:10,14,16 45:17 52:15 55:15 56:2,12,13 73:14 83:5 114:8 115:16 128:5 135:11 136:13,18 184:18 185:7 349:14 365:15,16 398:11 424:22
events 45:19,22 84:1 102:20 103:13 105:11 106:4,9,10 115:4 115:12 127:11,11 127:15 136:22 310:5 324:1 369:15 394:12,19 396:9 398:5,9,20 399:4
eventually 63:7 107:22 130:7
everybody 10:12 19:19 30:10 126:15 169:22 179:14 180:4,21 229:20 246:8 251:22 255:18 269:21 289:8 319:4 332:8 337:10 373:7 403:10 429:9
everybody's 223:18 332:3
everyday 84:20 113:21,22 136:10 137:1
evidence 33:12,15 36:6 39:8 53:2,8 54:16 58:2 61:6 88:8 97:5 200:14 270:5 372:2 374:14 380:22 381:6,16 382:5,6 383:14 385:12,22 388:3,19 393:17 398:17 399:10 402:11,14,16 403:7,14 404:6 405:21
evidenced 52:3
evidence-based 32:12 36:10 52:2 54:7 217:7 303:1 392:16,17
evolve 355:8
evolved 371:20
evolves 50:13 63:3
evolving 50:11
exact 220:16 262:20
exactly 77:15 94:19 107:9 131:2 198:14 211:6 222:8 224:16 245:22 286:10 300:6 309:22 420:16
examine 366:6
examining 365:21 366:5
example 12:11 35:15,20 37:9 39:10 95:8 109:2 133:7 139:4 156:16 159:2 165:19 172:13 185:6 201:15 234:14 236:5 241:7,20 254:8,15 265:2 293:13 300:13 301:18 315:5 331:13 343:15 349:15 360:18 385:14 393:14 397:7,20 398:21 402:19 413:19 414:14 426:19 429:4
examples 111:19 240:4 388:12 389:5,7 413:19,22 414:5
excellent 171:17
exception 372:13 382:3,11
exchange 231:6,9
excited 244:11 308:21
excluded 38:3,10 403:6
exclusions 402:20 403:14
excuse 94:6 119:8
execute 56:15 57:15,20 62:17 66:4 82:12 83:15
execution 57:6
exemplary 78:6
exempted 268:17
exercise 48:2 62:21 70:2 103:4 106:3 114:12 371:4 379:8,17 404:8 406:5,6 407:14
exercises 62:19 63:1 102:20 103:6 103:7 111:9,22 112:14 113:13 115:13 184:16 324:6 383:2
exercising 62:9
exhausted 267:18
exist 154:21 174:3 193:19 242:19 365:6 396:10 430:7
existing 175:22 186:1 196:5 241:20 342:13 369:7 411:3 418:6
exists 205:11 262:6 365:9
exit 118:4
exogenous 241:6 256:21
expand 104:3 182:7 224:22 272:16,20
expanded 272:12
expanding 320:7
expansion 117:9
expect 187:2 345:16 346:12
expectation 74:15 403:5

expectations 51:6 59:21 372:2 401:15 413:17
expected 325:7
expecting 151:17 232:14
expects 388:8
expeditiously 250:9
expensive 277:20
experience 102:22 131:15 152:17 157:17 171:12,14 171:19 176:5 204:22 211:21 218:10 275:14 278:14 288:20 290:15,20 315:21 326:9 327:8,9,17 344:21,22 347:12 369:1 381:3 388:14 397:19 428:6
experience-of-care 177:7
experimental 348:2
experiments 391:11
expert 1:7,17 11:22 14:10 96:22 206:13 267:21 382:6 385:21 391:16,16,19 394:2 399:21
expertise 43:11 44:17
experts 10:22 28:21 97:1
explains 272:10
explicit 224:13 233:20 357:1,5
explicitly 6:5 220:15
exploring 362:11
explosive 52:14
extend 113:17 132:7
extended 231:12
extending 133:17
extent 178:17 186:2 210:10 234:3 285:5 304:22 409:17 420:22
extenuating 359:15
external 103:16 133:20
extra 128:13 140:7 277:9 433:12,12
extraordinary 85:22 134:17 135:11 136:22
extreme 75:19 127:16 138:9 140:6 299:3
eye 281:16
E&M 246:22

F

face 47:6 123:20,21 125:6 377:21 378:2,3,8 379:9
facilitate 343:3 426:13
facilities 51:15 60:1 69:5 74:5 84:2 90:14 109:8 166:12 266:5 310:10 345:17,18 349:15 364:14 368:21
facilities-specific 364:10
facility 23:18 52:10 52:17 55:19 74:11 75:13 76:16 83:22 152:16 245:17,18 246:15,16,18 254:9 306:13,21 355:5 363:4,8 370:17
fact 20:4 23:11 32:3 33:3 67:11 75:20 77:19 96:4 96:11 107:8 115:5 160:1,22,22 179:22 205:7 206:21 232:3,17 253:7 270:6 271:2 292:10,22 381:15 392:11 417:10
factor 164:1 250:7 251:3 257:10
factored 175:21
factorial 88:12
factors 88:1 218:21 221:13 241:6,8 245:3 248:6,13 249:17,19 255:4,5 255:10 256:21 257:13,17 258:8 258:14 262:15
facts 9:12
factuals 88:15
fact-track 281:19
faculty 15:5,7 16:8 22:21
fade 170:1
failed 151:13 326:17
failing 235:5
failures 297:4
fair 85:1 213:10 300:14 320:5 398:1
fairly 190:12 268:9 273:3 276:15 279:17 384:5 388:21 425:9
fairly-uniform 220:21
Fairview 17:21,22
fall 65:17 94:20 96:10 121:9 157:12 231:14 245:16 374:8,10 431:20
falling 147:16
falls 96:7 281:9 326:13 332:21
familiar 256:3 268:9 302:9 425:9
families 32:13
family 57:4 265:1
famous 125:3
fantastic 186:3 190:15
far 17:18 36:17 85:13 99:16 114:5 183:11 184:11 205:18 228:18 270:16 397:22
fascinating 116:7
fashion 126:7
fast 62:13 117:8 166:5 219:6 300:13 301:19 304:6
faster 219:7,21 294:10
fatality-manage... 46:21
fault 209:10 319:5
favor 79:18 265:15
feasibility 35:7 40:22 108:14 408:14 410:3,7,10
feature 386:14
federal 16:12 23:18 28:11 328:22
feds 60:11 384:22 430:2
fee 278:3
feedback 82:4
feel 117:19 124:14 136:19,20 173:6 174:14 189:16 205:17,21 235:22 236:14,16 291:17 317:14 327:16 343:5 346:20 347:6 393:1,6
feeling 223:18 311:20
feels 129:4 145:11 154:11 155:1 253:8 254:4
Fellow 13:9
fellowship 20:19
felt 31:1 257:5 321:4
fiat 374:11
fidelity 113:11 200:9
field 8:9 27:14 29:18 35:20 39:13 119:10 198:2 214:18 233:13 338:8 377:8 381:15 393:20
fields 2:8 16:5,6 28:20 78:8 113:16 134:8 204:10 215:19 234:6 240:9 265:13 279:13 291:10 301:2 304:11 309:4 329:9 346:8 350:13 383:8 410:9 424:12 431:6
Fifteen 122:5
Fifty 60:6
fighting 124:10
figure 29:21 53:13 62:16 64:15 82:1 98:16 99:3 101:12 128:11 146:5 168:16 176:9 183:5 218:18 222:17 238:21 259:21 268:14 274:2 280:1,22 354:19 358:8
figured 228:14 277:19
figuring 130:22 283:6 306:20
fill 11:17
filled 10:15
final 27:8 186:17 186:18 249:1 266:2 372:12 431:13,15
finally 12:1 34:1 35:12 86:7 120:20

190:20 310:11 349:9
finances 50:22
financial 12:4,5 154:4,5
find 129:10 155:13 210:4 211:15 213:15,18 253:7 256:6 269:8 309:11 323:16,21 430:22 431:3
finding 293:4 347:13
findings 408:20 409:6
fine 11:9 178:1 229:18 246:2
finish 177:14
finished 15:2
fire 157:19 309:14 360:19
firmer 337:2
first 12:22 33:7,9 44:12 47:15 50:9 54:5 55:20 59:1 62:10 63:17 70:19 76:15 80:16 86:10 90:16 91:11 92:8 103:1 120:3 122:16 165:8 167:19 175:2 183:13 196:17 237:18 276:14 280:10 287:5 292:20 314:13 318:10 326:6 329:12,12 336:20 340:21 347:17 356:15 374:7 381:19 402:5 406:1 415:17 431:7
fit 96:14 143:11,16 196:5 216:12 236:10 312:3 409:22
fits 79:13 313:2
334:9 335:11 409:16
five 9:7 33:4 45:3 50:15 58:1 59:22 60:3 74:4 92:15 242:6 267:11 279:3 291:14 352:9 423:8 424:8
fix 314:14
fixing 243:2
flagged 337:10
flashed 354:17
fledgling 273:8
flew 334:6
flex 159:13 160:7 312:9 335:19
flexibility 81:7 132:10,14 299:15 414:13
flexible 133:8
flex-up 133:10
floating 82:18
flood 388:17
floor 1:19 54:8 73:18 148:10 168:21 169:4 175:12 230:6,11 339:1
flow 56:9,12 225:9 303:9,16,17 304:9 306:1 308:2 312:7 314:4 315:8 352:1 352:22 428:3
flowing 419:14
flows 425:12
flu 114:4
fluctuated 229:13
fly 334:7 359:20 360:5
focus 15:12 28:15 33:13,13 40:12 121:11 178:12 183:16 269:15,15 375:16 381:1,6 388:20 402:15
focused 23:16 26:12 75:7 79:6
204:5 431:10
focusing 58:1
focusing-in 35:16
folks 29:4,5 35:3,3 116:2,5,5,6,12 122:12 129:15,18 146:18 162:21 175:14 205:14 222:15 229:16 246:21 429:10 433:11
follow 70:9 109:10 109:18 204:11 234:7 270:12 283:19 286:2 303:5 337:22 343:13 344:11 415:21
followed 250:22
following 34:12 306:8
follows 199:22 305:18
food-borne 127:5
force 8:6 14:1 19:2 269:7 386:16
forces 41:9 78:12 155:19 209:15
foregoing 122:6 188:19 322:5
forever 310:12
forget 273:18
forgetting 52:3 86:15
forgot 291:20 350:14 433:9
form 10:14,14 49:12 55:21,22 70:1 138:9 162:14 261:7 398:12,14 398:15
formal 245:5,8 352:6,11
formalized 48:7
formally 233:2
format 167:18 227:15
forming 77:16
forms 314:2
formulating 164:16
forth 47:14 49:13 250:5,16 264:16 270:2 271:21 273:15 286:3 327:3
fortunately 42:10
Forum 1:2,19
forward 9:20 39:21 41:6,9 60:20 75:16 97:8 102:19 111:1 180:17 234:9 286:5 314:19 325:3 393:15
found 47:20 48:5 214:19 223:15 241:4 244:5 248:5 258:4
foundation 15:1 20:12 22:16,17 28:12 58:2 147:9
foundational 45:21
four 24:5 33:2 39:11 52:10,20 53:22 54:1 56:18 58:8 117:13 140:19 180:3 216:22 221:7 225:9 227:8 228:6 230:10,21 235:9 237:11,13 268:13 283:19 284:7,10 286:22 287:9 295:16 310:1,7 336:3 372:9 375:10 376:13 395:7 404:3 405:17 406:17,18
four-hour 179:22 238:6 268:10 269:19 275:17
fraction 88:5 244:8
fracture 56:19
fragmented 89:3
frame 157:8 170:7 190:6 197:2 340:11 373:9 394:11 398:6
framed 368:5
framework 29:6 77:4 95:7 108:2,9 126:6,12 141:20 142:9 195:7,9 196:6 204:17 392:22
framing 4:22 186:21 188:8
Francisco 2:24 14:7
Frank 125:17
Franklin 3:13 4:4 4:18 8:3,13 26:8 42:8,15,19 43:3 186:19 187:8,12 188:2 189:3,8,11 189:13,19 325:5 432:5,13 433:15
frankly 148:2 430:17
free 124:14 189:16
freestanding 367:4 367:8
frequently 23:12
Friday 16:2
front 47:7,8 83:1 291:13 373:22
full 10:2 86:4 207:3 263:12 280:16 398:14
fully 27:1
full-capacity 301:7
function 59:11
functioning 366:15 414:21
functions 99:15 395:14
fundamental 95:16 96:1 169:14
fundamentally 101:19
fundamentals

140:8,9,12
funded 27:17 153:11 426:21 431:8
funding 11:3,5 13:5 14:9 19:14 20:5,7 22:13,15 24:4 25:11,12 28:11 66:1 97:8 98:10
funds 66:2 328:22
further 36:3 44:20 149:21 239:4 382:5 421:10,10
fusing 383:11
futility 345:2
future 106:8 193:15 302:22 343:9

G

Gab 53:3
Gabriel 2:7 42:8,10 42:12 55:6
game 154:14,15 201:22 211:8 359:7 398:1
game-able 214:16
gaming 194:11 203:4 235:19 285:4
gap 201:12 374:15 374:17,22 376:5 376:16,18,22 379:1 380:22 385:12,19 395:3,7 395:22 396:6 411:18
gaps 27:1 193:18 396:10 430:14,15 430:21
gates 62:11 77:16
gee 116:19 117:14 380:11
Geisinger 2:22
general 4:14 10:7 70:7 93:14 100:15 191:20 197:4,16 200:22 251:12 342:4 362:15 372:9 379:10 407:8 410:4
generalize 192:13
generally 142:15 250:10 251:1 351:14
generate 278:1,3
generated 38:15 417:18
generations 343:9
generically 141:5
geographic 66:15 411:14 416:18 417:4,12
geographical 27:7 425:5
geographically 278:21
geographies 421:5
geography 143:13
geometric 6:19 298:18
geopolitical 415:19 415:21 418:7 425:11
George 2:10,13 22:22 23:10
Georgetown 2:21 15:6 90:12
getting 44:5 66:1 80:11,14 85:21 94:5,6 118:15 139:10 160:11 180:2 181:8 192:10 213:11 217:10,17 227:14 230:16 232:18 271:20 283:11 285:7 286:10 293:1 294:9 298:4 312:14 318:17 326:8 355:10 388:5 422:14 432:21 433:5
give 27:13 31:17 32:22 36:1 43:21 57:16 64:1 80:3 83:21 111:4,19 180:20 181:19 200:2 211:22 240:4 320:5 364:20 371:1
given 40:12 88:13 99:4 119:10 136:21 142:17 224:3 231:2 264:19 284:20 307:2 337:6 377:8 377:17 378:15 393:1 401:7
gives 48:16 176:20 306:16 328:11,12
giving 29:20
glad 42:13 55:6 58:13
global 219:14 232:22
globally 101:7
go 8:11 10:17 12:17 26:9 36:11 37:13 41:5,14 44:8 78:3 81:19 85:11 87:9 87:14 91:18 95:21 96:12 102:1 107:14 108:6,21 113:14 121:14 125:20 145:8 147:3 151:21 159:8,15 168:19 169:3 171:12 180:9,16 187:7 188:3,5 190:7,22 193:15 195:2,5 197:6,17 202:4 219:21 221:12 228:22 230:10 235:15 242:8 249:9 252:16 255:8,16,22 260:14 264:13 267:20 271:4,7 274:3 280:18 282:22 285:16,21 297:12 304:8 307:14 310:6 311:12 322:22 325:14,19 326:5 333:14 334:5,15 339:1 341:17 346:7 347:6 352:9 352:10 354:5 356:15 360:1,6,6 369:18 370:5,20 372:20 373:19 383:12 387:10 392:21 393:15 399:5 404:1 405:7 406:9 407:2 415:11 429:21 431:22 432:22
goal 28:14 29:11 40:9 51:4 53:21 59:1 74:13 91:2,5 92:20 104:13 120:5,14 121:2 151:7 158:19 412:6
goals 29:3 44:3 95:5 97:7
goes 37:18 56:14,21 123:13 124:7 133:7 159:11 169:9 178:7 181:13 327:14,18 341:13 342:7 398:18 400:22 429:21
going 9:13 10:1,16 11:12 12:1,13,16 24:20 26:22 27:9 29:22 33:21 36:14 38:17 39:21 41:13 41:15 44:6,8,20 46:14,15 49:9 55:22 58:1 59:10 65:6 75:9,14 76:20 77:7 80:18 80:19 86:3,6 92:11 95:17 100:2 101:13 102:19 107:5 111:1 118:19,19 126:10 130:5,12 146:16 147:22 148:14 149:4 151:3 152:21 154:20 155:7,9 157:14 158:12 160:13 163:17 164:2 168:22 169:15,21 170:3 172:20 174:2 176:3 180:19 182:3,11 182:12,22 183:17 183:18,21 184:10 185:19 187:3 190:7,21,22 191:9 192:7,9 194:13 196:9,15 202:13 203:6,8 204:3 206:15 211:7 212:5,5 219:12,16 219:21 221:7 224:20 226:13 228:20,22 229:4 231:15 235:3 237:2 238:13,16 238:18 243:11,12 243:20 244:17 245:12 252:9,14 258:1 260:2,14 262:19 264:20 269:17 270:1 271:8,13 274:10 275:2 277:13 279:19 284:18,22 286:5 288:9,11 296:11 307:10 308:19,21 309:1,4 312:12,13 313:1 315:16 316:10,16 318:16 320:12 325:14 326:7 327:5 333:16,17 336:2 343:20 348:22 349:4,19

353:22 356:12
357:14 359:2,6,21
361:6,17 365:2,3
366:4,18 368:5
369:12,17,18
370:8,14,20 371:1
373:13 378:7
379:15 381:7
384:13,20 387:1
387:14 388:13,21
389:5 394:3,4,15
395:22 397:13
401:8 403:6,13,14
406:1 408:4
418:11 419:2,10
421:4,8,9,11,12
421:17 422:10
424:18 425:9
428:19 431:18
good 8:3 9:15 10:4
15:3 16:19 17:4
17:15 18:5,15
19:5,18 21:7 23:7
24:9 26:6 30:9
60:19 69:2 78:10
97:3 98:8 118:5
122:21,22 124:1,2
136:19 155:3,4
167:3 171:15
172:16,16 174:1
177:22 179:20
187:1 216:9 229:8
253:18 259:5
272:15 282:16
286:7 291:18
293:7 294:7
303:13,14,15
312:18 320:13
324:20 342:19
344:12 361:14
362:17 371:5
372:7 383:1 389:8
396:22 397:5
399:9 401:21
408:9 410:20
413:8,19 419:12
419:16 426:9
430:11 432:18
gotten 9:7 33:3
86:7 104:22
229:22 243:18
333:8
government 179:12
268:14 269:10,11
governmental
59:11 89:7 429:1
Governor 424:9
Governors 205:5
GP 282:9
GPs 271:4
graduated 268:11
Grady 2:3 298:6
grant 11:3 14:9,11
14:20,22 19:14
24:4 25:12 50:15
64:12 65:7 105:10
granted 147:7
grants 17:13 22:16
28:8 66:11
granular 354:14
355:8 356:11,16
granularity 355:10
355:21 356:13
grappling 168:10
grassroots 135:13
gray 138:9,10
147:7,8 148:18
150:5 281:8 305:1
grayer 137:14,15
great 8:22 12:6
27:22 42:5 43:3,5
59:12 70:3 72:9
82:4 119:22
131:14 150:1
184:7 189:8,13
190:1 203:12
226:22 234:3
235:17 236:5
238:15 240:19
266:9,10 267:17
271:2 286:9 313:7
321:12 323:8
344:15 366:4,6,9
398:1 432:3
greater 57:17
218:11 237:8
360:17
greatly 382:9
Greg 16:20 20:3
Gregg 2:12 306:4
308:14 330:12
415:11 421:3
Greyhound 56:18
57:3
grind 202:8
grips 178:6
gross 354:13 355:4
355:9 356:15
ground 12:15 95:6
129:10
groundwork 26:14
group 14:16 15:21
15:21 16:2 17:22
22:1 27:4 42:14
48:21 59:9,10
109:22 125:9
131:11 165:7
184:5 185:10
203:12 225:5
226:17,20 229:13
232:16 253:21
255:14 263:17
264:8 287:5
316:12 326:4
330:18 366:19
372:10 374:17
379:13 386:5
390:15 407:8,21
408:1,17 425:21
431:14
groups 34:5 224:7
229:14 263:15
328:21 333:16
429:2
growing 219:1,6
Guam 60:8,8
guess 14:18 23:2,19
23:22 24:13 31:1
68:11 71:13
102:12 143:17
144:21 153:17
155:7 165:3
169:17 188:2
196:21 197:4,15
203:18 209:7
215:10 218:2
220:7 249:11
268:8 277:2
289:12 301:17
310:15 313:4
315:8 318:3 335:9
346:2 349:8
356:22 362:12
366:4 374:16
378:21 381:20,22
389:19 407:3,5
409:8
guidance 27:14
28:17 29:20 30:2
96:22 97:5 108:11
200:1 312:18
315:20 379:14
407:6
guide 10:7 120:15
guidelines 33:16
38:7 429:9,10
guy 71:6,8 73:10
guys 354:10 398:7
404:12 410:18
GW 28:6

H

half 44:2 116:8
120:4 320:2
hallucinating 415:6
hallway 148:10,11
314:13
hallways 149:19
hammer 309:6
hammering 213:22
Hammersmith
3:14 4:14 10:4,6
24:19 25:22
hand 258:19
260:16 272:4
289:17 328:11
348:9 362:6
handful 371:5
handle 39:18 81:2
81:3 123:15,15
139:13 415:8
handles 125:9
handling 125:12
234:2
handoff 230:7
hands 12:10
hang 365:8
hanging 145:15
happen 29:15
61:17 67:20 73:3
88:7 115:5 126:17
177:22 217:14
222:5 228:21
272:12 290:4
354:21 394:17
424:20,21
happened 88:16
105:16 116:1,20
120:3 137:13
158:7 163:18
185:7 190:10
272:10 282:5
371:22 386:6
396:7
happening 126:18
126:20 164:5
174:9 182:4 183:1
282:18 329:16
happens 114:11,21
118:16,16 133:20
134:7,14 139:17
201:13 317:11
337:20 338:22
421:7 430:4
happy 16:17 30:17
87:13 284:8
hard 88:7,12 97:13
124:19 128:15
148:15 173:5,6
207:2 213:11,17
219:16 222:20
236:22 359:9
400:5 423:13,14
424:5 431:2
harder 94:11 99:8

hard-boiled 59:18
harm 39:14 237:9
harmonization 414:18 423:3
harmonizing 35:18
harms 237:6 382:9
harm's 79:8
Harvard 15:7,8 20:14 87:2 103:3 125:2
hat 365:8
hate 333:4,8
hazard 139:19
HCA 13:16 220:20
HCAHPS 176:6 177:4,5
HCPC 247:2
HCUP 212:17 298:14 334:14 347:19 427:3,12 427:13,15,21
HCUPS 266:9
head 62:7 272:9 273:14 350:5 373:10,19
headed 364:20
heading 45:2
heads 202:15
health 2:6,6,9 9:9 13:9 15:8,22 16:21 18:10 21:2 21:12 22:3,10,22 24:11,14 25:16 28:6 30:13 35:11 40:11 46:5,6 48:19 49:18 82:10 82:17,21 83:2,15 87:18,21 89:2,4,8 89:21 91:8 92:16 92:20 97:1,20,22 98:15 100:17 101:6 102:3,4,9 103:11 105:12,13 118:22 121:3,6,10 121:10 127:4,8 132:14 146:8 154:8,9,9 155:17 156:8 157:9 236:4 240:13 312:6 326:13 328:4,12 328:13 392:18 409:10 414:2 417:8 426:21
healthcare 16:22 22:14 24:7 25:20 40:10,11 46:3 48:9,10,13,21 49:17 50:11,12 51:11,19 53:5,11 54:22 55:15,16 56:2 57:16 63:5 67:14,16 75:7,11 76:9 89:8,21 90:6 90:10,14 92:16 104:11 105:15 112:12 115:1 121:4,13,14 134:16 140:13,16 152:2 166:12 168:11,19 180:12 182:21 277:21 319:15 363:5,9 392:19 399:13 417:6 419:4
hear 55:5 72:19 148:5 187:14 249:8 282:18 380:2 404:13
heard 27:18 39:12 41:3 61:21 108:18 115:19 116:3 118:6 140:18 145:18 151:2 174:14 177:13 184:11 220:19 250:20 297:14 310:3 380:19 401:9 406:13 418:15 423:9
hearing 61:3 164:11 165:5 168:2 253:18,20 332:12
heart 88:3 290:10
heartened 67:11
heat 417:19
Heavy 216:1
Helen 3:12 4:23 30:6,11 42:6,7 91:19 173:10 181:18 186:2 193:17 196:1 198:14 206:14 208:4 222:8 367:18 372:8 385:20
Helen's 204:1
helicopter 359:19
helicopters 156:17
Hello 8:21 249:8
help 27:13 29:4,12 55:6 77:3 84:18 95:15 133:21 135:12 137:1 143:9 161:15 176:18 205:15 206:1 218:20 227:15 305:1,20 311:4 314:18 344:12 384:17 387:11 417:2 430:9 431:4
helpful 31:16 60:20 141:3,4 178:20 233:19 261:8 264:8 274:21 303:13 309:2 329:6 432:4
helping 417:7
helps 220:2 263:19 295:4 371:12 379:2
hemorrhage 358:2
Herculean 154:12
hesitate 433:3
heterogeneity 242:4 389:14 390:6
Hey 221:6
HHS 17:2 25:21 27:17 82:9 83:13 414:7
Hi 20:10 22:7,20 23:7 122:9
hierarchical 33:6 36:8
high 82:15,22 136:21 141:13 142:1 151:18 159:19 160:1,8 246:3 261:19 307:20 336:13 375:20 384:5 419:11,15,15
higher 27:5 33:4 52:9,20 73:19 178:4 186:6 254:15 298:5 331:12 412:13
higher-acuity 53:6 55:10 57:8 63:12
highest 238:9 383:21 426:9
highlight 26:11 334:20
highly 141:1 404:11
highly-consolidat... 79:16
highly-variable 192:21
Highway 19:15
high-cost 344:8
high-impact 34:3
high-performing 159:22 335:20
high-risk 273:13
high-volume 149:16
high-water 50:16
Hill 47:8
hint 83:7
HIPAA 55:21
historical 388:12 389:4
historically 168:16
history 276:16
hit 52:14 56:14 62:7 96:11 243:2
HIV 414:3
hives 176:21
hoc 39:16 55:18 107:6
Hogarty 418:14
hold 223:6 328:15 361:17 385:2,3 394:4
holding 116:17 117:5 161:18 209:20
holistic 106:22
home 56:21 125:20 130:12,15 168:21 169:3 221:12 238:15,19 240:6 259:9 264:22 269:7 274:3 276:17 311:14 337:8 350:18
Homeland 2:15 24:12 89:9
homes 311:15,21
hone 120:13
honest 71:1 77:18 146:13 430:17
hone-in 226:20 370:8
hook 244:22 245:2
hooked 153:1
hope 29:19 44:1 50:14 58:4 63:12 64:11,13 66:12 138:4 174:11 430:2
hopeful 60:14 81:22 396:11
hopefully 29:15 45:13 66:13 310:12 325:13 329:6 399:19
hoping 111:2 325:15
Hopkins 53:3
hospital 13:3 18:9 20:22 22:4 48:13

48:14 51:6,20
57:22 65:2,4,21
70:14 71:3 73:1
79:15 80:13,20
81:11 82:8 90:12
98:6,15 103:10
109:5,12,16 111:2
115:18 116:2,8,9
132:21 134:11,15
136:19 139:7
144:4,16 149:1
154:2 155:19
157:5,20 159:5,18
162:8 172:16
176:9,12 177:7,11
179:12 180:4
182:3 204:6,13,17
207:17,22 208:1
209:5,5,16,16
210:8 215:7,13,14
216:20 218:22
234:4,12 235:14
238:13,17,22
240:1 241:5,14
242:10 244:20,22
245:14,14 246:3
247:1,9 250:15,16
251:11 252:8,13
252:15 255:1,4
256:9,12 261:15
262:15 265:4
267:4,12 270:18
272:22 276:8
277:11 280:17
282:8 283:7 291:5
296:19 297:21
299:14,16 301:10
304:21 307:19
315:5,15,21 316:3
317:1,6 320:1
321:6 329:15,18
330:8 331:13
333:2 336:11,15
337:2,21 339:1,15
340:1,8 343:13,17
344:6 346:15,16
348:17,17 351:17
351:18 352:12,19
353:4,16 355:19
355:22 356:5
359:17,18 360:21
365:17 368:10
374:19 376:17
380:12 395:8,17
396:2 403:3
410:12 416:22
417:8 427:6
hospitalist 280:9
281:6
hospitalists 282:7
hospitalization
174:10 179:16
219:18
hospitalizations
329:21
hospitals 48:18
49:16 50:7 59:9
65:17 69:4 74:6
78:17 79:5 85:19
90:10,13,15,18
96:14,22 104:10
109:9 113:19
114:5,10,18
117:17 124:1
135:2 137:1 139:9
140:7 144:15
145:5 155:2
156:14 162:13
171:22 172:17
182:19 192:14,20
194:4,5 205:2
211:2 214:19
215:12 235:10
239:21 245:1
247:7 248:13
256:6 257:3,18
262:16,17 265:22
266:4,8,20 267:7
267:8 269:8 276:5
287:19 288:20
297:3 299:19,21
300:16 304:4
305:11 309:12
330:7 333:18
345:15 346:5
363:11,14 375:7,9
376:8,8 384:11
403:1,2 408:18
419:5 424:17
425:4,7
hospital's 193:12
249:18 252:3
337:12 344:5
hospital-associated
166:22
hospital-based
154:10 265:7
321:11
hospital-level
121:15 260:22
261:9 411:2
hospital-specific
264:15
hospital-wide
204:19
hospital/coalition
370:18
hour 44:2 120:3
164:18 215:4,14
217:4 230:22
235:10 320:2
366:13
hours 39:11 52:11
52:20 53:22 54:1
56:18 58:8 117:13
134:15 140:19
161:18,18 180:3
190:3 211:12,14
214:22 215:1,3,13
216:21,22 217:3,4
225:10,12 227:12
228:6,6,21 230:10
230:12,21,22
235:19 237:11,13
237:18 238:4
242:7 268:13
274:3 275:20
276:15 283:20
284:8 286:22
287:8,9 288:12
291:19 292:13
293:18 295:16,17
295:20 304:8,8
310:1,7 326:16,21
336:1,3,4,4 362:8
366:14 375:11
376:13 385:2
395:12,15 404:3
405:17 406:17,18
HPP 24:3,16 63:19
100:6,10 386:14
387:22 391:18
HRR 418:9 419:9
419:14 422:16
HRRs 419:12,19
420:3
HRSA 2:4 18:12
19:14 414:6
HSAs 419:20 420:3
huge 128:6 318:1
334:10 403:9
Human 25:16
hundred 395:15
Hunt 44:15 54:18
354:11 360:13
395:2
Hurricane 400:21
hurry 235:11
hurt 139:21,22
143:9
hypothesis 257:22
hypothetical
109:18
H&P 278:2,6
H1N1 101:7,8
115:4

I

IAA 426:18
IAAs 48:7
IBA 52:6 57:15,20
62:9 63:3 69:20
83:16,17 84:4
122:1,2 373:8
374:3,6 375:19
376:11,12 384:13
385:15 386:10
399:18 406:15
IBA-type 69:1
ICU 221:7 345:1
id 67:13
idea 34:20 39:6
66:19 80:10 89:2
95:13 105:10
144:22 179:5
180:10 207:18
217:6 250:11
268:16 293:3
296:16 304:14
316:10 325:11,16
336:17 347:7,9
361:11 362:22
363:3 373:8 383:5
385:15 389:3,3,6
398:5,11 418:12
420:15
ideal 109:13 195:11
ideas 80:15 170:7
312:8 325:22
408:6 417:18,20
identifiable 173:7
identifier 347:22
identifiers 427:4
identify 26:21 92:7
127:7 173:6 199:1
239:7 323:12
359:2 379:2 427:5
identifying 60:16
91:14 217:13
338:4
IDIQ 426:12 427:1
427:16
iffy-ness 321:8
ignoramus 124:16
ignore 234:13
IHI 428:10
ill 158:3
illness 144:13
146:7 172:14
358:14,15 418:11
419:4,13
illnesses 419:8
illuminated 116:15
illustrate 131:16
imagine 84:17

124:19 150:22 162:9 213:7 388:10 400:5 403:22 422:3
imagined 141:6
imaging 219:9 280:2
immediate 18:2,21 52:6,8
immediately 169:7
impact 23:5 78:20 256:21 265:9 309:14 315:7 329:22 342:8 349:21 375:20 385:8,10
impacts 230:17 400:17
implement 303:17 309:20
implementable 27:2
implementation 26:16
implementations 307:22
implemented 23:13 35:8
implementing 262:18 304:2 360:21 423:1
implements 251:2
implication 198:10
implications 260:17 276:20
implicit 92:19
implied 78:20
implies 425:5
importance 33:8 47:1 87:10 108:19 373:2,21 374:2,5 374:16 375:5,19 377:12 389:6 400:8 401:17
important 32:2 33:16 37:20 39:20 39:21 40:17 41:19 45:9 75:17,21 76:9 87:12,16,22 93:16 96:19 98:12 111:8 119:11 122:19 153:6,13 160:14 173:2,4,7 194:20 207:10 214:3 216:18 217:18 224:13 227:4 240:8 243:21 244:9 255:18 258:17 262:9 264:2 266:22 271:12 281:8 289:20 298:11 306:14 314:6 318:5 323:13 327:18 334:9,17 335:1 341:11 343:7 348:7 350:14 351:9 375:6,9 376:1 377:7 378:19 381:17 382:12 389:21,22 390:3 394:3 400:19 412:3,6 422:9 430:22
importantly 257:8 371:22
impossible 93:2 334:13 343:10
impression 176:12 224:2
impressions 176:11
improve 17:12 42:1 131:3 153:21 167:2 172:19 173:5 211:8 295:2 330:8 347:5,11 356:14
improved 199:3 302:18 303:9,10
improvement 33:19 34:8 35:6 39:5,7 40:10,16 40:19 92:2 105:2 172:12 173:9 201:7 296:3 349:7 374:9 376:4 379:3 379:6,16 409:21 420:8 424:19
improvements 162:2 243:17 293:1 295:1,21 296:1
improves 296:2
improving 131:7 240:12 352:1
inadequacies 372:18
inadequate 23:12 310:2 379:9,12,19 379:22
inadvertently 80:9
inappropriately 38:3
Inauguration 400:14
incentive 154:5 173:5,8 201:2 235:12 266:20 331:19 348:19,21
incentives 348:6 357:3,4
incentivize 154:8 172:12 332:5 349:7
incentivized 177:11
incentivizing 154:9 421:5
incident 115:17 117:4,13 118:17 119:3 148:8
incidents 105:20 149:9
include 68:21 170:19 320:8
included 20:19 69:4 116:2 224:11 311:17 341:12
includes 213:3,4 313:4
including 76:11 87:6 172:17 285:15
inclusive 421:19
incorporate 341:2
incorrect 38:19 272:11
increase 77:13 131:6 161:20 270:9,9 318:18 376:13 383:1,6 396:20 399:12 400:4 405:16
increased 61:8
increases 128:10
increasingly 35:9 38:13 90:10 346:21 347:19 349:11,17
incredible 162:2
incredibly 142:3
incremental 62:15 310:20
independent 50:11 68:6 258:6 347:1
independently 235:4 248:6
index 16:1,4 244:15 245:5 328:5
indicate 430:15
indication 179:15
indications 39:12
indicator 174:17 183:1 399:2 426:15 427:11
indicators 14:13 91:15 174:12 181:21 182:2,6,13 182:18 348:2 413:21
indirectly 341:17 342:6,7
individual 11:13,22 75:13 85:7 111:2 124:10 127:21 132:4 157:5 179:6 179:17 182:19 203:20 207:9 247:18 292:9 333:2 344:11 368:21 384:11
individually 309:12
individuals 92:17 345:15 397:9
individual-based 168:11,19
industries 397:21
industry 32:15 64:14 234:12
infected 139:10
infection 139:6 140:5
infectious 93:4 101:1 139:18 140:10 141:1
influenza 138:22
inform 27:13 261:1 261:11
Informatics 21:10
information 32:6 101:16 113:1,3 208:3 213:2 225:17 231:6,10 232:11 267:2 307:1 315:9,12 320:5 334:13 409:4
infrastructure 111:15 113:14
inherently 225:22 226:1
initially 40:13 257:20
initiated 429:20
initiative 67:2
injured 419:6
injury 362:6 419:8
innercity 253:15
innocently 11:15
inpatient 72:1,6,13 72:15 81:10 182:1 216:6 234:20 235:20 236:21 261:6 281:5,10 318:19 336:22

337:6,7 366:14
inpatients 116:16 116:20 279:4
inpatient-oriented 182:6
input 32:13 66:14 183:18 190:16 195:13,15,22 228:7 283:5 320:8
input/throughpu... 190:14 195:4
inside 182:22 204:18 205:11 346:14
insights 329:8 371:18
inspection 237:16
instance 60:6 112:17,20
instances 353:20
instantly 143:21
Institute 57:11 89:5 328:7
instituting 86:8
institution 212:10 290:5,6 326:17 341:18 342:5
institutional-dire... 334:22
institutions 127:22 152:2 171:5 362:2
institution-specific 290:3
institution-to-ins... 295:5
instruct 222:21
instruction 213:14
instructions 169:5
instructive 235:8
instrument 239:14 272:3,4 324:10 404:19 405:13
instruments 110:21 110:21 185:6 405:4
insurance 362:8
insurer 369:8
integral 84:6
integrate 60:21 84:15 101:16 320:6 326:2
integrated 18:1 63:4 111:3
integrates 51:22
integrating 422:10
integration 155:20 157:5 173:15 176:16
integrative 319:2,9
intend 287:2
intended 32:11 200:5 412:8
intending 223:6
intensity 219:9
intensive 280:2
intent 74:17 208:12 208:22 209:8,12 364:13
intention 216:7
interact 330:8
interdependent 221:15
interest 4:13 10:8 10:10 11:10 12:5 14:16 19:16 21:22 46:13 49:22 72:18 131:6 146:1 165:6 295:7 316:12 366:18 416:3
interested 11:2 28:18 138:20 418:21 420:6
interesting 60:18 61:12 70:10 78:14 116:14 148:18 149:11,14,20 150:11 155:11 207:5 277:2 280:9 311:13 313:8 338:7 348:10 349:10 350:2 398:6 420:9
interface 136:17
interim 433:4
intermediate 171:3 193:20 274:9
internal 215:11 217:10
international 23:19
internationally 382:17
internist 54:8,12 173:13 280:13
internists 273:2 282:7
interpret 390:6
InterQual 235:18
interrelated 165:13 168:5 289:2 364:4
intersection 153:12 158:20 260:19,20 392:18
interval 220:16 286:7 356:5
intervals 194:1 213:3 289:11 338:2
interventional 210:3
interventions 385:14
interviewed 112:4
inter-rater 291:7
intracranial 358:2
intrigued 78:9 143:10
intriguing 107:19
introduce 42:9
introduction 4:16 9:3
introductions 4:12 8:20 10:2,10 25:7
intuitively 256:9,12
inventories 96:8
invest 349:4
investigated 334:11
investigating 235:16
investigation 149:21
investment 79:2
invited 181:19
invoke 397:21
invoked 382:11,13
involve 314:3 324:8
involved 9:7 48:2 60:1 65:20,22 112:11 131:10,13 158:11 166:3 270:20 429:11
involves 91:11 112:13,18
involving 352:11
in-flow 320:9
iPad 323:7
ironic 384:3
irrelevant 134:20
irrespective 50:21 51:2,2,3 52:12 68:4
Isabelle 400:22
island 157:19 359:17,18
isolated 319:12
isolation 312:11 365:6,22 366:5,7
Israel 382:18
issue 68:5 81:16 117:22 118:22 122:19 129:14,14 131:8 159:1 169:14 170:14 171:8,16 176:15 181:8 192:12 226:6 244:20 259:7 277:12 283:3 285:4 289:8 291:3 294:15 299:16 307:6 314:18 318:1 319:22 327:2,12 327:13,13 328:6 332:4 348:3 356:10 360:4 365:12,13 382:21 385:8 387:13 403:9 405:19 414:18 420:13 422:22 423:2,3,4 423:14
issues 5:7 20:8 22:19 26:12 31:14 43:12 44:5 55:7 68:2 150:6 151:15 155:10 157:5,6,13 165:15,16 166:10 175:13 176:14,18 177:2 190:5 192:9 193:5 194:22 201:18 233:20 239:11 248:20 256:11 264:9,16 277:7 314:7 319:10 322:13 333:6 335:18 342:19 362:8 381:3 385:13 386:5 396:17 399:8,8 400:16 404:16 412:3 417:4
italics 102:14
item 213:19

J

JAMA 256:4
Jay 2:19 20:21 59:6 59:13 60:14 103:4 155:6 158:18 163:5 168:5 225:15 239:17 243:4 247:12,19 260:12 289:13 292:19 303:4 309:3 310:18 361:7 362:14 398:3 428:15
JCAHO 228:9 308:2 309:22 353:18
Jefferson 254:21
jeopardy 234:9
Jesse 3:17 4:20 5:6 5:19 8:16 23:11 27:20,21 28:4

42:4 44:10 119:20 148:3 152:16,20 159:12 164:6 165:3 166:17 167:6 169:16,20 170:1,6 177:15 184:2 189:20 214:13 240:17 256:8 300:7 302:10 332:12 341:14 367:21 370:5 396:20 413:5 422:6
Jesse's 41:4 172:6 218:17
job 9:13 12:18 18:16 21:9 22:9 58:7 65:14,15 124:1,2 146:21 174:22 235:17 249:18 274:1
jobs 16:6
Johnson 20:12 22:17
Joint 62:20 96:12 111:11 194:15 225:8 230:2 237:16 251:13 352:22 353:19 428:2 429:6
joke 350:15
Jones 288:11
judgment 107:2 112:9 130:17
judgments 409:14
juice 34:6
jump 46:14 81:17 82:1 129:21 331:2
jumps 165:3
juncture 355:7 356:12
junctures 401:16
jurisdictions 99:7
justifying 379:4
just-in 51:18 160:3 221:10
just-in-time 51:12
juxtaposed 86:2

K

Kathy 2:18 19:6 217:21,21 345:7,7 360:11
Katrina 341:8
Katz 25:2 42:21
keep 73:2,17,17 76:16,20 168:22 188:11 213:22 223:11 227:5 237:7 269:2 271:13 282:17 288:11 309:5 393:3
keeping 187:4 277:4 284:9
Kelen 53:3
kept 109:11 139:10 269:5 278:17 395:22
key 46:1 74:1
keypad 187:18
Khan 3:16 8:15
kicked 417:17 420:12
kicking 416:16
kidding 275:1
kids 188:16
kind 44:22 53:19 55:12 62:4 68:12 75:2 77:12 79:1,6 80:11,22 86:14,16 91:5,7 92:2 97:11 98:22 103:9,22 105:13 106:1 109:16 115:11 123:17,20 124:6 125:4,6,13 126:6 126:16 127:9 128:3 131:9,9 136:8,9 137:16 139:13,18 140:9 141:17 151:8,22 151:22 152:3 159:8 160:15,20 170:21 171:2 179:10 184:17 197:10 202:11 214:8,9 219:18 237:19 259:20 262:5 268:11 269:20 271:8,12 272:18 294:4 295:6 296:12 299:22 303:21 306:2 307:15,18 308:1,9 314:9 315:9 316:6 326:19 332:19 333:13 341:13,21 342:6 346:3 352:2 352:13 363:4 370:6 373:9 374:5 377:12 378:9 379:9 380:12,14 383:2 389:15 391:1,7 403:18 408:22 410:7 413:3 416:11 418:1 427:1,4 429:12,14
kinds 103:13 118:11 123:22 124:2 140:8 174:18 188:13 304:16 382:14 389:19 392:4 396:9
knew 96:20 112:7
Knight 115:22
know 10:22 14:19 28:1,2 31:1 32:1,9 34:6 42:1 51:4,5 53:17 56:11 59:15 59:16,20,22 61:16 62:11 64:4 67:6 69:11 74:15 88:11 88:12,15,17 94:16 103:3 107:14 109:4,19 110:7 115:14 116:14 117:15 118:7,18 118:21 120:2,9 121:7 123:18,21 123:22 124:17 125:18 127:12,13 127:19 128:3,11 128:14,19 129:3,6 130:1 131:1,3 133:1 138:19 141:9,15 142:2 143:8,13 144:5,9 146:15,16 150:5 150:22 151:8 152:4 164:12 170:20 171:13 173:2 174:6 176:3 180:10 185:7,21 192:5 198:2 200:9 201:16 202:3 205:21 207:14 208:9,12 211:6 212:18 213:21 214:9 220:19 223:11,17,22 224:20 228:17 229:4,12 230:9,21 233:13 238:19 245:6 252:5,11,12 260:13 261:18 263:11 271:12 274:4 283:19 284:10 285:21 287:14 288:2,9 289:4 290:10,14 290:20 291:22 292:8,14 295:19 296:13 298:1,10 300:5 304:9 305:2 305:5 309:17 316:4 317:13 318:15 319:11 320:1 322:3,20 327:16 331:16,17 333:14 334:5 335:10 337:9,12 337:13,20,22 340:6,13 345:1,3 348:8,16 349:3,22 350:20 352:20 353:15 354:5 355:3 360:4 363:14 364:11,16 367:11 369:6,15 373:7 380:6,17 381:11 382:20 386:4,6,11,22 388:22 389:15 390:21 391:4,18 392:12,15,20 394:2,13 397:8 403:15 405:1,7 407:22 408:12 411:9,19 415:10 415:13,20 416:21 421:9,22,22 422:8 422:21 424:9,21 425:18 426:5 428:9,11 432:2
knowing 9:12 219:22 267:4 335:19 357:16
knowledge 292:17 397:11
known 104:19 389:4
knows 94:19 112:11 126:16 240:18 295:14

L

lab 100:17 156:18 210:2 230:17 291:16
Labor 269:10,13
laboring 12:19
labs 101:1 209:3 285:22
lack 136:1,6 152:1 237:9 238:8
lacking 97:6
Lancet 53:3
land 360:6,6
language 386:9 407:22
languages 120:7

large 22:18 54:1 69:15 264:21 265:2 299:21 323:14
largely 273:10
larger 143:12 203:4 314:7 343:2
largest 16:7
large-scale 45:17 63:1 69:21 323:20 375:22
lastly 166:11 176:3
lasts 50:14
late 19:21
latest 98:8
late-stage 414:2
laughter 17:20 23:15 31:3 110:15 117:10 123:7 125:21 131:22 137:8,11 138:11 143:3 145:10 179:14 183:9 199:16 202:11 212:3 229:2 279:8 285:10 288:8 289:16 297:9 309:7 313:18 314:22 326:18 340:14 351:2 363:1 366:8,20 394:22
launch 425:2
law 82:19 166:5
lay 26:14
layers 352:12
lead 95:14 222:22 304:17 378:7
leadership 117:4 209:15
leading 29:1 433:10
lean 392:10
leaner 51:12
learn 105:15,19 115:7 118:13 119:3,11 138:3 207:5
learned 101:3 139:11
learning 105:10 119:6
leave 37:3 197:21 211:17 214:11 226:6 255:4 317:12
leaves 340:18
leaving 71:7 85:6 296:6 317:22 357:13 358:10
led 24:14 128:6
left 38:5,7,8 45:16 63:21 69:17 99:22 226:12
legislature 205:1
length 53:12,19 128:16 133:6,12 160:5 162:3 192:17,21 193:8 194:6 203:2,22 214:20 215:2,15 239:9 241:9 242:10 244:6 253:4 254:16 256:4,22 259:10 259:17 261:19 262:19 264:20 265:2,16 266:10 280:3 291:11 295:15 300:12,20 301:22 305:7 315:5 316:5,21 329:22 331:14 363:7,12 366:11 421:3
lengths 257:4
lengthy 10:14
length-of 264:15
length-of-stay 326:11
lens 35:1 142:12 186:14,16
lesser 81:14
lessons 137:22
less-urgent 163:14
letting 180:15 411:20
let's 8:10 44:22 92:6 107:16 109:2 141:7 165:17,19 169:19 177:14 230:5,19 238:21 254:20 267:20 275:7,16 297:12 301:19 322:4 419:3,5,9
level 27:12 33:12 34:17,18 37:6,10 64:10,10 75:7,11 75:13 80:14 86:4 89:15 93:15 109:16 110:18 111:2 121:1,4,15 132:21 133:11,22 135:13 140:6 141:7,8 143:13 144:4 145:2,4 154:1 155:22,22 157:22 159:5 172:15,19 173:18 173:18 174:2 176:9,20,22 178:4 180:20 186:5,6 196:8 207:7,8,9 213:18 241:5 247:18 250:13,18 252:1 261:4,15,16 264:1,5,6 266:16 266:19 292:5,6 296:4 306:14,15 310:9 311:15,15 311:15 324:4 328:14 330:5,9 333:1,3 336:16,16 337:2,4 351:11 355:6,6,7,8 357:2 357:20 363:4,5,6 363:8,10 364:12 364:16 368:10,19 370:17,18,19 374:20,20 376:17 376:18 383:21 384:6 394:6 401:13 409:4,5 410:21 411:1,6 412:7,13 413:22 416:2,2 427:4
levels 23:18 27:6 57:18 192:17 257:18 264:3 288:13 311:14 331:12 333:6 358:6 368:9,10 370:14
leverage 49:10
Levine 2:9 21:7,8 163:1,3,4 321:1
lib 54:9,9
life 21:20 24:14 161:1
light 116:4 274:15 307:8 417:19
liked 271:1
likelihood 130:18 369:11 426:9
likes 93:14 97:12
limit 358:17
limited 109:15 180:14 290:19 427:20
Linda 2:12 22:2 362:18
line 42:21 46:4 160:16 189:4,6,9 199:8 228:13 330:15 417:10
lines 42:21 89:17 199:6 318:8 335:22 421:8
lingo 87:19
link 134:2 167:12 185:22
linkage 167:21
linked 36:9 37:20
linking 120:11 164:22 186:7 405:8
links 99:21
list 47:4 96:9 312:3 333:10 395:19,20
listen 407:9
listened 354:16
listening 367:1
lists 396:9
literally 78:3 326:17
literature 192:18 200:19 300:15 301:20 302:9,19 305:6 318:16 380:5 386:1 389:1 393:13 396:15,15 396:19,22 397:1,2 397:16 418:13
little 10:11 15:17 30:7 31:17 58:16 61:22 68:12 86:2 86:6 104:18 107:14 108:8 118:1 121:22 122:1 123:12 124:12 126:4 128:20 132:8 137:14 139:15 150:9 155:21 169:19 183:10,11 190:4,9 196:9,12 203:5 218:16 225:1,2 240:21 255:1 257:13,16 259:14 271:16 273:9 278:11 280:19 281:12 288:19 308:1 310:21 319:17 320:8 325:13 333:13 345:13 348:21 378:17 388:15 403:17 405:9 410:13 416:11,13,17,21 426:2
live 254:6
lived 39:10
lives 403:7

living 235:4,4 347:1,2
loaded 254:5
local 36:2 58:9 69:10 83:7 121:9 414:13,15 415:5,7
localities 98:14 99:3
locality 68:22 69:9
locally 68:21 101:7
locally-produced 419:2
location 98:17
locations 345:17
logarithmically-l... 114:8
logic 54:19 95:1 378:6
logical 99:22 175:12 378:9 382:10 430:11
logically 389:18
long 10:21 85:6 100:20 130:15 161:16 194:6 205:8 211:1,2 229:8 230:17 239:9 261:19 262:19 275:18 286:16 292:18 316:13 317:14 331:15 354:16,17 354:19 358:7 359:8 395:19,20 432:2
longer 135:6 238:19 252:9,14 253:6,7 254:17 257:4 269:3 287:8 366:7
longer-term 216:10
long-term 48:18 60:1 69:4 74:4,10 74:11 109:8 345:17
look 27:1 31:20 35:2,14 37:8 39:2 50:17 61:12 62:17 63:8 66:10 70:3 71:5,14,22 76:6 76:11 79:3 83:3 89:19 96:4 100:20 105:20 106:3,7 113:10 114:20 118:2 121:3 128:1 136:9 144:2 147:14 148:12 150:16 154:1 155:14,15 157:4 167:1 170:15 172:20,21,22 182:22 183:17 187:1 193:16 202:17,19 207:7 212:10 222:22 230:20 232:7 235:1 236:22 266:9 267:8 289:3 293:5 312:12 315:14 317:9 323:7 325:6 328:6 342:12,13 348:22 366:10 367:15 370:12 371:10 373:14 374:18,18 387:15 388:11 392:3 397:4 410:3 413:20 417:11 418:6,10 419:5,22 424:1
looked 12:12 46:10 68:8 124:18 128:10 144:1 155:21 192:16 194:3 198:4 199:20 201:8 241:2 290:10 298:12 302:13 311:18 380:8,9 418:19
looking 9:20 26:14 27:3 28:9 34:4 49:7,9 60:20 62:8 66:2,7 71:19 75:15 101:6 107:3 107:21 120:2 127:21 128:15 129:19,20 151:12 152:3,5 153:22 163:2,6,7,10 171:2 173:21 175:16 176:8 182:17,19,19 190:16 192:4 193:4,5,7 196:14 200:22 203:21 205:8 206:20,20 213:7 214:1,10 222:9 234:8 256:4 285:1 290:22 298:14 301:20 304:14,15 306:7 314:1 352:4 360:1 362:2 364:17 389:2 396:18 397:8,15 407:20 409:13 414:2 425:10 427:16
looks 69:2 143:5 215:14 216:20 217:1 230:20 231:21 232:2 236:7,8 267:17 330:6 348:18 372:12 411:10 427:21
loop 175:17,21
loose 282:20
lose 190:6 267:1 347:13 395:14
lost 58:15 84:13 171:8,10 172:3 262:3 336:21 347:18 361:6
lot 15:14 16:10,15 20:7 34:7 35:8,15 37:8,17 43:9,10 63:20 74:22 78:18 85:11 86:16 87:4 87:20 90:13,15 94:11,14,20 96:6 97:14 99:8 101:21 107:12 111:10 112:13 114:14 115:17 118:6,13 120:4,10 124:11 127:21 130:10 131:10 133:2,14 134:18 135:6 137:15,16 138:16 139:4 141:22 146:21 155:18 156:12 158:10 162:20 164:16 166:20,22 175:20 178:14 179:16,19 181:12 184:8 185:4 192:15 194:5 201:9 206:21 216:1,9 219:5 224:8 235:17 236:19 238:17 240:12 242:4 243:16 246:4 252:2 253:18 258:17 265:11 267:1,10 270:4,17 271:10 271:15,17 277:6 277:18 279:17 283:6,16 285:6 288:14 289:1 290:4 292:22 294:13 295:1 302:11 314:20,21 320:16 321:6 322:12 324:16 327:1 331:11 335:14 337:17 344:9 345:1 349:16 353:10 354:22 369:11 370:15 374:4 379:15 385:8,19 386:1 387:21 388:6 391:18,19 393:14,21 394:2 397:2,8 402:8,12 404:11,21 405:5 408:17 412:10 415:14 417:16,17 422:5,10 424:13 427:11 428:4,10 428:11 430:14 431:9 432:3
lots 9:12 40:16 41:21 153:13 157:15 174:14 178:10 256:10 257:13,16 383:13 383:13 399:8 414:7 421:13,13
love 31:4 63:7 175:7 289:17 362:21
loved 30:14
low 142:1 157:21 160:19 266:11 273:12 383:18 407:10
lower 56:3,16 81:8 130:18 156:22 381:13
lower-acuity 57:8 73:15 164:4
lower-level 161:11
low-acuity 234:17
low-level 160:20 161:2
luck 158:10
lucky 140:22 396:3
lumped 332:10
lumping 330:22
lunch 184:2,5 187:7,8 188:17,20

M

MacINTYRE 2:10 23:7,9 74:21 140:11,15 152:9 152:12 363:22 396:14 400:10
macro-level 134:7
Madrid 83:22 395:8

magical 228:20 230:21
magically 148:9 183:7
main 62:3
maintain 132:14,20 133:11,21 134:3 397:11
major 34:13 37:16 44:4,5 196:3 264:17 385:8 386:14
majority 166:9 395:8
making 26:1 39:7 40:15 43:14 86:11 107:13 127:17 131:1 156:10 158:21 164:20 187:3 194:10 209:5 238:2 255:7 288:18 297:19 299:6 355:14 377:13
manage 71:21 73:18 149:3 205:4 272:5 312:7 314:4 330:10 358:7,8 365:9
managed 315:18
management 24:6 48:19 148:21 149:17 203:14,16 205:10 209:17 304:3 347:4 365:11 396:21 397:5 424:14 425:6,10
Manager 19:8
managers 75:6
managing 121:7,8 149:8 383:18
mandate 153:15
mandated 177:8
mandates 137:2
mandatory 62:20 62:21
Manish 2:20 17:5 319:16 332:16 340:18 353:6
manner 124:6 210:22
manpower 345:22
manual 200:12
man-down 165:19 166:10,12
map 313:4
Marcello 316:10
Marco 318:11 406:13 421:14
Marcozzi 2:11 5:8 25:15,15 43:21 44:9,10 58:18,21 59:12 62:6 64:11 67:4,10 69:11 70:9 72:17 77:14 81:17,21 145:22 165:1,2 433:13
Margolis 2:12 16:19,20 20:3 306:5 330:14 332:1 415:12 423:15
mark 50:16 53:21 68:3 69:3
marked 98:4
marker 54:11 220:3 358:18,20
markers 47:12
market 78:12 145:13 155:19 344:3
marketplaces 137:2
markets 79:16 343:16,20 344:1,4 344:9
marks 47:12 355:14
Maryland 424:10
mass 102:7
Massachusetts 353:13
massive 311:16 375:22
massively 272:11 333:18
matchmaking 430:9
matter 122:6 128:17 188:19 266:3 322:5 399:12
matters 7:19 207:13 239:5
mature 77:19
maximized 160:5
maximum 326:10
MBA 125:3
McCAIG 2:12 22:2 22:2
McCARTHY 2:13 22:20,21 77:5 123:4,10 124:22 128:9 139:1,3,22 140:21 207:16 227:1 298:20 299:18 362:21
mean 11:10 62:2 80:6 82:7 85:2 92:9 101:20 104:7 110:22 117:17 123:16 124:19 126:16 129:15 130:10 132:22 133:14 134:5 138:15 142:5 145:22 146:3 147:7 150:6 151:14 157:3 159:17,22 160:3 161:16 165:2 173:22 175:12 179:18 184:7 197:3,9,15 198:1 198:5 199:4 204:4 208:8 212:14 214:8 218:17 222:19 223:20 224:21 226:17 228:13 229:7 230:15 234:1 238:3,11 239:4 245:7 246:2 252:20 253:8 255:21 257:2,14 258:10 275:1 277:2 295:18 296:18,22 298:21 299:1,2 319:21 338:20 346:5 348:18 349:10 350:6 352:7 353:8 354:22 356:14,21 357:6 359:21 360:8 363:8,10 365:6 375:13 380:17 381:16 382:9 386:22 389:9,12 390:1,13 399:2,14 400:21 401:18 404:5 405:22 406:4,7 411:18 412:2 413:9,19 414:15 421:7 423:17 427:8,10,14,19 429:22
meaner 51:12
meaning 200:6 290:3 299:14
meaningful 215:11 283:22 296:9 307:1 343:9 350:19 409:4,6
means 6:19 16:15 101:18 194:13 213:16,17 222:5 243:18 245:6 250:2 254:5 266:6 286:21 298:18 300:7 388:19 424:16 426:14
meant 122:19 294:21 295:1
measurable 309:13
measure 5:22 6:10 7:15 8:5 14:3 26:17 27:15 28:17 29:5,5,8,10,14,17 29:20 31:14 33:8 33:13 34:14 35:7 35:17 36:18,18,19 37:21 38:14 39:11 39:17,17,21,22 41:22 42:1,2 44:7 47:22 49:20 50:10 50:14 51:9,22 52:5,18 54:4 57:7 57:21 60:21 61:7 61:14 68:9,19 69:2 70:18,19 72:14 73:4,9 74:6 74:12 75:8 79:11 80:17 82:22 83:9 84:18 85:5 88:1,4 92:2 93:13 95:17 100:11 103:9 104:4 107:4 108:12,15 109:14 114:5,11 119:2,7 119:8,9,13 120:15 120:17 122:1,3 142:11 145:3 146:6,7 150:12,13 159:3,5 164:10,19 165:5 166:18 171:4 172:13 173:9 175:16 178:9,10,12,13,15 178:17 182:2,16 184:14 185:5 191:4,16 192:2 193:3,15 194:10 196:19 197:3,8 199:1 200:2,4 201:8 202:22 203:2,4 204:13 215:11 216:13 222:17 226:6,12 232:12,14 239:20 240:7 244:16 245:22 251:3 261:15 262:18 268:1 275:10

279:14 284:4,20
285:3 298:19
301:12 302:15
303:2,16 308:18
309:22 310:21
311:2,5,6,6,11,14
311:16 312:12
313:1 319:1,3,8
319:20 320:13
323:17,20,22
324:22 325:6
326:11 335:10,20
335:21 336:15
338:19 340:4,10
340:11 341:4
342:12,22 343:3
346:14 349:4
350:22 351:8
354:18 355:4,9,15
360:9 361:11
362:10 371:10
372:2,14,15,19,20
373:1,3,8,12,18
374:3,6,19 375:17
375:18,18 376:12
376:12,14,15
379:12,20 380:22
381:6,22 387:19
388:20 390:2,17
390:18 391:5,13
394:4,17 398:14
399:17 400:9
401:10,13 402:15
402:17,22 403:2,2
404:20,21 405:15
406:1 407:7
408:13,14,18
409:2,7 410:17,20
412:7,9,19 413:11
414:1 418:9,17
425:22 426:3,13
427:14 428:6,16
431:10
measured 85:19
91:14 92:7 171:22
188:10 203:15
217:20 261:4,16
320:4 331:15
336:12 403:4
measurement 5:7
5:23 15:12 38:4
40:8,8,8,15 43:17
43:17 44:1,4
88:20 91:10,12
104:2 107:7
113:14,21 121:1
126:6,11 143:15
184:13 185:3
186:8 190:4
191:20 195:10
196:21 200:21
201:1 205:20
227:16 279:18
309:19 324:9
337:1 373:15
375:16 410:21
420:21 423:2,14
429:5 430:13,18
measurements
204:18 205:9
280:22
measures 4:24 5:4
5:18 6:4,12,18,22
6:24 7:8 8:8
13:22,22 21:17
26:14,16,17 27:2
27:5,12 28:18,19
30:1,12 31:12,18
31:19 32:4,20
33:17 34:7,17,21
35:2,13,17,18,21
36:14,21 37:4
38:8,12 39:2,20
40:18 46:17 47:14
47:16 59:15 61:21
62:1,1,18 64:9
66:5,14 67:21
75:9,15 76:3,4
82:3 84:18,20
85:9,12,17,22
86:8,13 88:18
91:1 99:16,17
100:12 101:21
102:15 103:19
104:17 105:4
106:5,18,22 107:1
107:8 108:13,19
114:20 120:19
121:13,15,21
142:8,8 148:15
150:18 151:22
156:7,12,14 157:4
157:9,13 158:11
158:13,16,18
159:14,16,20
160:12,15 164:21
170:10 171:11
173:4,17,21 174:1
174:6,8,10,19
175:6,22 176:17
177:20 178:8
179:4,10 181:7,10
181:12 183:21
184:17 185:17,20
186:1,3 187:2
188:9 190:8,10,18
192:4,12,15 193:9
193:17 195:10,11
195:14,22 196:1,1
196:5,7 197:18
198:3,7,13 199:2
199:8 201:20
203:7 206:4,10
214:2,8,18 215:9
220:12 224:8,15
226:14 227:14
236:15 240:4,5,7
241:3,11,15 244:7
248:5 250:16
251:2,12 259:6,15
260:17,22 262:10
263:10,18,19
264:3 266:19
268:3 269:17
270:3 274:11
292:2 297:12
301:1 302:4,5
303:8,10,13,14,14
303:16 305:5,7,9
305:15,20 306:13
306:15 308:8
310:17,19 311:1,3
312:17 315:3,4
317:1 319:9 320:9
324:3,16,17 325:2
325:7 326:10
327:11 330:7
331:4,6,11 334:10
334:22 341:15,16
342:13 344:14
345:4 348:10
350:6 354:13,14
361:15 362:1
363:17 365:3,3
366:10 368:8
370:1,13,16,16
372:9 373:13
374:4 378:14,19
382:14 385:9,18
386:9 387:3,10,15
387:16,21,22
388:4 391:8,10,20
393:7,15,20
394:11,14 399:3,9
402:13 403:8
408:5 412:22
413:9 414:19,20
420:5 425:2
426:10 428:10,12
428:13 429:16
430:15 431:1
measuring 33:20
47:6 61:4 86:9
95:20 102:21
104:5 108:20
110:18 111:1,14
142:14 145:1
156:10 157:10
161:16 171:21
184:20 188:15
203:20 207:19,20
207:21 211:7
228:15 234:9,10
236:3 281:11
299:16 301:16
379:5 407:12,12
meat 44:6
mechanism 181:21
293:5 339:16
426:12,18 427:17
mechanisms 311:3
426:8
median 241:16
274:13,17,21,21
275:6 297:13
299:4,13 363:12
medians 6:19
298:17
Medicaid 2:17
248:17
medical 1:5 2:11,20
2:22,24 8:5 17:9
17:21 18:19 21:10
21:12,21 47:1
50:1,3 52:22 77:9
78:2 102:8 135:16
235:21 273:20
311:14,15,21
339:3 396:15
Medicare 2:16
78:16 135:3 216:3
234:19 245:9
246:10,11 263:4
281:10
Medicare-partici...
79:4
Medicate 246:13
medication 227:10
medicine 9:11 14:6
14:17 16:7 17:6
18:8 20:14 21:9
21:16,21 22:9
23:1 57:11 89:5
127:13 273:5
278:5 280:8 328:7
MedStar 90:12
meet 28:2 70:4 95:5
95:15 104:13
235:18 268:20
270:1 308:22
309:1 387:8
410:17
meeting 1:7 9:2
16:2 26:7 29:2
71:7,9 107:9

183:14 274:20
366:11 386:22
433:10,12,18
meetings 9:19
251:12
Melissa 2:13 22:21
74:20 123:4
127:19 132:8
192:15 362:20
364:15 366:17
member 14:5,15
15:3,7 16:5,19
17:4,15 18:5,15
19:5,18 20:10,21
21:7 22:2,7,20,21
23:7 24:9 25:5,15
25:19 30:20 42:10
44:10 58:18,21
59:7,12 60:15
62:6 63:16 64:11
67:1,4,6,10 68:11
69:11,22 70:9
71:11 72:17 74:21
77:5,14 78:8 80:7
81:17,21 84:12
85:2 86:20 108:7
110:4,6,8,10,12
110:13,16,17
111:7 113:16
115:2 118:21
123:10 124:22
125:19 126:22
128:9 129:3,19,21
134:8 137:6 138:8
138:14 139:1,3,22
140:3,11,14,15,21
141:2 143:1,8
145:22 150:1
151:14 152:9,11
152:12 153:8
155:7 157:7
158:15 160:18
162:9,12 163:4
165:2 170:2,5
172:5 177:18
179:3 181:18
188:7 189:7,10,12
189:17,18 197:7
198:1,22 199:5,18
200:17 201:3,5,6
204:10 205:13
206:6,8 207:11,16
208:4,12,15,20,22
210:16 212:4
213:21 215:19
216:15 218:1,16
225:16 227:1
228:12 231:1
233:9,12 234:6
237:2 239:2,18
240:9 243:5
244:14 245:7,12
246:9,14 247:5,14
249:5,10 251:19
252:19 254:3
255:2,21 257:2,11
258:10 259:4
260:13 262:7
264:11,14 265:13
268:7 272:14
273:7 274:8
275:12 276:2,18
277:1 278:15
279:1,5,13 282:4
284:6,17 285:8,12
285:14 286:8
288:2 290:1,13
291:10 292:20
294:1,19 297:6
298:20 299:18
301:2,15 302:8
303:5,21 304:11
305:17 306:5
307:15 308:16
309:4 310:15
313:10,19 314:11
316:2,9 317:8
318:3,22 319:17
320:11 321:1
323:1 325:9 326:7
327:22 329:9
330:14 331:2
332:1,12,18
334:19 335:9
336:19 338:9,22
339:11,18,22
340:5,12,19
342:21 344:17
345:8 346:8
347:16 350:4,13
350:22 351:5
352:17 353:1,7
354:2 356:18
358:20 359:5,14
360:12 361:9
362:21 363:22
366:2 370:4 371:2
375:1,3,4,13
377:6,20,22 378:1
378:4,21 380:4,7
380:16 381:11
382:20 383:8
386:11,20 388:1
389:8 390:13,19
391:22 392:9
393:3,9 394:9,20
396:14 398:4
399:7 400:2,10
401:6,9,11,18,21
405:14 407:3,16
407:17 408:11
409:9 410:2,9,19
411:8,13,17
412:18 413:7,15
414:9,17 415:2,12
417:15 421:2
422:21 423:15
424:5,12 425:15
426:11 427:8
428:1,9,18 429:19
431:6 432:13
members 11:14
12:3 44:13 57:4
187:13
membership 21:13
21:18 63:21
mental 231:18
426:20
mention 37:2 105:8
224:6 326:2
332:17 426:11
mentioned 38:21
93:18 97:19
195:14 196:2
301:8 311:8
316:11 325:22
328:4 334:21
386:3 392:2
426:20
mentioning 108:20
message 209:8
messed 217:11
met 1:17
metaphor 136:5
meta-analysis
389:13 390:7
method 149:4
245:10 290:15
methodological
26:12
methodologies
54:17 185:1
202:20
methodology
185:15 205:3
241:18 242:18
248:12 255:13
267:15 321:7
391:17,19 399:22
methods 38:16
149:8 324:13
metric 67:8 135:22
243:11 310:8
334:2 340:6
metrics 21:19
155:3 163:7,11
164:2 207:6
234:11 332:20
339:12 357:2
420:1 425:2
metro 79:20 114:10
400:13,22
metropolitan 78:11
136:11
Mexico 101:13
MI 52:13
Michael 2:16 42:20
260:13
micro 424:21
micro-event 424:21
micro-level 134:5
MICU 73:14
MICU's 73:8
middle 85:20
117:16 215:6
mid-management
227:12
mid-range 383:18
migrate 169:16
Mike 2:21 5:11
15:5 24:22 43:21
80:3 86:19 120:21
126:21 137:5
177:17 185:8
201:17 249:5
252:21 305:16
322:20 327:21
364:19 377:4
386:3 387:17
389:1 399:6
422:20 433:13
mild 149:1
miles 156:17
million 64:13,18
65:5 66:3 67:7
142:4 223:13
431:8
mind 16:13 62:4
129:7 187:4
188:11 220:10
223:11 227:5
298:13 313:11
325:10 326:1
332:11 361:10
393:3 417:21
mindset 125:14
161:5,9 181:2
mindsets 123:14
mind's 281:16
mini 20:18
minimized 160:6
minister 326:13
Minneapolis 17:22
minor 287:9 336:8
minorities 248:18

minus 53:13 65:5
minute 180:13 321:13 331:3
minutes 51:1 75:1 116:21 120:14 122:5 169:21 275:21 291:14,16 295:3,16,18,20 423:11 425:19
mirror 71:19
miserable 422:4
misleading 115:3
mismatch 135:4
misnamed 48:14
misrepresenting 205:9
missed 70:8 117:12 205:16
misses 69:3 70:6
missing 38:19 80:4 147:11 175:10,20 206:17 365:18 383:9
mistake 313:14 314:12
mitigate 92:21
mix 241:7 244:9,15 245:5 248:21 254:14 257:8 258:7,15 367:17
mixed 278:21
mixes 137:9
mobilize 46:20
mode 147:4 410:13
model 15:20 50:21 54:19 95:1,9 99:22 106:1,7 183:4 190:14 195:4 219:4 236:7 254:12 255:3,8,11 256:1 258:4,5 278:13 283:19 292:12 311:22 328:7 361:14 378:6
modern 50:13
modified 176:18
modify 191:6,6 197:20 378:16,18 385:17 386:8 408:4
moment 41:21 48:11 92:5 187:19 332:15 355:20 423:7
money 12:9 49:13 270:20 271:20 277:10 328:11,12 328:16 425:12 430:18
monies 48:15,16
monitor 58:22 59:1
Montgomery 152:18
months 10:13 131:15 140:22 241:2 256:17 288:21 428:20
moral 132:2 345:2
morbidity 63:9 92:22
morning 8:3,7 9:16 10:5,16 15:3 16:19 17:4,15 18:5,15 19:5,18 21:7 23:8 24:9 26:4 30:9 43:8,20 119:17 124:13 186:14 191:5,12 204:15 206:16 278:6,8 304:12 306:10 308:4 322:2 323:11 364:2 372:8 373:9 377:13 406:13 421:13 431:7
morphs 314:6
mortality 63:9 92:21 159:7
mother 30:21,22
motivated 302:16 369:14
motivators 147:19 148:1,13
MOUs 48:8
move 36:19 55:5,8 57:12 64:20 65:6 73:18 75:16 104:8 109:3,5,7 110:10 122:10 131:1 143:17 206:10 219:14 231:13 265:21 267:13 273:2 274:5 284:18 287:21 288:10 314:18 319:8 335:3 345:18 346:14 356:13 370:21 375:7,9
moved 36:7 117:1 212:9 354:22 404:10
movement 367:5
movements 367:7
moving 35:10 41:6 60:20 77:22 93:19 346:22 347:17 353:12
MSA 248:21 257:7
MSCC 24:3
multi 88:11
multiple 38:15 143:6 170:13 301:13 312:4 352:12 388:10 411:2 414:14,18 414:20 422:3
multi-state 415:9
municipal 416:2
must-pass 390:16
must-past 373:2
Mutter 2:14 25:19 25:19 172:5 181:18 199:5 247:5 290:1 347:16 417:15 426:11 427:8
mutual 424:15
mutually-accoun... 145:5

N

nail 62:7 309:5
name 8:13 16:5,20 17:5,16 18:6 20:11 235:15
narrower 212:22
NASEMSO 19:13
Nashville 13:18
nation 31:13 58:5,6 66:11 71:4 394:5
national 1:2,19 2:18 9:9 13:9 15:22 19:9,14 22:3,4 34:2 56:2 58:10 83:8 89:15 154:8 175:15 213:8,18 222:20 289:18 328:4 353:3 354:3 374:8 374:10 376:1 384:6 385:10
nationally 256:18
national-level 352:6
nation's 383:21
natural 430:7
naturally 299:22
nature 12:7 267:9 378:15 427:20
NCQA 311:13,14
nearly 263:6
nebulous 412:1
necessarily 12:4 48:3 159:22 168:1 174:13 208:7 217:16 235:12 250:22 261:1 264:20 265:6 371:20 385:16 415:21
necessary 101:10 101:10 250:9 311:4
necessity 235:21
need 30:2 54:3 55:11 56:8 66:21 67:13,14,15,19 72:3 76:4 78:19 79:10 81:1,13 82:11 88:17 90:21 94:8 97:2 98:2 99:1 100:1,7 105:3 106:17 107:4,6 109:10 113:8 118:10 120:18 121:12 125:10,11,14,19 127:5,7 130:8 131:12 133:20 141:15 142:13 145:14 147:4 150:15 153:2 175:1 178:6 179:11 181:4 185:11 200:2 204:17 205:19 206:2,9 208:2 221:7,11 234:22 236:6 237:7 242:17 260:9 266:8 268:20 274:4,5,5 282:2 287:11 294:4,14 311:5 316:20 318:14 321:4 324:11,18 331:3,5 346:1,13 347:8 355:8 356:22 357:5 360:16 369:4,15 372:19 379:7 380:5 382:13 383:3,5 384:17 390:9 400:10 415:8 422:11 425:5 426:8 430:16 431:1
needed 57:20 89:11 94:3 268:12 269:9 282:21 316:14
needing 77:7 345:11
needle 64:20 65:6
needs 60:14 62:11

70:20 71:20 79:7 82:9 107:3 111:15 131:1 200:3 210:6 261:15 289:14 310:8 355:4 372:14 379:5 383:22 413:16 424:4
negative 230:4 272:2
negative/testing 418:5
neighboring 81:11 344:6
neighbors 359:10
Nelson 92:14
NEMSIS 167:7,10 167:12
nested 203:2,19
net 190:18 256:6
neuro 316:15
neurosurgical 358:3
never 36:19 126:19 184:4 185:9 206:20 312:14 394:11,17,19 398:5,9,11
nevertheless 180:22 203:6
new 16:14 51:15,17 52:4,22 53:1,1 60:9 101:14 117:8 131:16,18 142:2,3 219:2 263:2 266:7 269:11 278:4 284:11 384:9 393:20 397:14 398:17 433:7
newcomer 107:18
newer 174:7
newly 44:16
newly-defined 422:17
news 115:16
nexus 48:20
NHAMCS 212:16 212:17 222:21 241:4 248:1 256:18 334:14 338:2
NHS 179:20 276:3
nice 28:2 176:7 278:7 327:19 429:4
nicely 212:20 219:2
night 117:16 157:18 158:7 278:10 298:1,2 317:13,16
nightclub 157:19
nine 15:11 330:3
nine-step 222:4
noise 227:16
nomenclature 335:5
nominated 11:20
nominations 122:15
non-acute 163:21
non-safety 256:5
nook 210:4
noon 169:18
normal 137:15 369:18,19 384:12
north 144:6
noses 47:18
note 26:22 175:18 175:18 231:19 343:7 382:12 394:1
notes 307:17
Notice 52:15
noticed 187:11
notification 221:5
notion 331:17 332:9
novel 110:3,19 111:5 125:6,10 406:22
NQF 3:10 4:6,15 4:19,24 12:19 17:18 18:12 20:19 27:3,16 28:7 29:6 30:7,7,13 31:18 31:22 32:11 33:1 33:5 39:13 40:9 87:20 91:7 93:13 97:12 108:2,8 120:19 121:16 122:3 153:15 171:13 175:8 186:4 197:17 199:3 222:9 226:3 228:7,8 263:2,11 311:12 324:21 334:10 339:5 361:11 370:21 371:6,10 372:14 378:13 380:15 387:11,20 397:14 397:18 405:7 408:3 422:19 429:22 433:5
NQF's 10:6
NQF-Endorsed 7:8 177:20 215:9 241:3
nuanced 280:7 284:15
number 19:2 21:22 22:16 51:14 60:19 74:7,9 87:5 138:19 155:10 161:17 187:18 195:14 201:19 213:10 215:6 225:7 226:8 241:5 241:10 293:18 310:4 329:21 335:22 336:1 384:18 385:1,1 399:19,21 400:1 400:19 419:11,15
numbers 127:9 151:19 243:10 295:11 359:7,8 364:17 368:20
nurse 221:11,12 290:1 352:8 356:2
nurses 18:22 19:11 73:18 134:22 135:14 210:20 223:20 288:5,17 289:2,5 317:17
nurse-run 282:10
nursing 18:17 19:12 288:4,16
N.W 1:20

O

objective 290:11 378:13
objectives 95:16,18
objectivity 107:1
obs 131:21 272:12 275:22 276:19 277:3 278:1,2,5,5 278:9,13,13,16,17 285:7,15,17,18
observation 142:20 215:21 216:7,10 216:11 233:3 236:20 272:20,22 277:5,15 280:1 281:2 329:17 346:20 349:9,11 349:16
observations 354:12
observe 273:14 285:13,19
observed 281:22
obtained 291:14
obvious 291:11 299:2 428:2
obviously 16:1 21:16 32:1 40:12 55:11 75:6 90:2 123:1 141:10 231:11 336:2 397:13 399:14
occasions 230:3
occupancy 192:4
occur 162:22 231:7 346:17 400:16
occurred 52:15
occurring 367:9
OCTOBER 1:13
odd 119:18
offer 102:18 357:11 384:21 416:19
office 2:7 16:22 18:10 20:3 24:11 175:15 269:11
official 89:7 423:20
officials 2:18 19:9 416:1,9
offload 55:2 59:3 72:3,4,6 81:13 218:8 319:21 320:2,12 333:1 338:16 345:13
offloaded 57:5
offloading 359:9 406:16
offload/onload 70:4
oftentimes 40:7 95:20 208:7
of-life 394:1
oh 67:4 131:11 162:6 177:6 183:11 188:3 189:8 233:10 243:3 247:12 249:10 294:17 296:20 320:21 372:6 380:10 404:4 406:9 409:9 413:6
OIG 235:16
okay 8:22 10:4 24:19 25:4,6 26:6 43:1,3 74:19 80:1 80:4 86:18,20 143:6 144:20 145:2,3,3 147:3 148:9 161:7 163:16 173:3,11 177:9,18 179:1,21 181:16 183:11 184:1 187:7 188:17 189:11,19 201:5 210:14

214:13 220:9 222:10,13 226:22 228:9 233:6 238:5 240:17 252:10 253:6 255:17 257:11 261:17 263:8 273:13 276:18 279:5 293:21 294:17 296:17 297:11,11 300:5 307:12 308:14 325:9 332:15 352:16 354:8 356:17 357:13 362:13,16 367:18 376:6 381:10 392:7 393:2 395:14 401:3 407:1,1 408:10 411:13 418:19 419:3 425:16 432:5
old 223:16 314:21 352:8
older 17:12 240:6
ology 274:4
Olympic 119:15
onboard 64:6 86:17
once 129:13 132:6 228:17 315:13 363:16 432:8
ones 31:8 36:15,16 97:7 98:5 102:8 109:6 115:9 127:16 205:17 333:20 403:4 423:10 424:18
one's 131:17
one-by-one 196:15
one-hour 288:12
one-size-fits-all 240:15
ongoing 22:18 201:1
online 91:4
onload 59:4
onsite 55:3
onus 179:16
onward 425:14
open 222:12 284:19 332:11
opened 42:22
opening 196:13
operate 172:1
operated 140:13,17
operating 137:2 384:12
operational 53:9 68:7 126:10 129:13 149:12 157:22 158:13,17 159:14 243:17 260:22 292:22 296:4
operationalize 94:12 99:9
operationalized 97:11
operationally 54:19 126:4 129:8 154:18 162:1
operationally-ten... 52:4 53:20 58:3 74:12
operations 46:19 56:11 76:19,20 77:2 125:5,12 129:6 131:12 154:12 162:13,18 174:20 314:3 349:20 363:4 366:19
operator 42:18 43:1 187:16 235:14 428:2 432:8
opinion 64:2 193:2 382:7
opinions 123:5 253:19
opportunities 178:10,12,15,21 323:19 324:5 424:19
opportunity 5:15 7:22 19:1,7 33:19 67:18 103:8,9 111:12 173:16 176:7 232:18 286:14 290:17 313:12 321:10 335:3 376:4 420:8
opposed 148:10 152:5 156:11 171:5 193:11 203:21 221:16 227:17 245:20 250:11 254:22 308:7 329:5 332:7 378:10
opposite 262:20 357:3
ops 116:6
opt 329:15
optimal 231:4,16
optimize 334:3
order 4:4 121:12 152:21 187:17 197:17 202:6,13 203:12 210:13 221:9,17,17,19 222:1 225:21 242:16 251:6 285:18 287:10,17 288:10 316:14 317:10,11,21 354:15 356:9 372:15 378:8 408:5 410:5
ordered 212:13 213:20 214:7 220:22
ordering 209:2,3 213:13,13 221:16
orders 355:22 356:1,5,6
ordinary 136:10
organization 21:13 81:7 226:4 365:10 428:19
organizational 397:4
organizations 28:11 49:6 140:13 140:17 328:14,15 328:20
organized 158:9 220:11
orientation 330:4
oriented 63:6,8
original 209:12
orthopedist 362:7
ought 157:4 317:2 327:11 395:13
ounce 202:9
outage 149:2 152:18
outbreak 101:8,11 112:2 127:6,6
outbreaks 101:1
outcome 36:19 37:21 38:12 56:6 63:7 64:21 94:19 130:19 145:6 151:6 152:6 155:22 159:7 171:3 181:9,10 211:22 231:4 240:10 257:3 303:14 308:18 310:19 373:16 374:21 381:20,21 387:5
outcomes 36:8,9,16 53:7 61:9 63:13 88:2 93:10,13 95:18 108:19,21 136:5 143:15 144:4,14 145:1 151:21 152:5 155:12,14 156:10 156:19,21 157:10 158:2 167:1,13 187:1 231:8,15 239:6,12 250:6 262:18 279:20 281:1 302:1 303:11,19 304:16 306:1 313:1 342:9 347:5 378:7 383:15 385:14 386:2 422:2
outcome-based-t... 171:3
outcome-oriented 63:6
outdated 293:3
outflow 6:24 315:4
outpatient 56:5 72:2,7 81:10
output 195:22 226:17
output-related 218:21
outside 90:6 121:7 143:20 183:2 409:6 419:14
outsider 233:13
outskirts 144:9
outweigh 382:9
overadjust 244:19
overall 176:11 193:8 203:2 254:16 277:20 285:3 306:17 343:2
overcrowded 169:1
overcrowding 165:14 168:20 308:7
overdose 286:2
overflowing 344:6
overlap 126:2 135:8 142:5 161:11 162:10 422:5
overloading 351:17
overnight 277:9
oversaw 30:18
overuse 293:14 294:13
overview 4:22 43:22
overwhelmed

359:10
owned 209:15
owns 165:20 166:4 166:5,7,9 211:13
o'clock 211:10 317:12,13,16

P

package 325:3
PACU 210:1,11
page 43:15 44:3 120:8 147:2 183:5 183:10 196:16
paid 277:13
pain 41:4 131:19 224:18 230:9 269:4 276:16 291:13 293:17,17 361:12
paired 366:12
pale 326:22
palliative 393:19
pandemic 45:18
panel 1:7,17 26:20 87:7 391:16
panels 13:21 32:10 391:19
Papa 2:15 18:15,16 71:11 210:16 245:12 246:9,14 288:2 290:13 303:21 314:11 317:8 344:17 350:4 359:14 428:9
paper 4:22 15:15 71:6 75:12,18 91:2 96:3 123:6 182:12 199:19 201:3 219:3 223:16,16,20 241:1 256:2,17 257:1 258:15 270:7 368:13 430:3
papers 226:7
paperwork 55:20 55:21
paradigm 50:1,7 51:9 169:14 178:5
parallel 19:11 203:17 221:15
parallels 130:10 397:12
pardon 52:17 67:14 83:17
Park 119:15
part 9:19 14:1,10 17:22 37:17 41:3 44:13 52:3 56:1 63:19 78:21,21 90:7,12 98:19 101:14 103:1 105:9,22 107:9 134:16 135:19 162:12 175:11 198:12 199:11 202:17 209:14 217:19,20 224:11 227:20 252:8 261:12 269:12 270:22 271:22 281:8 294:12 311:20 318:9 319:12 340:13 352:22 367:13 374:12 375:19 379:4 388:1 402:7 405:11 421:16,18 423:14
participants 103:15 112:14
participate 19:7 130:4 359:12
participating 42:14 135:2 301:4
participation 86:5
particular 26:13 34:22 36:15 37:10 41:11 61:7 92:1 103:2,22 104:6 114:2,22 115:1 142:16 150:19 158:8 179:4 202:22 216:3 218:3 249:21 283:12 317:6 367:19 405:15 412:19
particularly 17:11 36:9 93:3,15 104:18 156:9 243:20 267:3 305:8,22 394:12 399:17 405:2
parties 166:3 201:19
partner 72:14
partners 49:13,15 49:17 59:16 66:16 72:1,2,13 89:20
partnership 16:7 201:21 263:18
parts 90:11 101:13 104:11 134:10 135:7 413:1
part-time 16:8 20:2
pass 27:3 33:9,9
passed 100:22 204:22
paste 414:8
path 27:14 109:18 109:19 110:22 172:12 221:15
pathway 7:8 31:11 202:4 269:4
pathways 219:17
patient 56:4 73:15 73:16,16 79:7 82:14 88:21 109:18 123:16 124:10 146:11 156:17,19 158:4 163:9 165:20 169:2,7,9 171:13 171:19 175:17 176:4 193:4,21,22 201:15 211:11,20 214:1,22 216:18 216:21 218:10 221:7,22 223:7 225:9 230:15 234:17,19 237:10 237:18 239:15 245:3 246:1,15 247:18 250:7 252:12 254:7 255:4 259:9 264:19 271:7,9,14 272:7 275:17 276:1 278:1,17 282:9,18 288:10 288:13 291:12,15 291:18 292:8,17 295:12 303:11 314:13 316:15,16 317:12,22 327:2,9 327:15 342:9 343:11,14 344:21 347:1,11,20,21 350:20 357:22 358:7,9 359:19 362:3,5 383:15 398:8 403:5 409:5
patients 32:13 38:2 38:5 51:14,16,18 52:10,20 53:6 54:11 55:2,10 56:15 57:8 63:12 64:6 72:3,20,22 73:1,20 81:14 83:11,19 84:2 88:3 109:6 110:11 116:18,22 118:8 123:19 128:6,22 130:22 131:19 134:4 139:8,9 148:9 151:19 156:2,3,4 158:3 161:8 163:14,21 164:4 173:22 174:22 175:4 176:10 177:22 178:11 180:2 192:10 196:2 203:3 206:21 209:6 210:5,11 214:21 216:3,5 218:8 232:5,6 233:2 234:1 235:18 246:5,8,9 246:13 249:2,20 249:21 256:10 260:6 264:22 268:12,17,19 269:2,8 270:12,16 270:22 271:3 275:15 276:7 278:5 279:11,20 283:7 285:16 287:7,9 293:17 296:22 298:6 311:20 315:16 317:16 320:3 321:6,9 334:4 337:5 338:16 339:3 343:17 344:11 345:16 350:17 352:10 353:10 357:19 358:21,22 359:9 360:22 361:13 382:8 393:22 395:9,11 396:5 403:3 415:20 419:6
patient's 109:9 171:12 193:11 228:17 229:9 242:5
patient-centered 210:7
patient-measure... 373:17
patterns 105:21 295:8 396:17 415:22
Paul 103:2
pause 187:19,21 432:10
pay 55:22 263:14
payer 236:8,13 279:6
payment 262:12 276:9,10

payments 219:14
peak 128:2
pecking 210:12
pediatric 18:7 341:20 342:5
pediatrician 341:7
peer 106:1 383:13
peered 124:18
peer-reviewed 380:5 384:4
Peggy 44:14 368:15 384:7 406:10
penalize 238:7 286:11,16
penalty 154:5
pendulum 70:15 220:3
Penn 18:18 246:3 254:21,22
PennSTAR 360:5
Pennsylvania 2:5 2:15 18:18 20:2
people 11:20 12:4 16:16 24:20 32:14 35:3 38:17 43:9 47:18 48:1,1 60:16 72:10 80:8 85:21 86:7 87:4,6 87:6 90:16 94:1 94:13 96:5 100:21 107:19 110:1,22 113:1,2 117:13,18 119:18 120:4,16 122:17 127:7 130:7,11,14,15 131:12 132:6 133:4,6 135:1,11 136:15,16 138:15 138:16 141:9,21 142:4,4 149:14,19 158:6 162:14 176:21 179:21 192:7 202:11 203:6 206:13 213:8 217:14 223:19 226:8 229:14,17 234:11 243:10,18 251:14 254:1 268:18 272:5,21 273:2,12 281:17 283:6 284:13 303:17 304:2,4,6 307:22 314:21 321:16 337:19 341:8 351:6,14 353:12 356:20 357:4 361:17 369:2,10 369:13 371:5 380:8,9 396:9 399:10 404:9 406:14,17 408:20 409:13 417:3 418:20 419:1 421:15,18 429:13 430:20 431:4
people's 428:13
percent 45:14 50:4 50:5 51:10 61:7 66:10,20 68:3 69:16,17 70:13,20 70:22 71:17 72:5 73:21 74:2,7 80:13 93:1 104:3 109:3,6 110:11 113:18,19 129:11 129:11,11,12 132:17,18 205:22 213:15,16 217:9 217:10 246:20 247:2 248:17,17 263:4 268:12,14 268:16,17,19 269:20 283:20 284:10 333:22 336:9,10 375:10 376:8,13 382:22 383:20,20 384:11 384:13 400:3,17 401:1 404:3 405:17 419:7,10 419:13,15
percentage 50:4
percentile 274:14 275:7 297:14 298:5,7 299:9
perception 312:6
perfect 139:4
perfectly 11:9,14 397:20
perform 128:8 203:9 266:1 299:17 395:10 397:10
performance 4:24 7:8 18:3 20:17 21:4,15 30:12 32:4 35:5 46:16 47:22 50:10 51:9 51:22 52:4 54:4 57:7,21 61:21 62:1,18 66:5 68:19 70:2 82:3 85:8 86:9 99:15 99:17 100:12 102:15 119:13 122:21,22 128:2 154:10 155:3,5 157:3,4 158:13,18 159:16 160:1,9 239:21 248:4,16 263:14 274:16 300:21 301:14 336:13 348:13 366:10 374:15,17 376:5,16 379:1,3 379:8,11,18,22 380:21 385:12,18 385:19 391:14 395:3,7,22 396:6 409:19,20 426:10
performed 395:10 395:16,18
performing 159:20 215:16
period 238:19 286:16
periods 231:12
perseveration 234:7
person 125:3 130:5 130:18,20 179:11 253:6,8 291:8 318:13
personal 157:17 245:1
personally 229:22
personnel 124:5 135:15 136:19 139:6 360:22
perspective 30:3 73:9 156:1,19 184:13,21,22 185:2 192:3 193:4 193:11,12 195:10 214:1 228:17 242:6 260:20 267:4 288:4 290:2 295:8,10 296:5 336:14
pertinent 20:9
Peter 316:10
pharma 231:18
phase 20:20 219:21 320:14 387:2
phenomena 101:15
phenomenon 219:1
PHEP 87:18 89:6 106:14 386:15
PHEs 83:18
Philadelphia 144:2 144:3,6 360:3
Phillips 2:15 24:9 24:10 30:20 85:2
phone 24:20,22 25:2 201:17 264:12
phrased 232:2
phrasing 331:7
physician 17:8 18:2 18:7 19:22 21:1,9 23:10 28:5 42:11 179:17 209:2 210:20 212:8 246:22 280:14 300:14 342:5
physicians 2:19 21:5 135:1,14 179:8 268:15 271:11 273:11,16 274:1 284:9 292:6 294:10 326:21
physician's 225:20
pick 12:21 50:4 113:19 163:10 186:20 357:18 358:1
picking 284:11
picture 75:2 111:4 207:3 218:11 324:20 366:15
piece 32:2 55:20 64:5,5,9 146:20 148:17 153:17 163:6 166:4,5,11 167:4 175:9 202:16 206:19 207:2 210:18,22 218:6 219:8 289:2 321:5 337:2,16 354:15 362:1 364:9 395:3 416:12,15 421:4
pieces 16:12 64:5 146:12 175:20 220:5,6 240:8 397:5
piggyback 152:13 350:9
pile 119:14 132:6 431:11
pileup 83:10
pillar 55:1 57:6 64:8 318:7,10
pillars 54:2 57:20 58:17 59:5 70:5
pin 251:9
Pines 3:17 4:20 5:6 5:19 8:16 27:22 28:4 42:5 43:5 119:22 132:7 164:7 184:3 190:1 197:14 198:11 214:14 224:5 227:19 240:19

243:22 247:20 253:12 254:11 255:6 256:16 257:6,19 258:12 260:1 266:13 275:4 283:10 287:3 290:21 291:22 299:12 300:8 301:5,17 302:19 305:4 307:9 321:12 322:15 325:18 331:9 340:9 352:21 353:2 367:22 370:10 378:11 385:5 387:13 391:3 399:16 400:7 403:18 404:17 406:3 407:19 422:7 425:17 428:15 431:13 433:8
pinned 56:21,22
pinning 56:20
Pioneer 219:15
pitch 431:8
Pitts 1:21 2:3 4:8 8:12,21 9:1 13:1,1 58:15,19 68:10 71:10 74:19 78:7 80:1 81:19 84:10 84:22 86:18 107:12 113:15 119:14 122:5,13 124:14 126:15 127:19 129:17 131:14 137:5 138:6,12,18 139:2 139:20 142:19 143:4 145:18 147:11 149:22 151:11 153:7 155:6 157:1 158:14 160:17 161:13 163:1 164:6 165:1 169:15 170:4 172:4 173:10 177:4,9,12 178:22 181:16 184:1 187:6,10 188:5,17 189:20 199:14 200:16 204:9 205:12 206:3,7,12 208:21 210:14 212:1,15 214:11 215:17 216:14 217:21 220:9 222:7,13,19 226:22 228:4 231:17 233:6,10 233:21 237:1 239:1,15 240:17 243:1 244:10 245:4,11 246:7,12 247:4,12 249:9 251:18 252:18 255:17 258:18 260:11 263:1,8 264:13 265:11 267:17 272:8 273:4 274:7 275:11 277:22 278:20 279:3,9 284:16 285:6 286:6,18 288:1 289:7 290:9 292:19 293:21 294:17 296:17 297:10 298:22 300:2 302:6 303:4 303:20 305:16 306:4 307:12 308:14 309:3 310:14 313:7,16 314:20 315:22 316:8 317:4 318:2 318:21 319:16 320:10,21 322:8 322:19 325:12 326:5 327:20 329:7 330:12 332:16 334:8 335:6 336:18 338:1 339:4,8 340:17 342:20 344:15 345:6 346:6 347:15 350:3,12 351:3 352:5 353:6,22 354:7 356:17 358:11 359:1,13 360:11 361:7 362:12 363:21 366:1,17 367:18 368:14 370:3 377:4 378:3 379:21 382:15 383:7 384:7 386:19 392:7 394:7 395:1 396:13 398:3 399:6 401:2 406:9 407:1 408:8 410:8 413:5 415:11 417:14 421:1 422:6,20 424:11 425:13,16 427:3 427:22 428:8 431:5
pivotal 146:11
place 29:17 36:11 41:21 47:17 56:18 63:10 86:14 89:19 94:7 97:13 98:2 139:13 145:16,17 146:17 149:18 175:2 181:13 204:3 210:12 270:14 281:18 285:2 288:21 295:21 297:22 299:7 301:7,9 305:10 308:9 333:5 350:8 352:19 392:1 430:12
placement 253:11
places 59:22 68:4,6 77:17 209:22 215:2 246:18 277:18 282:8 331:18 352:10 359:7,8 360:7 361:1 372:13,18 382:17 422:2
plan 29:16 56:4 63:2 116:5 144:18 144:19 147:2 154:14,15 308:5 308:20 309:1 346:1 352:19 359:7 360:21
plane 126:1 131:18 131:20 149:15 353:16
planning 45:8 47:5 56:20 73:10 190:16 227:20 307:20
planning-based 45:7
plans 45:9 47:17 48:8 56:17 369:9
plasticity 131:17
plausible 36:12
play 90:3 210:13 281:4 360:1 367:10 392:3,15 430:9
players 29:22 68:22 71:15
plays 233:5
please 10:20 31:21 55:5 154:16 189:16 288:5 322:2 432:9 433:2
pleased 31:5
plenty 381:7 414:6
plot 141:6 142:11
plus 53:13 65:5 274:22 288:16 358:18
pneumonia 39:10 168:20 169:3
PO 54:9,14
poetic 180:12
point 38:1 58:16 84:13,21 88:19,19 89:2 92:4,10 93:21 94:10 96:1 101:11 124:4,7 134:8 149:12,20 160:4 162:16 168:18 169:6 171:8,10,14 172:3 174:5 176:4 178:7 186:8 193:12 204:1 209:13 220:4 225:17 232:10 237:20 256:2,13 259:4 268:11 272:15 298:15 300:6 301:10 318:9 332:14 344:20 347:17 359:14 384:19 386:22 410:11 417:18 425:2 428:21
pointed 219:2
points 38:22 41:4 74:22 75:4 84:14 91:19 150:11 177:19 220:3 249:6,12,15 250:20 340:20 341:8 347:16 364:22
pointy-headed 297:18 298:16
point-in 192:14
police 118:9
policeman 9:13 199:15
policy 16:11,22 20:1 22:22 162:17 343:2 409:4
political 134:22 135:20
Politically 275:1
politics 275:8
poll 254:1 265:14 433:5

poor 422:2
pop 114:21
popped 350:5
pops 224:18
popular 16:15
population 40:11 66:17 70:7,13,22 79:8 124:8 145:2 145:4 151:22 156:8 163:9 206:11 233:2 236:3,4,7 240:13 264:21 330:4 347:4 367:11 414:1
populations 137:3 304:15 341:5,10
population-based 168:13 169:6 179:6
population-level 413:22
porcelain 288:13
portal 282:3
portfolio 24:15 36:22 106:18
portion 13:7
posed 70:11
position 332:2 390:22
positive 329:21 417:22
possibility 427:2
possible 34:15 36:16 39:19 104:5 127:1 128:1 143:2 178:17 239:12 258:21 259:1 323:22 334:14 343:19 344:5 417:2 423:18
possibly 131:7 163:17
post 182:12
potential 54:10 106:7 166:14 184:14 198:6 244:13 271:5 302:4 319:20 329:20 382:9 391:6 399:8 409:17 428:2
potentially 73:15 73:16 80:17 85:10 121:4,13 161:19 167:1 169:1 175:2 176:14 184:15 185:14,22 186:4 192:9 193:6,16,18 196:7 214:16 216:8 228:1 234:17 236:16 241:19 242:20 252:4 283:22 300:22 301:12 303:2 304:13 320:4 330:10 333:2 347:10 348:3,7 349:18,21 378:20 382:11 385:20 391:21 402:17 405:6 412:11 428:16
pounding 309:5
pouring 212:16
power 149:1 152:17,22 153:1
powerful 304:14
practical 120:16 165:18 395:5
practicality 91:16
practically 29:7
practice 97:10 155:17 157:16 235:2 280:16 303:1
practices 85:18 300:17 397:19 398:21 399:3
practicing 21:1 209:2
pre 18:8 136:18
preceded 31:8
precise 33:3 34:14 198:18 227:2 422:18
preciseness 411:12
precision 412:3,6 422:15
predates 384:19
predict 101:9 330:10
predictable 114:4 134:14
predictably 135:12
prediction 288:18
predictive 244:6 248:7,16 249:17
predictors 258:6
prefer 38:9 114:5 289:4
preference 36:8
preferred 387:5
preliminary 183:14 183:15 249:15
prepare 126:19 231:9
prepared 47:10 65:18 71:8 84:19 184:15 189:22 328:10
preparedness 2:8 5:4 15:10,22 16:4 17:1 22:14 23:17 24:15 25:17 26:19 27:10 28:19,22 29:6 30:3,19 31:15 43:16 44:1 44:4 45:1,2,20 46:4 47:7,13 48:4 48:6,13,15 51:6 51:21 57:22 60:21 60:22 61:16 67:16 67:17,19 70:14 71:3 75:20,22 76:1 80:16 83:4 87:3,18 91:9 92:9 92:11 94:1,5 95:6 96:6 97:20 98:6 98:10 102:7 105:9 116:5 120:19 121:6,21 130:2 131:4,6 132:12 142:11 146:14,18 147:10 148:16 157:3,13,14 158:17 159:16 160:1,9 164:13 165:15 167:21 170:19 178:3 181:11 184:12,21 185:2,5,18,21 186:14,15 190:6 191:13 197:1 260:18 261:8,12 265:5,9 294:22 305:21 306:3 312:3,7 313:2,5 314:8 323:2 328:5 328:8 333:7 336:14,17 349:21 360:15 364:19 365:1,19 370:16 372:16 373:11,12 374:4,9,20 375:21 378:15 379:4 385:9 386:1 387:22 391:8 393:8,12 394:13 394:18 399:8 402:13 405:2,2,3 405:8 409:1,8,10 412:21 414:22 415:3 416:7,10 428:5
prepares 309:15
preparing 15:21
Presbyterian 18:19
presence 301:18
present 2:2 21:17 44:21 141:3 213:14 291:15 411:1
presentation 80:4 108:4 115:22 120:21 322:22 357:17 358:9 371:1,3 414:3
presentations 43:20 108:10 433:13
presented 372:8
presenting 52:16 83:11
present-day 114:9
President 4:23 13:15 17:21 18:21 19:10 21:10 30:12 82:11
Presidential 45:4,5
presiding 1:22
press 47:8 187:17 432:9
pressure 219:12 271:11
presuming 339:1
pretend 145:8
pretty 13:10 39:12 119:19 125:19 135:21 162:2 217:1 222:22 234:16 235:5 272:4 296:3 299:1 302:20 303:15 330:2 354:4 368:1 400:18 409:22
prevent 92:17 161:3 162:14 194:11
prevention 93:1 182:1 413:20
Preventive 386:16
preview 114:6
previous 13:20 20:20 21:20 22:15 24:13 150:16 241:3 320:14 335:11
previously 47:16 50:6 65:2 193:10 235:4 236:21 345:10
pre-hospital 17:11 135:14 167:9
pre/post 302:17

primarily 22:17 365:8 401:16
primary 48:18 60:2 81:12 173:12 207:19,20 276:6 280:14 281:6
primer 429:21
Principal 42:12
principle 258:20
principles 55:14 181:1
prior 231:7 275:17
priori 197:11
prioritization 8:5,8
prioritize 77:12
prioritized 77:8
prioritizing 130:22
priority 76:14,18 136:21
prism 68:8
private 59:10
probability 417:6
probably 33:11 41:7 46:12 84:14 114:13,15 115:3 134:9,14,18 135:19 155:13 156:21 167:2,10 179:8 183:20 192:9 198:17 200:1,12 202:12 204:17 213:17 219:6 227:8 234:9 234:12,15 238:4,5 245:21 246:19,20 272:10 280:2,19 281:12 312:19 313:14 316:22 330:2 336:13 361:16 371:9,21 372:5 373:20 379:13 382:13 393:6 401:7 403:10 413:15 415:19 416:6 417:18 428:18
problem 94:20 97:4 98:19 111:8 115:8 135:4 181:13 203:5 210:16 219:22 236:15,17 237:22 295:2 296:19 297:1 310:13 322:9 335:16 347:8 350:19 356:13 424:14,15
problems 106:13 113:22,22 114:1 130:1,16 137:1 219:5 234:2 251:17 280:12 358:13
problem-solving 355:5 356:16
procedure 344:8
procedures 140:6
proceed 80:2 86:19
proceeding 425:14
process 9:21 30:7 36:13,14 61:6 63:5,10 64:21 94:18 120:19 121:16 156:12,14 159:20 181:9,12 197:10 198:8,12 198:14 199:11 200:22 201:7 203:16,16 204:6 216:19 222:4 255:22 303:14,15 310:19,21 311:6 311:12 312:15,21 317:1,20 318:17 352:11 371:4,7,17 372:17,21 373:1 381:22 387:2,10 390:9,11 396:17 398:17,18,20 426:6
processes 36:10 72:13 139:13 141:16 142:17 152:6 155:15 156:11,20 160:4 217:11 239:6,14 239:20 245:1 270:19 313:6
produce 154:17
professed 124:16
professional 107:2
Professor 14:6 17:6
proficiency 100:22
profound 135:4,4
program 19:8 48:14,15 51:7,21 57:22 64:14 70:14 71:3 85:9 98:6 103:5 106:3 201:2 219:13 263:20
programs 89:6
progress 39:7 120:10
project 4:5,16,18 8:14,16,17 20:20 22:12 26:10 27:17 28:7 31:7 35:1 41:8 45:22 60:7 60:11 75:3,6 181:22 182:15 198:20 202:19 320:14
projects 16:14
proliferation 367:8
prolonged 349:16
promote 79:11 370:19
promoted 146:4
properly 297:4,8
proportion 177:21 254:15 337:4
proportions 248:3
proposed 4:22 308:17 374:19
proposing 206:4 253:4
pros 228:5 268:4,8
prospect 242:10
protect 92:17 266:8
protocol 301:7,9 304:3 324:9
protocols 305:10
protocols/policies 333:5
provide 27:4 28:16 29:9 57:17 277:14 307:1 372:11 379:14
provided 136:2 285:4
provider 40:10 78:17 109:10 176:20 193:6,21 207:9 210:20 211:3 221:20 264:5 280:15 281:6 288:6
providers 32:7 33:22 55:9 79:12 79:19 134:19 139:21 140:1 174:14 259:18,21 292:7,13 377:1 425:3
provider-level 412:15
provides 48:15 383:10,16
providing 55:13 108:11 167:17 245:19
provision 164:2
proxies 201:14
proxy 208:14,15
psych 231:22 232:5 232:6 234:2 338:3 338:5 339:2 358:14
psychiatric 233:1
psychological 92:22
public 5:15 7:22 15:7 24:14 46:5,6 48:19 78:15 82:10 82:17,20 83:2,15 87:17,21 89:2,3,7 89:20 91:8 92:15 92:20 97:20,22 100:17 101:6 102:3,9 103:11 105:12 118:22 121:5,10,10 127:4 135:15 166:4 187:11,13 215:9 253:15 262:11 263:14 392:18 409:9 432:7,14
published 256:16
pull 41:14 147:2 232:20 406:19
pulled 235:9
pulling 56:19
punch 337:13
punish 262:16,19
purpose 27:8 91:12 111:13,14 215:8 305:12 310:2
purposely 335:4
purposes 104:16 105:3 202:21 373:6 420:19,21 423:19
push 84:1 351:22
pushback 177:1 216:1
pushes 67:8
pushing 111:4
put 41:9 47:14 49:13 50:9,14 53:21 63:10 97:8 102:6 108:1 117:7 149:19 169:22 195:6 210:5 221:9 221:22 226:18 227:13 238:13 249:20 255:4 272:5 295:21 310:9 314:13 316:14 319:7 325:3 367:16 382:3 391:11 398:10 430:3,13 430:20 433:11
puts 86:1,12 319:3
putting 197:9

230:18 234:10 286:19 296:14 331:10
puzzle 175:9 207:2
P-R-O-C-E-E-D-... 8:1
p.m 188:21 189:2 322:6,7 433:17
P9-to-the-P50 298:9
P90 299:8

Q

QA 215:7,11
QI 91:13
qualified 346:19
qualitative 22:18 104:17,20 105:5 106:22 185:11,12 278:12 311:19 312:16
quality 1:2,19 5:22 6:10,22 14:12 18:3 21:4 23:5 25:20 27:12 28:10 32:5 33:14 34:2 41:9 62:1 85:12 85:13,17,22 86:8 92:1 105:2 106:19 108:13 132:15 133:13,16 134:4 150:21 151:1 153:19,20 171:17 181:20 182:1,6,13 182:18 196:18 199:8 200:21 201:1,7 227:17 230:7,13 231:13 238:10 240:13 268:1 269:16 270:2 300:21,22 301:12 302:4,15 302:15 315:7 342:7 344:14 374:8 376:1 399:1 413:20 420:5,7,20 426:15 427:11
quality-of-care 420:1
quantify 202:14
quantitative 104:17 105:4 106:21 185:13 354:4
quantitatively 164:22
quantitize 309:10
quantity 33:14
quarter 270:1
question 42:16 59:13 65:11 66:22 67:1 68:12,19 69:12 93:8 97:14 117:3 120:22 122:21 149:12 170:3,5 172:6,18 178:8 187:17 192:22 196:22 197:7 200:17 215:10,20 218:17 220:8 228:5 237:3 240:10 241:12 253:13,17 259:1 275:13 277:2,6 279:2 307:5 308:15 315:8 332:19 370:5 374:16 375:2 376:10 378:22 379:13 381:4,20 389:9 399:17 401:22 402:9 407:5,6 410:20 413:8 422:14 430:8,19 432:9
questions 4:22 5:10 5:12,20,24 6:7,9 6:14,17,20,23,26 7:12 26:2 42:7 44:19 58:14 63:17 75:5 124:15 167:11 186:17,21 188:1 194:21 198:21 201:21 251:14 375:11 402:1 415:15 432:11
quick 38:22 164:8 170:3 228:5 239:18 260:1 291:11 321:20 354:2,11 388:2 422:7 426:1
quickest 336:12
quickly 26:9,10 39:15 42:9 188:7 230:16 273:3 329:10
quite 41:22 75:13 76:8 89:13,21 111:10 115:9 123:12,15 148:2 155:20 187:8 223:19 266:7 286:4 290:16,18 328:1,20 344:4 348:8 349:22 393:11 397:22
quote 249:17
quotes 172:8
Q&A 187:20

R

radiation 139:19
radically-different 223:1
radiology 210:3
raise 251:14 336:2 414:17
raised 240:11 346:9 348:4 381:5 398:22 413:8
RAND 111:21
range 32:14 263:12 263:15 392:4
ranking 296:21
rapid 56:17 280:20
rapidly 55:2 57:5 59:3,4 134:17 281:20
Rapp 2:16 24:22 42:20 189:9,10,12 189:18 249:5,5,10
rare 87:22 93:12 374:21
rarely 128:11 246:5
ratcheted 86:14
rate 53:10 245:15 245:21
rates 245:9 290:10 366:12,13
ratio 298:9
rationale 383:10
raw 265:16
RCT 394:15
reach 95:5
read 75:12 92:18 225:21 283:12 302:12 352:18 409:15
readmission 244:21 277:12
readmissions 219:13
ready 94:1 199:3 430:10
real 29:20 80:17 111:8 114:5,6 115:4 149:10 173:15 176:6 227:17 259:13 266:11 289:7 295:3 309:21 354:2 396:7 423:3
reality 41:12
realized 180:6
really 9:20 19:16 23:19 28:15,15,16 29:2,3,4,9,11 31:5 31:10,13 32:7,11 32:14 33:13 34:4 34:8,20 35:16 36:7,11,17,20 37:11 38:8 39:18 39:20 40:14 41:22 43:19 44:1,2 47:21 49:22 59:2 61:5 64:12 65:5 69:2 71:20 72:4 78:8 84:14 86:17 86:22 87:3 89:1,4 91:5 93:6 95:1 96:7,19,20 97:18 98:8 99:20 100:19 101:9,10,16,22 102:16 109:18,19 112:13 113:13 114:16 115:10 116:15 117:7 118:15 119:9 120:5,6,8,14 121:3,6,9,11 123:12,17 128:11 132:20 133:16,21 134:2 136:19 137:21 138:2 141:14 142:20 155:8 161:18 164:9,14,22 165:8 166:9 167:5 168:17 169:13 171:1,15,18 177:20 178:4,6 179:11 180:7 183:4 184:8,20,22 185:8,9,10,17 186:7,12 190:6,21 191:3 192:14,16 193:3,3,10,14 194:11,12,15 195:7 196:13 201:6 202:4 204:5 204:14,21 205:15 207:10,18,20 209:12,15 210:6 211:18 215:5,8,12 216:4,5,12 217:11 218:5,11 222:20 225:5 227:4 229:8 229:14 230:6,13 231:12 232:15 234:8,22 236:5,10 236:22 237:19 240:22 241:6,12

244:11 245:16,18 248:4,8,10,12 252:5 253:16 254:19 261:10 263:9 264:2,9,17 265:21 267:16 268:22 269:7 270:4 271:1,7,9 274:14 275:18 277:10 281:11 283:18 286:19 289:3,19 294:3,8 294:12 298:11 299:8 304:4,11,14 304:21 306:9,12 308:11 309:8,17 310:17 312:12 313:20 315:16 318:5 319:11 321:5 323:9 324:17,18,22 326:22 328:14,18 330:2,3 334:9,12 334:17 335:2,3 343:7 344:1,10 346:10 347:14 349:10 351:9 355:4,12 360:13 361:17 364:3,9 368:16 369:22 373:13 377:7 378:6,8 381:5,21 382:1 386:2,4,6 387:6 390:10 395:4,4,5,13 396:7 397:4 398:4 399:10,11 401:12 405:7 407:21 409:7 410:11 411:17 412:20,22 422:9 423:13 424:2 429:17 432:3

realm 94:21 293:7 397:17 430:1

real-world 114:17

reason 73:2 154:22 165:22 247:1 248:2,2,10 305:19 324:15 357:2,7 384:3 402:13,16

reasonable 299:5 397:20 407:5,15

reasonably 383:19

reasoning 380:13

reasons 50:8 160:19 214:15 272:20 317:3 346:11 386:3

reason-for-visit 257:9

Rebecca 25:2 42:20

recall 203:11

receive 19:13 51:16 112:22 328:21

received 10:13 20:18 51:18 113:1 116:12,17 223:5 267:21 328:16

receives 340:3

receiving 109:7

recognition 45:11 390:14

recognize 44:12 87:17 136:7

recommend 75:21 172:11 179:4 243:15 254:2 255:12 275:9 284:3 287:13,21 292:2 362:11

recommendation 6:15,21,24 194:20 196:18 197:1,5,13 197:15,16,20 200:13 202:18 218:3 220:14 226:3 228:8 242:20 248:19 253:22 255:7,15 261:14 267:22 275:5 283:13,21 286:18 287:2,19 287:22 294:7 300:6,9,18 302:2 302:21 303:7 304:19 305:13 306:7,19 307:13 307:19 315:2,3 320:8 328:2 330:6 332:22 340:10,22 341:3,15 345:11 363:20 422:12

recommendations 6:11 7:4 27:4 29:10,13 44:7 120:16 164:10,19 165:4 166:18 170:8 172:7 184:9 187:3 191:1,3,7 191:10,11,12,14 194:10 195:16,21 196:12,14 205:19 206:9 228:2 242:13 266:14 268:2 296:14 319:6 321:17,17 321:22 322:14,16 322:18 323:5 325:20 326:3 329:13 342:22 343:1 364:8,21

recommended 241:15

recommending 173:3,4

recommends 386:17

reconcile 29:4 108:1

reconciling 5:13 122:11 228:2

reconnecting 320:19

reconvene 322:4

record 122:7,8 188:20,21 201:12 214:12 229:8 322:6,7 332:1 343:19

records 35:11

recount 10:20

recover 336:8,12

recovery 210:2 335:21

recurring 396:16

red 98:4 413:16

redo 270:18

reduce 93:6 227:15 236:2 266:21 329:20 347:12 378:18

reduced 95:20 269:20

reducing 240:13 242:10

reduction 219:13

redundancies 421:21

refer 175:17

reference 373:10

referral 175:17 415:22 417:1,9,10

referred 96:13

referring 115:4 201:4

reflect 32:12 98:8 148:16

reflected 98:22

reflects 85:17 87:4 93:18

refocus 164:8

reform 16:12

regard 44:17 47:9 47:13 49:3,8,10 57:11 59:14 62:7 62:19 66:8,11 83:7 165:13 166:8 170:6,16,17 171:16 188:8,13 340:21,22 341:16 341:18 344:21 360:17 383:4 404:5 417:22 418:4

regarding 196:2 237:3 372:2

regardless 131:19 132:5 242:7 422:15

regards 345:12

region 66:15 70:21 83:11 104:12 144:12 145:5 150:21 151:1,18 153:20 155:17 159:19 174:3 196:8 262:4 264:19 265:10,22 266:1,17 310:10 319:20 334:3,22 338:13 356:21 357:9 364:14 403:4 410:22 411:10 413:12,14 414:11,14,16 415:1,4,6,7,9 417:10 418:3 419:5 422:16 423:7,9 424:6 427:6

regional 22:14 27:12 35:3 36:1 58:10 64:10 83:7 83:12 89:16 111:6 154:8 155:22 156:18 178:3 207:7 249:13 250:13 261:4,11 261:16 266:19 304:15 306:15 324:4 333:1 336:16 343:22 363:6,10,18 364:12,16 368:9 368:19 370:18 374:20 376:18 412:9 413:11 414:4 422:12

regionalization 7:6 19:1 27:10 155:12 156:8 196:10 233:15 266:18 307:5 321:20 322:11 325:17

330:20 332:6,10 341:1 342:18 343:6 346:4 351:10 368:2
regionalize 346:12
regionalized 1:4 8:4 20:6 23:20 27:6 31:9 60:22 90:2 146:5 157:8 157:15 159:3 165:9,14 166:2,2 166:15 167:15,16 167:17,18 170:10 260:18 313:22
regionally 336:12
regionally-exclus... 423:17
regional-ness 338:13
regions 333:15 354:3 404:2 411:3 414:6,7,19 415:18 417:1,9 421:5 422:18 423:5,12 424:3
region's 337:14
registry 105:12
regular 13:11 175:3 232:5 309:11
regulations 148:14
regulatory 16:12
rehab 134:13 265:1 345:18
reimbursement 246:10 263:5
reimbursing 266:4
reiterate 206:16 294:2 329:10 332:19 351:6 364:22
reiteration 236:6
relate 90:5 102:9
related 16:1 17:14 37:19 84:19 114:3 164:15 233:22 307:16 378:22
408:12 420:17,22
relates 215:21
relation 75:2
relationship 36:13 181:5 361:20
relationships 141:20 142:15
relative 19:16 107:18
relatively 105:14 163:20 263:2
relatively-little 389:14
release 46:3 270:6
released 46:6,9
relevant 10:18 11:4 11:6,7 12:13 18:4 22:12 23:2 25:10 35:19 68:22 69:4 142:17 405:19
reliability 5:22 34:16 37:5 91:16 196:20 197:11 198:5,9 200:3 202:17 218:19 220:12 291:7 324:12 401:19 402:2,6 404:18 405:5,12,18 407:4 412:14
reliable 103:19 106:5 197:18 199:9,13 200:15 291:2,6 404:6
reliably 37:12
relieve 337:3
relive 202:1
rely 377:12
remarkable 158:2
REMCS 1:5 7:8,8
remember 40:17 41:20 281:15 310:3 352:7 366:3 398:9,12
remind 11:12 12:2 398:7
reminder 41:16
repeat 171:2
repeated 396:17 406:6
replace 391:7
report 27:8,11 28:15 29:12 33:8 70:1 81:1 89:5 91:3 112:19 121:2 127:8 183:5 213:8 216:20 226:19 241:16 242:16 243:10 247:16 248:16 255:9 299:10 323:3 357:1,6 368:6 370:11 372:12 400:9 430:14
reportable 398:20 399:4
reported 101:2 241:1,13 242:15 266:16 320:18 325:7 329:14 338:10
reporting 215:10 216:13 217:12 243:7 249:1 262:11 263:14 267:2 274:13 301:3 409:13
reports 101:3 241:21 284:2 372:1
represent 18:12 101:22 348:16
representative 212:21
represented 91:20
representing 11:16 11:18,19,20 28:7
represents 136:12 225:19
reps 338:8
request 202:7
requested 223:4,10
require 37:4 86:6 110:19 279:18
379:2 412:7
required 111:11 197:9 242:2 409:12
requirements 62:22 353:19
research 11:5 15:8 15:10 16:14,16 20:5,7 21:2 22:13 24:15 25:11,20 30:16 38:6 72:14 87:3 89:6 91:13 176:7 293:7 295:8 311:18 334:16 343:2 393:16
researcher 20:1 22:10 28:6 30:14
researchers 105:19 234:22
resentful 271:18
resident 356:2
resilience 58:10,10 58:11 83:13 362:10
resiliency 83:8 365:12
resolved 395:3
resonated 367:2
resounded 360:13
resource 276:20 285:15
resourced 262:17
resources 18:11 79:2,19 99:4 104:10 112:5 133:21 134:19 135:5,18 139:4,12 144:19 180:7,14 180:15 204:16 210:8 221:10 245:22 249:20 252:4 264:19,22 270:10,17 345:21 361:1 379:16 384:21,22 417:7
respecify 342:16
respect 198:9
357:10 358:12 364:18 379:11
respond 69:21 79:12,21 83:12 88:13 92:18 94:3 94:8 95:4 103:13 103:21 106:8 112:1 114:6,7 117:4 118:19 124:5 136:13 146:9 152:14 153:9 162:21 178:19 234:11 310:11 336:6 356:19 423:16 424:17
responded 88:16 106:9 168:8
responding 55:14 147:6 148:19 156:13
response 2:8 15:10 17:2 23:17 25:1,3 25:18 26:5 45:19 45:20 49:15,19 75:20 76:1,3,7,13 78:10 83:4 88:11 88:13 92:11 93:7 93:9 96:6 99:18 101:7 106:15 114:9 115:6 127:2 135:12 136:18,22 161:7 170:19 184:20 185:3 195:1 218:17 239:19 300:4 308:6 313:22 314:2,7 316:7 330:11,16,17 365:1,20 380:1 431:7,17 432:16
responses 40:3 118:15 151:12 224:3 308:6 330:5
responsibility 416:3 422:1
responsible 90:21

97:15
rest 37:13 135:15 271:17 319:15 379:20
result 40:3 45:4 104:22 136:4 351:19
results 35:4 223:1 232:15,17 250:3 409:19
retriaged 56:8
retrievable 41:2
retrofitting 188:12
revector 66:21
revenue 368:19
reverse 53:4 64:8
reverse-triage 337:8
reverse-triaged 318:14
review 26:17 32:13 39:16 96:2 195:4 200:7 389:11
reviewed 383:14 388:5
revise 70:18
revised 70:18
revisits 366:13
revolved 17:10
re-endorsing 193:16
re-reviewed 39:16
Rhode 157:19
Rick 44:15 394:8 395:1
rid 243:18 272:1 293:2 333:9
right 18:13 45:16 62:9 65:11,12 69:22 70:3,15 71:1,15 82:1,8,17 84:21 88:13 110:9 110:16 113:15 115:21 122:13 124:10 128:20 129:1,7,12 134:9 144:3 146:10,10 146:10,20 147:5,9 156:13 161:20 162:11 163:7 165:3,19,20 167:11 169:18 177:12 178:2,13 198:5 206:6 207:22 209:1,8 212:14 214:8 221:1 222:7,12 223:10,10 225:13 232:2,19,21 235:12 238:18 246:8 252:22 253:5,12 254:11 258:18 259:2 278:19 280:3,4 283:12 284:12 289:9 293:7 295:6 296:4 299:3,11,12 301:5 305:8 307:12 311:16 313:1,22 315:1 322:14 333:17 334:7 338:14 339:10 340:17 350:11 352:21 354:7 357:22 367:21 372:6 376:12,16 377:10 378:4,5,11,11 379:1 380:18 385:15 388:15 390:15 399:15 400:7,7 401:4,12 406:3,3 408:20 411:13 413:14 415:5 426:16 428:3 429:13 431:3
right-size-fit 51:14
right-size-fit-it 167:11
rigor 399:20
rigorous 32:12 185:11 391:17,19
rigs 166:7
rise 154:7
risen 161:19
rising 154:6
risk 6:8 71:12 134:21 233:7 238:10 240:18,22 242:18 248:11 249:7 250:7 251:20 252:21 253:9,10,22 254:2 254:4,18 256:14 257:14 267:18 273:13 287:11 292:11 293:5 294:5 316:20
risk-adjust 243:13 245:3 250:1,14
risk-adjusted 38:13 253:3 259:16,18,19
risk-adjusting 243:7 249:14 252:6 253:4 265:15
risk-adjustment 241:18 254:12 255:12 256:1 260:10 267:15 321:4,7
road 57:9
Robert 20:12 22:17
robin 322:16
Robinson 2:18 19:5 19:6 218:1 345:8 360:12
robust 167:10 190:12 305:8 368:2 393:13
Rochester 2:20 17:7 353:14
role 199:15 284:20 361:22 367:10 430:9
roll 36:1 250:17
rolled 119:18 167:6
rollover 149:15 153:5
rollup 334:21
roof 326:12
room 1:20 16:16 71:15,16 74:3 120:2 129:13 163:20 168:15 173:13 175:3 191:9 192:6,7 202:9 206:22 208:10 223:22 224:1 229:18 289:5 297:22 321:21 325:15,20 371:5 389:2 392:10 395:13 398:11 432:14
rooms 116:10,11 163:15
roots 421:18
root-cause 105:14
roster 187:20
round 322:16
rounded 278:19
rounds 107:16 278:7,8
round-robining 322:20
route 180:9
routine 41:3 127:5 127:11,15 178:18
row 205:1
rule 217:3 235:10
ruleout 57:1
rules 79:3 147:20 148:8 149:18 154:21 161:2,3 392:14,16
rule-writing 16:13
run 62:12 273:1,10 282:6 387:14
running 221:15 333:19,21 400:13
runway 29:14,19 425:22
rural 79:20 136:10 242:9 253:14 255:1 256:12 266:8 267:7
RWJ's 41:8
Ryan 2:14 25:19 166:21 167:13 172:4 174:7 181:17 195:13,17 195:19 247:4 289:21 347:15 350:6 354:7 356:19 417:2,14 421:2
Ryan's 207:18 291:3

S

s 24:7
SAEM 14:16,20 15:1 19:1
safe 76:17 397:19 398:21
safety 19:15 76:15 78:15 135:15 190:18 365:12 397:21 398:8
safety-net 183:19 256:5 262:16 266:5
safety-net-hospit... 265:8
safety/security 77:1
sake 10:11
salary 13:8
Sally 2:15 24:10 30:17 84:22
Sally's 123:13 124:4
SAM 21:22
SAMHSA 426:22
sample 123:3 212:18,20 213:8,9 298:10
San 2:23 14:7 353:13
sanction 263:4
sand 355:14 421:9
SARS 123:16 139:1

139:2,3,8,9 140:4 140:22
sat 32:9
satisfaction 239:16
satisfy 176:18
satisfying 109:22
saw 57:10 83:22 395:8,11
saying 15:17 31:12 69:19 80:9 99:1 104:2 144:21 145:2,12 150:10 150:15 151:2 157:2 179:14 183:14 185:8 212:6,13 239:3 252:21 258:22 283:18 289:13 291:8 312:22 315:11 323:18 358:16 360:8 366:5 370:6 381:13 387:5 390:19,20 391:12 392:13 403:12 409:7 414:10 428:19
says 13:18 129:10 130:8 145:15 159:12 225:13 240:17 242:14 269:22 296:20 312:16 376:6 394:3
scalability 410:15
scalable 80:10
scale 81:8 126:12 130:17 281:8 287:14,18,20 323:15
scaled-up 364:12
scales 291:6
scan 152:21,22 285:7,13,18 358:4 387:16
scans 285:9,11 293:15
scant 396:15
scenario 45:7,8 104:7 124:20 139:17 272:9
scenarios 79:5 138:19,20
schedule 317:5
scheduled 134:13
scheme 425:6
scholar 20:13
school 15:7 128:4 128:13
Schuur 2:19 20:21 20:21 59:7 155:7 157:7 225:16 239:18 243:5 244:14 245:7 262:7 292:20 303:5 361:9 398:4 428:18
science 91:6
scientific 32:12 34:10 401:8 402:3 408:7
scientifically 334:12
scientifically-bas... 418:9
scope 26:10 51:3 121:7 156:7 281:13 400:19 427:10
score 34:18 37:6 233:1 241:22 288:3 289:4,9
scores 38:14 103:18
screen 183:8 224:19
Scroll 183:10
se 201:8 308:7
season 114:4
seats 122:12
Seattle 77:20 79:17
second 34:11 50:19 55:1,1,21 59:2 64:1 66:22 67:1 82:5,6 88:10 92:6 167:20 175:11 182:14 243:14 258:20 260:15 278:2,6 293:4 324:2 337:16 341:13 348:5 364:18 365:5 372:3 374:13 387:2 395:6 402:5
secondary 76:18
secondly 88:6 111:17 180:7 250:12 372:17
Secretary 2:8 17:1 24:13 25:17 42:13 82:9,22 83:3,13
section 191:14 195:8 199:22 219:4 275:5 307:11 325:19 368:13 370:6,11
sector 16:17 136:3
secure 76:17
security 2:16 15:22 24:12 76:16 89:9 116:5 328:4 365:13
sedated 73:17
see 33:18 39:2 42:20 69:1,13 78:17 94:12,16 97:12 102:11,13 104:12 105:20 107:19 112:1,22 120:4 121:20 128:16 130:5 136:4 137:19 142:7 182:7 187:2 189:5 199:5 207:5 211:3 214:4 215:8 222:17 224:17 230:20 231:4 232:17,18 233:5 246:5 248:4 249:3 251:20 257:15 261:5 265:18 271:4 281:7,16 289:10 290:4 312:14 320:22 321:21 334:16 348:11,13 352:2 366:9 380:15 385:8 389:12 399:20 407:20 408:18 414:16 420:4 432:6
seeing 28:16,19 60:4 77:15,16 106:9 130:1 150:17 201:15 220:7 338:5 429:14
seen 33:21 90:9 96:10 129:2 138:2 193:21 213:5,6 231:11 234:18 256:2,13 311:11
sees 214:22 216:18 326:14
select 35:16
selected 11:1
selection 40:17
self 59:8
self-select 164:4
self-selected 163:22
semantics 243:9
semi-non-contro... 327:6
send 130:14 156:17 175:18 258:14 259:8 282:9 326:3 407:22
sending 113:3 276:19 277:3 337:8
senior 4:5,18,23 8:14 30:12 235:3
sense 32:22 68:14 98:21 103:21 151:9 152:8 182:4 198:3,6 240:12 296:7 306:16 312:18 330:22 337:4 348:12 353:11 375:15 408:22 410:16 415:20 423:13 424:18 431:9
sensitive 355:12 392:13
sent 130:12 270:13 275:19 339:22
separate 107:20 125:9 129:16 150:6 151:15 168:3 171:9 221:3 224:10 277:5 278:18 282:14 319:14 331:21 332:22 363:17
separated 367:16
separately 277:17 277:19
separations 81:5
sepsis 361:20
sequence 322:9
series 380:18
serious 203:5 265:21 287:7 398:20 399:4
serum 288:12
serve 11:1,21 20:16 300:22 301:12 309:9 367:12 416:5
served 12:11 13:20 14:14 21:22 371:6 371:9
serves 387:7
service 78:12 79:12 132:21 133:11,22 211:15 278:8,18 280:9 304:20 327:1 358:3
services 1:5 2:17 13:15 18:11 21:2 25:17 28:6 30:14 31:10 36:2 133:10 135:5 136:2 216:7 236:19 281:19

304:16 329:17 345:20 346:20 349:9,11 386:16 425:4
serving 24:5
session 318:8 321:19
sessions 318:9
set 29:14 31:12 40:18 79:3 85:18 89:5 139:7 154:4 156:21 170:10,20 171:9 173:20 182:2 267:9 277:5 280:5 324:19 325:2 361:12 371:12 373:15 425:22 429:8 432:21
sets 21:17 170:13 170:16,17 188:10 324:15
setting 6:11 29:19 103:20 127:3 140:7 182:5 200:21 234:18 268:2 281:5 296:2 375:21 376:6
settings 30:16 178:18 219:7 347:21
seven 60:2 317:15
seventy-two 395:15
severity 244:18 289:19 290:5
sexy 131:9
shades 147:7
Shah 2:20 17:4,5 319:17 332:18 341:7 353:7
shape 77:3 231:3 231:16
share 85:1 104:9 105:17 222:15 232:16 422:1
shared 177:2 343:18 421:7,20
422:2
shelf 147:2
Shelly 2:22 264:11
shift 45:6 46:1 50:1 57:18 117:19 169:14 192:5 396:4
shifted 51:10 53:9 70:15
shifts 119:17
shine 274:15
ships 154:7
shoot 82:4 288:5
shooter 365:16
shooting 140:18 388:16
shoots 163:19
short 43:20 59:5 84:11 194:7 238:3 238:16 259:10 281:9 359:6 370:22
shorten 156:15 217:14
shorter 254:17 267:10 280:1 398:15
shortsighted 71:12 365:22
short-stay 281:2
short-term 216:11 236:17
shot 138:15,17 141:10
show 37:12 70:3 128:18 144:16 256:13 329:20 376:5,15 385:9
showed 158:3 214:17 393:16
showing 113:18
shown 133:3,15 299:22
shows 192:18 270:7 302:18
shuts 400:22
shying 284:14
sick 125:18 142:4 253:6,8 254:6 256:10 271:7 362:3
sicker 169:2,8 180:16 268:18 296:22
SICU's 73:9
side 78:15 132:12 132:12 160:10 185:16 190:16 195:13,15 208:2 210:9 252:22 261:6,11 294:22 299:3 364:19 393:4,12 405:3 408:14,16 409:1
sidebar 355:17
side-by-side 227:21
sign 17:19 55:18
signal 37:8 227:18
signal-to-noise 412:12
signed 356:2
significant 36:7 46:13 209:21 258:9,13 310:5 347:2
significantly 256:22
signing 55:20 201:11
siloed 397:17
silos 129:16
similar 77:6 105:18 105:20 119:16 144:14 185:4 287:10 345:5 365:17 386:17 391:8 415:5
simple 244:2 247:22 248:8 256:19 276:7,10 317:5
simplest 49:12
simply 11:11
simulated 379:7,17
simulation 392:1
simulations 324:7
single 279:6 343:18 343:18
sit 11:13,21 19:1 32:2 237:19
sites 35:19
sits 401:12
sitting 233:14 423:7
situation 69:1 278:9 388:11 390:11 413:4
situations 118:11 125:6,10 134:18 140:2 141:19 250:6 390:3,12 392:5 397:10
six 131:15 214:22 219:7,8 288:21 292:13 317:12,15 380:18 428:20
size 51:2 66:17 123:3 254:9 267:9 298:10
skewed 274:15
skills 397:11
skipped 335:7
sky 400:12
sleep 298:1
slide 34:11 41:18 93:10 95:8 96:2 96:16 97:17 99:11 100:12
slides 86:21
slightly 53:15,17 65:16 91:4,21 322:9
slow 209:4
small 13:7 14:10 242:9 267:7 297:20 298:3 359:16
smaller 138:7 148:20 256:11 299:19,21
smallpox 112:1
127:6
small-scale 323:14 324:1
smartly 64:15
Smith 288:9
smoothness 136:1
smooths 296:15
social 92:22
society 11:16 136:12,21
socioeconomic 255:10
socioeconomics 264:16
socks 350:17,21
soft-call 56:22
solely 174:16
solicit 44:18
solution 348:9 349:3
solve 14:21 137:1
solving 329:6 356:14
somebody 112:22 128:3 130:3,7 142:22 143:4 147:12 148:22 180:15,16 211:11 238:7 251:6 276:14 277:3 278:10 291:19 309:6 325:15 384:18 388:14 410:4
someday 67:7
someplace 382:19
somewhat 87:19 88:8 114:1 149:11 282:5
soon 125:22 182:13 188:18 229:10 275:3
sooner 355:11
sorry 19:20 27:21 67:5 80:5 81:18 152:20 163:3 177:6,17 187:10

187:12 188:3 215:17 233:11,12 243:3 245:4 247:13 249:10 289:6 293:22 298:16 300:5 302:7 306:19 307:13 313:9 320:21 335:6 339:19 345:6 351:4 354:9 366:2 368:14 377:22 384:8,9 406:9 413:6
sort 41:20 43:14 47:12 59:8 75:1 76:14,18,22 85:4 85:6,18 86:1,11 107:5,6 113:17 115:15 120:2,10 121:6,11 123:4 128:5 131:4 132:22 135:22 141:5 143:12,13 144:9 145:12 147:14 149:5 151:9 153:8 154:4 154:15 156:1 157:8 158:9 159:3 164:8,15,18 169:16 170:1 172:7,15 175:20 181:6 182:5,10 184:19 185:7,11 185:14 186:14 192:22 195:3 196:14 197:4,16 197:19,21 199:6,8 199:10 207:12 209:18 212:19 215:5,20 216:15 216:17 218:20 220:2 224:19 231:14 241:18 242:21 243:8 247:10 248:9,11 249:21 251:17,20 260:10 263:5 266:2 267:5,16 268:21 269:3 273:8 274:1 277:14 289:18 292:3,8,11,15,16 293:1,2,18 299:12 302:22 303:5 308:10 311:13 318:6,18 325:22 326:12 327:5,18 332:6 337:1 346:10 348:6,11 349:20 350:1 351:21 352:6,13 352:15 355:9 357:22 361:14 367:3,16 369:5 383:12 386:2 391:10,11,11,16 392:3,21 398:8,13 399:20,22 408:12 417:16,21,21 418:1,2,4,8,13 419:17,19,21 420:3,12,17,19,20 421:17,19 422:11 422:13 425:18 426:7,8 427:9 430:6,7
sorts 130:7 157:9 361:3
sound 199:10
sounds 170:12 212:1,8 233:18 276:21 283:13 286:7 408:8 424:13 430:10
source 200:4 287:22
sources 38:15,18 41:13 108:15 200:5 380:4
southeast 144:10
so-and 112:6
So-and-So 11:15
space 35:13 39:9 51:17 53:1 63:18 63:21 65:12,16 66:8 68:14 69:17 143:18 153:13 183:20 408:15 421:7,14,15,21 428:7
spaces 429:17
Sparr 44:14 368:16 384:9 406:11
sparse 302:20
speak 48:10,12 51:8 54:18 57:11 60:17 72:16 115:15 120:6 145:9 148:4 165:17 166:21 167:15 174:7 216:16 250:1 255:19 268:7 282:4 289:5
speaking 11:6 25:12 62:5 79:18 82:13 198:22 205:7 207:17 251:1 281:15 320:15 382:15
speaks 83:6,9 166:13 167:6 168:9 281:22 337:18
special 18:10 341:5
specialist 274:5
specialty 273:5
specific 29:13,16 29:17 30:1 44:6 45:19 46:11 50:8 91:15 170:16 194:19 198:18 200:13 202:5 203:13,15 226:2 239:10 260:5 264:3 276:3 300:10 301:6 303:18 305:6,10 307:21 315:6 316:22 364:7,8 385:7,13 395:5 397:7 402:8,17 405:20,21 414:10 422:14
specifically 27:11 67:21 108:5 121:2 164:21 179:4 186:13 190:17 191:15 194:3 225:4 260:5 308:5 323:4 339:12 354:15 382:4 385:11,13 387:21
specification 422:15
specifications 16:3 34:14 251:2 375:17 402:10,18 412:4
specificity 364:21
specifics 251:16
specified 371:21 401:12 402:8 408:13 410:22 413:10
specify 405:22 413:10
specs 222:11 225:18 232:21
spectrum 74:1 147:15 159:11 323:16 364:3
speculation 123:2
spend 191:9 227:12 242:6 282:2
spending 285:1 393:5
spent 9:4,8 13:8 16:10 37:17 191:21 275:18 320:15 397:8
spheres 107:20
spiral 141:11
spirit 10:1
spirituality 393:22
splint 56:21
splitting 209:9
spoke 46:10 146:21 165:4 166:18 168:5,8 421:3
spoken 47:17 165:9
spread 64:18,22 65:2 141:11
squeeze 34:6
squirming 120:5
squirrel 138:13,14 148:19 150:5
squirrels 137:10,14 137:15,18 138:5,6 138:8,21 147:8 305:2
stable 73:12
stack 161:7
staff 3:10 44:13 51:16 52:22 327:9 342:2 345:21 356:4 365:15 406:20
staffed 304:7 356:4
staffing 51:13 396:5
Stafford 82:12,18 82:21
staffs 135:16
stage 325:1 378:10
staged 62:16
stakeholder 14:11
stakeholders 32:14 194:17
stamps 201:10
stand 47:7,8 53:3 55:4 58:5 65:14 67:17 83:14 146:14,18,18 147:5 179:13 184:4
standard 152:1 225:9 289:18 308:18,22 324:13 352:22 354:3 379:17 384:10 388:3 397:14 398:13 408:5 410:17

standardization 242:21 292:21 352:14
standardize 287:17
standardized 32:3 287:13 288:3
standardizing 6:16 286:20
standardly 320:18
standards 30:8 57:12,19 96:13,21 132:16 154:21 198:15 226:5,11 283:15,17,22 284:3,18 378:17 378:18,19 381:13 387:9 391:6 408:3 428:4,5
standards-of 392:10,21
standing 49:7 53:8 386:18
standpoint 54:7 82:6 154:13 157:2 162:19 212:11 229:10 265:5 284:22 314:1 345:22 360:14
stands 51:21 87:19 146:14 147:10 179:12 374:3
Stanford 14:12 182:16
start 8:7,19 12:22 32:19 44:5 53:19 73:13 77:12 81:9 86:7 92:13 123:8 149:18,19 164:16 167:8 186:5 189:21 191:19 193:19 196:13 225:5,6 229:10,20 237:5 274:14 285:2 286:9 315:11 318:18 355:13 363:16 369:18 372:22 373:21 430:12
started 8:10 36:21 43:8 122:10 132:6 162:1 189:4 209:19 272:16 347:22
starting 38:1 174:4 219:4
starts 229:11 231:14 318:5 321:19
state 2:18 19:9 23:18 65:3 69:9 89:14,17 102:16 119:10 328:13,14 344:7 377:8,17 381:14 384:20,21 414:11 416:10 424:7
stated 61:6 230:2
statement 92:14
states 60:6 82:11 267:22 414:14
static 56:10 274:10 274:22 275:2
stating 80:8
station 109:21 157:19
statistical 380:14 391:1
statistically 300:1
statistics 9:9 13:10 22:4 115:20
statistics-type 9:8
status 205:4,5 215:21 216:6 221:21 236:21 247:10 257:7 265:22
statused 221:18
statutory 281:9
stay 53:12,19 128:16 133:6,12 160:5 162:3 192:18,21 193:8 194:6 203:3,22 214:20 215:2,15 239:10 241:10 242:11 244:6 253:5 254:16 256:5,22 257:4 259:10,17 261:19 262:20 264:16,20 265:3 266:10 271:10 280:1,4 281:9 287:7,9 291:11 295:15 300:12,21 301:22 305:7 315:6 316:5 316:21 320:1 329:22 331:14 343:17 363:7,12 366:11 397:16
staying 162:15 206:22 417:6
stays 265:17 349:16
steal 316:10
Steering 371:6 388:7
STEMI 146:15 156:3 159:2 173:22 291:15
step 49:21 77:15 80:3 86:10 92:7 239:4 248:10 274:9 322:10 374:13 375:14
Stephen 1:21 2:3
stepped 24:5
steps 172:19 201:14 334:15
Steve 9:1 13:1 219:1 298:21 299:19 433:10
Steven 4:8 8:11
sticks 172:1
stomachache 291:21
Stone-Griffith 1:22 2:4 4:10 8:12 9:15,17 13:13,14 115:14 122:9 147:13 161:14 162:11 203:10 209:11 218:13 221:2 225:15 230:1 246:17 281:14 291:9 315:10 322:17 338:18 339:7,10 339:14,21 340:2 366:22
stop 33:10 42:3 185:21 314:9
storage 406:20
stories 149:14
story 246:21 337:17 338:16 340:7
Stoto 2:21 5:11 15:3,5 43:21 80:3 86:19,20 110:4,8 110:12,16 111:7 115:2 118:21 126:22 137:6 138:8,14 140:3,14 177:18 185:8 198:1 233:9,12 305:17 323:1 325:9 327:22 331:2 332:12 377:6,22 378:4 380:7 381:11 382:20 386:11 389:8 390:19 391:22 399:7 400:2 401:9,18 405:14 407:16 409:9 412:18 422:21 424:5 433:13
Stoto's 120:21
straightforward 279:17
straight-out 341:3
strata 232:22 233:4 248:7 338:19 367:14
strategic 277:14 313:14
strategically 67:9
strategies 303:18 303:19 304:19 374:11
strategy 34:2 304:1 309:20 374:8 376:1 384:6
stratification 244:1 244:2 247:22 248:9 256:19 257:21 258:3 267:16,19 292:3 293:5
stratified 38:9 241:22 243:8 247:15
stratifies 287:6
stratify 243:12 247:17
straw 254:1 265:14
stream 88:2
street 1:20 165:21
strengths 96:17,18 142:14
stress 57:1,2 115:6 115:9 130:13 271:16 327:13 335:2
stretch 54:2
stretcher 218:9,9
strike 411:14
strikes 129:3 332:13 337:11
stroke 429:4,6
strong 77:10 141:19 142:6 389:13
strongly 37:20 393:6
structural 6:21 184:16 300:19,22 301:6,20 302:4 303:2,8,9,12 305:5,6,9,14 310:17,22 311:3,6 311:11,16,17 312:12,17 330:6

341:14,16
structure 36:10,13 94:18 119:9 127:17 300:10 313:4
structured 99:13
structures 89:16 99:5 142:16 312:2 312:3,4 425:10
struggle 211:14 299:7
struggling 102:3 117:21 126:3 160:19 161:10 212:6 218:3 328:3 364:1
stuck 109:20 110:4 155:1 239:8,13
students 78:6
studied 103:17 128:7 198:8 200:20 388:9
studies 38:6 124:17 250:5 290:22 301:13 302:12 391:1 392:1 393:21
study 14:20 22:14 22:18 88:7 176:7 200:22 316:14 344:4 389:15
studying 2:6 22:10 191:22
stuff 9:8 53:1 91:7 102:10 108:1 128:3,16 141:22 184:17 188:15 223:13 238:18 240:11 322:21 332:6 433:12
stunned 356:8
stunning 117:7
sub 401:22
subdivided 374:5
subject 107:17 189:21 227:6
subjective 226:1
290:16,19
subjectivity 288:15
submission 405:7
submitted 173:21 399:18 422:19
subpopulation 236:11
subsequently 46:7 48:17 55:11 322:13
subset 203:3
subsets 231:18 236:8
substantial 235:13
substantially 236:18
suburban 256:11
success 50:18,18 314:17
sudden 73:13 147:1 163:20 317:15
suddenly 148:8 228:21 364:12 367:3
suffers 133:17
sufficient 110:1 302:14 411:4
suggest 200:15 217:8 243:6,6 244:14 251:8 274:9 306:18 319:7 357:1 374:14 381:8
suggested 119:2 392:2
suggesting 129:9 361:4 387:4
suggestion 274:19 398:2
suggestions 323:2 433:4
suggests 63:19 351:14 407:14 419:11 420:7
suites 366:9
sum 87:7 411:18
summarize 97:13
summarized 15:15
summary 363:15
summation 136:11
summed-up 143:12
summing 411:19 412:20 413:3
sunset 313:12,13
sunsetting 362:22
superior 35:17
supply 51:13
support 20:18 24:16 66:1 97:5 265:1 277:15 308:16 315:19 318:16 345:9 427:1
supported 402:10
suppose 220:13 359:16
supposed 352:19
sure 23:19 30:9 34:3 38:2,16 43:14 58:18 60:16 77:10 81:19 95:19 103:3 121:17 144:15 145:19 148:3 153:14 156:10 175:6 183:3 184:3 188:14 189:14,18 198:14 208:9,21 214:12 216:12 233:10 237:4 251:22 256:3 263:21 266:6,7 275:7 283:11 287:1,3 290:16 294:14 297:1 298:11,22 300:8 307:4,6,9 328:1 334:9 336:21 346:19 351:7,12 361:9 368:1,3 369:2,10 370:3 381:21 386:9 393:9,9 394:1 395:2 406:12,14
408:2 415:16 422:8
surge 5:14 26:19 47:1 50:2,3 52:22 71:18 76:8,13,13 76:17,21 77:2,9 78:2,18 81:3 102:8 118:2 120:11 122:11,11 122:19,20,22 123:1,15 124:9 134:4 141:7 142:1 142:6,12 147:16 147:16 148:1,2,16 149:13 152:15,20 157:22 159:10 160:21 161:11 162:14,20 174:20 181:3 299:20 305:1 308:4 309:10 314:4 330:11 335:15,21 336:8 344:3 355:19 365:5,8,12 365:15,21 367:12 375:22 384:6 389:20 400:17 406:15
surgeon 158:9 366:5 395:17
surgeries 134:13
surgery 85:16 246:4,5 317:6 394:15 399:1
surges 80:20 114:6 308:6 383:18
surgical 273:21 344:8
surging 86:11
surplus 128:6
surprising 355:20
surrogate 54:10
surrounding 152:19 354:13
surveillance 100:18 140:5
survey 22:5 177:7
185:6,14 222:21
surveyors 213:14 222:21
suspect 127:14
suspended 78:13 78:17
sustain 125:5,11
sustainable 50:21
sustained 162:2 336:1
sustaining 125:4,12
Suzanne 1:21 2:4 4:10 8:12 9:17 10:9 13:14 14:14 161:13 198:20 204:11 220:19 243:1 366:21 382:16 433:10
swan 134:17 136:13 137:7 138:1,13 309:16
swans 126:16 137:10,12 138:7
swat 118:8
switch 396:4
synergies 49:5
synergy 67:2,2,7
system 2:6,7,9 18:1 21:12 22:11 50:12 50:12 51:11,20 52:21 53:5 56:10 69:7 70:5 76:9 84:7 85:9 86:15 86:15 89:2,4,9,11 90:6 93:15 98:13 101:6 102:5 103:21 104:11 105:15 106:8 110:3 115:1 118:3 121:3,13 133:8 134:11 146:5,19 155:17 160:7,8 161:6 171:4 180:12 182:21 199:21 200:8,11 205:4 211:9 221:5 224:4 227:16

244:2 247:22 248:9 249:13 250:18 256:19 257:21 258:3 259:22 260:10 264:6 265:2,5 277:21 280:18 287:6,12,13 291:2 292:4 293:19 294:12 308:10 312:6,9 313:21 314:2 316:7 318:20 319:15 324:4 328:9 329:11 333:9 335:15,19,20 343:17 344:11,12 345:12 346:15 347:11,18 350:7 355:3,3,7 362:10 363:5,9 366:15 399:13 413:1 421:18,19

systematic 38:19 107:7 380:8 389:11 407:18

systematically 39:22 257:4 382:7 387:18

systemness 318:6

systems 16:21 20:6 53:11 79:16 90:2 92:16 98:15 99:2 103:10,11,12 105:13 107:4 109:17 111:3 115:6 132:14 156:13 166:15 168:11,13 178:19 227:22 242:4 264:9 283:8 291:1 304:21 320:17 330:8 336:6,11 343:21 346:16 363:18 365:11 393:16 410:12 425:8

systemwide 74:18 86:3 266:21 321:11

system-level 88:18

S-E-S-S-I-O-N 189:1

T

table 10:17 12:17 47:19 48:1 135:10 136:16 373:5 429:14 430:11,20 430:20

tabletop 111:22 112:6 114:15 184:15 406:4,6

tachycardic 395:14

tagline 52:21

take 58:13 71:17 80:2 93:9 100:21 106:2 109:2,19 119:21 121:18,21 122:2,12 141:9 143:20 144:17 169:21 172:19 175:22 177:15 179:16 183:16 193:10 237:21 250:9 252:9,14 254:1 257:20 273:11 288:14 290:3 317:16,18 321:13 327:2 338:17 357:21 358:7 363:7 368:20 370:11 371:13 378:13 408:17 412:13

taken 117:1 183:15 186:4 370:17

takes 76:14 94:22 113:11 211:1 218:8 235:6 248:12 250:4 253:5,7 316:13 431:6

talk 14:12 30:6 36:3 40:7 61:21 71:16 82:5 85:15 93:10 94:17 96:16 101:20 153:18 155:9 178:3 179:1 190:3,9 196:12 203:19 220:20 225:1 240:21 241:17 249:14 260:2 267:13 275:6,7 300:7 322:11 325:2 392:11 401:19 418:16 421:5

talked 40:22 43:19 53:4,4 110:18 115:3,17 123:17 203:12 212:17 219:18 220:17 274:11 283:4 327:8 335:14 345:12 368:6 418:15 421:13

talking 61:3 72:6 81:8,15 82:15 86:5 93:4 102:10 107:10 124:9 129:5 138:22 141:18 143:19 148:22 151:11,16 159:10 161:1 168:18 178:14 182:9,9 186:12 189:21 196:9 218:10 220:17 237:5 239:5 249:12 250:13 253:17 272:19 278:16 307:21 308:1,3 313:20 314:9 318:11 325:1 327:4 332:22 333:13 335:13 339:2,2,11 341:14 343:6 346:4 350:5 353:9 360:14 368:18 375:5 385:7 405:15 406:8,15 406:16 416:16 431:11

talks 125:3 328:8

tally 289:9

tangent 319:18

tangible 164:10 165:4,18 166:18 184:9

target 58:11 67:21 70:7 84:21 180:1 260:9 268:10 269:19 271:13 274:10,22 275:2 275:17 292:8 294:3,5,16

targets 260:3,4,5,8 267:14,20 268:20 271:21 275:8 284:13 294:8 314:5 327:5 366:11

task 8:6 14:1 19:2 164:9 260:15 386:16

teaching 247:10 252:7,13,15 257:7

team 148:21 149:17 421:16

tease 209:1,4

telemetry 230:11

telephone 2:17,22 187:18

tell 12:17,19 25:8 59:17,18,21 62:6 70:10 96:22 97:1 117:18 212:15 219:15 221:6 235:10 252:16 338:1 410:18 411:21

telling 154:13 338:15 358:10,12 358:12

tells 98:20 340:7

temptation 147:14

tempted 153:8

ten 9:7 267:11

tend 262:13 289:3 397:16

tendencies 300:3

tendency 6:18 297:13 298:19

tends 33:15 290:2

tension 91:22 160:12 271:6

tenuous 405:9

term 23:20 89:3 229:15 245:5 313:12

terms 25:11 28:4 43:15 44:3 68:16 80:14 91:10 95:2 108:13 109:1 113:20 132:9 135:18 173:3,18 174:2 176:11 177:21 178:9 213:1 230:18 240:12 250:8,15 261:21 262:5 276:20,21 279:18 279:20 280:11,22 283:5 291:7 308:4 329:19 330:9 347:4 351:9,10 367:10 372:11 376:11 378:5 382:5 390:6 395:18 396:8 413:16 415:18,22 416:7,18

terribly 175:7

Terry 2:4 18:6 149:22 153:18 179:1 188:4,6 210:14 318:21 340:18 344:18 350:10 370:3

Terry's 155:8 173:14 176:4

tertiary 76:14 242:8,11

test 37:12 62:8 63:2 121:22 130:13 214:18 232:13 282:11,12,12 410:17
testable 27:2
tested 61:15 127:10 127:15 291:5 385:16
testimony 47:9
testing 26:15 34:16 37:4 63:3 100:17 200:3 232:17 233:5 274:2 288:12 372:4 405:6 412:7
tests 100:22 209:3 288:10
text 323:3
thank 9:14 10:15 13:12 24:18 25:22 26:6 27:22 28:13 60:15 71:11 86:19 86:20 107:11 120:1 122:4 150:1 173:11 184:6 189:13,17,22 218:1 228:10 317:8 340:19 345:8 432:1 433:9
Thanks 26:8 42:5 43:4,5 44:10 74:21 84:8 107:12 110:8 119:22 122:12 163:4 177:18 189:19 190:1 265:11
theirs 348:20
theme 15:12
theoretical 396:8
theoretically 231:2
theory 213:5 425:3
thereof 225:20
thin 88:9
thing 14:18 15:19 55:13 61:13,20 74:1 75:17 76:6,9 82:5 98:8,11 99:7 100:5 102:13 104:14 105:1,7 107:21 112:10,21 139:14 153:22 173:9 175:5 177:22 178:13 223:14 247:5 249:22 250:4 261:3 265:20 280:6 281:3 285:14 293:6 294:2,6 296:10 306:2 307:20 308:2,10 310:16 317:9 319:12 327:7 333:12 348:20 350:4 351:21 353:17 355:20 357:11 361:10 362:9 366:3 372:5 405:20,21 425:17 433:8
things 12:2 18:20 23:22 33:20,21 37:7 41:21 43:18 61:4,18 62:4 64:17 65:8 76:15 78:10 80:22 84:11 85:4,10 86:22 87:8 92:21 93:5 94:20 96:3,9 97:12,15 98:1 99:1,4,12,20 100:10,20 101:4,9 101:12 105:5 108:14,16 111:9 114:3,14 115:5 119:1,11,21 121:8 121:19 126:17 127:14 132:3 136:14 137:19 138:4,21 142:18 145:4,7 147:4 149:6 150:14 153:3,14 154:1 155:13,18 156:4 156:15 158:1,21 159:7 162:3,4 163:17 168:4 172:12 177:14,16 178:15,17 180:11 188:13 191:16 196:3 203:20 213:4 216:9 227:6 227:20 234:10 241:20 244:13,21 245:9 247:11 248:15,17,22 250:10 252:2 258:5 265:9 270:11 275:19 281:7 300:16 301:6 302:13,18 305:21 307:22 314:14,21 316:11 319:19 321:15 323:10,16,17 324:19 326:8,20 329:10 330:20 333:3,4,10 334:20 336:7 345:3 346:17 350:7,11 359:22 364:4,6 366:12 367:2 369:17 371:22 376:2 381:18 388:9 394:18 395:19 405:11 408:17 409:11 414:8 416:15 419:16 420:9 431:15
think 9:22 10:18 13:18 18:13 20:8 21:5 27:19 28:1 29:7 31:6,7,19 39:12,19,22 40:4 41:7,19 43:12 46:12,22 47:5 49:21 53:20 54:2 55:17 58:3 60:14 60:19 61:2,8,9,11 61:19,22 65:9 67:8,22 68:14,15 68:18 71:4 75:4,9 75:15,17,18 77:3 77:5 79:14,19,21 80:1,10 81:1,4,5 81:21 83:8 84:13 85:3 87:10,12,16 89:6 90:1,5,16,21 91:6,10,18 92:6 92:19 93:16,20,20 93:22 94:10,22 95:14,16,22 97:1 98:11,21,22 99:20 100:7,10 101:17 101:19 102:4,8,18 102:19 103:5,18 104:18 105:5 106:6,13,15,17 107:6 108:18 110:2,22 111:7,9 111:17,21 112:16 113:4,4,10,19 114:16 115:10 118:2,10,10,12 119:10 120:9 121:19,22 122:18 123:1,5,10,12 124:4,7,11,15 125:11,15,22 126:2,9,22 127:1 129:16,22 130:2,9 131:4 132:4,8,9 132:10,22 133:1,2 133:14 134:1,9,15 134:21 135:19,20 136:3,6 137:9,16 137:20,22 138:3 141:5,15,21 142:13,19 143:11 143:16 144:14 145:13,19 146:11 147:13 148:12 149:20 150:7 151:5 152:14 153:2,9,11,19 155:9,11,12,13,18 156:6 157:12,15 158:11,15,20,21 159:12,13,17 160:11 161:4,6,8 164:12,14,17 165:5,11,22 167:22 168:4,5,8 169:12 170:21 171:9,20 173:15 173:16 174:1,13 174:19 176:15,21 176:22 178:2,5,9 178:16 179:7,9 180:10,11,13,18 180:19,22 181:5 181:18 183:6 184:8,11,20 186:2 186:5,9,21 187:6 189:20 190:15,21 191:2,13 193:14 194:1,9,10,13,18 195:9,17,19,21 196:3,4 197:14 198:19 199:7,18 199:22 200:12 204:11 206:17 207:1,4,9,17 208:2,8,11 209:18 210:17 211:18 213:12 214:5,7,14 215:6,22 216:8,19 217:11,18 218:4 219:11,20 220:18 221:12,14,18 223:2,15 224:12 224:14,14 225:17 226:5,18 227:1,19 228:7 230:1 231:17 232:8 233:19 234:8,14 234:21 235:2,8,10 236:3,21 237:6,8 237:15 238:1,12 239:2,19,22 240:3 240:9,15 243:12 243:16 244:16,20 246:2,17,21

248:10 249:14
250:7,8,14,15,17
251:9 253:5,13,16
254:10 255:9,18
258:20 259:5,12
259:12,15 260:7
260:16 262:1,9,10
262:13,22 264:7,8
265:6,16,19
266:17,18,22
267:1,14 268:5
272:6,8 274:11,21
275:5 276:3 278:3
279:13,14,15,16
279:22 280:6,17
280:21 281:10
283:3,16 284:1,7
284:12 285:12
286:9 287:8 289:8
289:14 290:18
291:17 292:1,5,14
293:2,6,11 294:19
295:4,6,13 296:3
296:5,10 298:12
299:1,18 301:8
303:12,15 304:13
304:14,18,21
305:2,9,18,19
306:1,12 307:10
309:2,8,17,21
310:3,8,16,22
311:1,7,22 312:18
315:11,14 316:3
318:4,6,9 319:3
319:19 320:13
321:16 323:18
324:7,16,18,22
325:13,21 327:10
327:18 328:19,20
329:4,10,16 330:2
330:5,19,21 331:3
331:4 334:8,17
335:1,17 336:21
337:16 338:12,14
339:6 340:6 341:9
341:15 342:8,15
344:12,20 346:11
346:13,16 347:8
348:7,8 349:2,9
350:2,9 351:8
352:3,4,21 353:2
353:8,17 356:12
356:19 357:6,12
358:11 359:6
360:2,9,18 361:16
361:22 363:18
365:21 366:3
367:14 368:1,19
368:22 369:5,13
369:22 371:3,8,17
371:21 372:5,10
372:13 373:10,12
373:17,18 374:1,2
374:4,9 375:12
376:11 377:6,11
377:17,18 378:5,6
379:12 380:7,9,14
381:2,4,6,8,12,14
382:12 383:12,16
384:2 386:12,17
386:20 387:7,11
387:13 388:2,6,20
389:9,17,18 390:4
390:9,10 391:9,12
393:10,18 395:21
397:12 398:5,21
399:4,7,11,16
400:8 401:6,14,22
402:22 403:10,18
403:20 404:11,13
404:15,17,21
406:2,12,14
407:19 408:11,15
409:15,21 410:9
410:14 411:6,8,11
412:17,18,21
413:18 415:17
416:14 422:8,10
422:21 423:2,3,12
424:2,13,14 425:1
427:9,19 428:1,14
428:18,21 430:5,8
431:2 433:16
thinking 41:11
58:20 65:8 68:18
77:6 80:8 87:8
92:8 93:18 95:12
98:9 99:9 108:9
108:17 120:10
124:8 125:2
131:17 134:12
135:9 138:4 142:8
150:12 155:16
156:2,7,9 157:10
160:14 164:13,20
172:6,14 174:4
176:16 181:6
184:12,16,18
185:17,19,22
186:3 191:10,19
191:21 193:18,19
194:12 196:6
199:6,7 218:2
229:9 233:14
253:21 260:21
261:2 271:8
275:13 280:10
293:12 299:13
300:9 305:4
310:16 311:8,10
311:22 320:20
322:20 331:9,20
334:2 348:5 349:5
361:18 362:15
363:16 371:11
372:12 378:9
379:1 386:13
391:3 394:10
402:21 403:21
404:18 429:13
thinks 95:10
109:22 373:7
third 56:1 57:6
59:4 76:6 89:1
234:21 281:16
324:14 349:8
thirdly 78:18
thought 31:16
32:21 41:10 61:18
84:21 117:11
122:18 126:18,20
141:16 142:22
144:17,18 151:2
173:14 179:21
214:15 246:6
251:19 271:19
291:20 298:13,14
314:10 323:9
332:3,8 340:12
341:21 352:17
355:2 363:19
365:7 366:19
386:21 404:12
429:12
thoughts 125:17
173:19 204:8
300:3 428:15
thread 67:14,15
247:15,17
threat 141:8
threats 37:16
123:20
three 54:2 57:19
58:16 59:5 64:5,9
70:5 142:3 165:6
205:1,16,21 206:3
216:21,22 217:2,3
219:8 227:8
234:15 238:4
276:15 291:19
310:3 323:10
326:8 329:12
336:4 340:20
344:14 432:22
three-day 281:9
three-four 430:22
three-hour 286:17
threshold 380:17
threw 285:18
throughput 19:3
175:6 219:3 236:7
264:18 308:8
341:17
throw 285:17
321:10 326:7
338:11
thumbs-down
266:3
tide 154:7 383:21
tides 310:6
tie 27:9 304:9 314:9
386:2
tied 20:8 64:9
303:19 308:17
311:19 384:15,19
385:1
tier 311:14
tiered 76:22 414:15
ties 316:6
tigers 71:6
tight 431:21
time 10:1,11,21
16:10 37:17 43:2
44:8 51:1,19 54:6
54:21 85:6 87:13
94:2,9 97:13
99:19 102:16
107:14 115:6
116:15,17 117:14
117:17 119:17
130:15 138:16
146:10 149:7
156:16 159:6
160:4,6 161:17
175:8 176:1,2
181:2 187:16,22
191:9 192:15
193:6,8,13 194:1
194:4,8 201:18,22
202:7,8,10,21
203:13 204:1
207:14,15,21
208:7,10,13,17
209:19 211:1,2,2
211:3,11 213:3,4
213:5,5,6,11,12
213:16,20 214:15
215:1,3 217:5,17
218:7,20,21 220:1
220:7,22 221:3,11
221:19 223:2,3,4
223:5,9,17 225:2
228:14 229:21
230:21 231:5,7,9
231:12 232:13

235:7 238:2,15,20 239:9 241:10 250:3 259:16,18 260:3,3,5,8,8 267:11,14,20 269:15,18 275:8 275:17,18 277:8 280:16 282:2 284:19,22 289:10 294:3,5,16 295:13 295:16,17,20 296:2,9 304:5 306:7 309:21 315:13 317:10,19 319:21 320:12,16 324:22 325:6 327:5 329:15 338:2 347:20 350:15 351:20 354:18,19,19 356:1 357:12,16 357:18 358:4,9,10 358:13,17 359:8,9 359:22 360:20 361:2,4,12 365:10 366:11 370:7 371:20,21 392:14 393:5 397:8,22 401:7 408:21,21 421:15 425:18 432:12

timeline 431:19,21
timely 210:22
times 13:20 78:11 78:16 85:22 145:14 163:11 229:8 290:4 295:3 310:3 327:1 345:14 361:18 392:12 410:15
timestamp 6:6 220:16 224:1 225:19 230:18
timestamped 199:20 200:20
timestamps 193:6 193:7,20 200:19 201:9 224:9 226:11,15
time-based 283:15 283:17,21 284:3 284:18 291:1 292:2
time-in 358:17 359:3
time-limited 232:12
time-out 359:3
time-specific 6:11 268:2
time-to-outcomes 361:19
timing 85:14 333:1
Timmons 2:22 189:6,7,17 264:11 264:12,14
tiny 248:8 254:22 297:21
tipping 168:18
title 75:22
today 10:19 11:5,6 11:7 12:14 15:18 16:18 19:7 26:11 26:21 28:6,14,14 29:4,11 32:20 40:12 41:10 44:21 46:16 50:2 53:11 57:13 63:5 67:12 87:11 102:10 121:11 130:13 143:19 146:20 147:5 162:22 164:9 168:12 239:5 281:13 318:11 387:3 432:1,2
toe 9:10
token 173:12
told 132:5 228:18 337:18
tolerate 54:9,14
tomorrow 56:20 68:1
ton 311:17
tons 298:6 405:3
tool 324:9
tools 32:4 426:7
top 33:1 118:2 335:15 372:22 381:5
topic 6:15 11:6,7 26:16 31:6 122:16 124:17 169:20 233:7 286:19 322:13 325:14,16 334:16 368:4
topics 12:12 25:13 122:15 313:21
topped-out 33:20
totally 80:10 81:16 125:15 137:12 138:1 143:18 144:22 164:12 224:15 238:11
touched 322:12 336:20 346:10
touches 22:19 23:4 71:4 75:18 286:19
tough 126:18 244:17
tower 117:8
town 78:21 331:13
to-day 127:3
to-noise 37:9
TPA 316:17
track 117:8 127:8 161:19 229:7 261:22 296:8 300:13 301:19 304:6 316:13 329:16 343:11 347:13,20 366:16
tracked 317:2
tracking 199:21 200:8 224:19
traditional 243:19 313:5
traditionally 378:22
Traffic 19:15
tragic 141:10
trailing 204:13
train 139:5
trained 20:13 103:16 142:2
training 22:8 103:7 280:13 342:1
transaction 347:2
transcend 210:6
transfer 144:18 156:3 159:4 173:20 196:7 232:1,3,7 233:18 233:22 305:11 339:5,8,16 346:15 347:3 357:11,12 357:14,19 358:18 358:19 359:22 361:12 362:1,4,6 367:5
transferrable 345:5
transferred 337:21 338:6,20 343:12 343:15 357:19 358:3,21,22 359:2
transferring 156:2 156:4 196:2 362:2 362:7
transfers 173:22 186:6 337:18 338:3,15 344:7 346:13 347:10,17 361:10 367:6
transit 208:17
transition 168:6 220:4 229:21 230:4,8 231:5,5 235:6 236:9 237:10 238:9 346:22
transitioning 240:6
transitions 231:7 347:9
translate 48:3 108:11,13 122:22 208:7
translates 63:13 383:14
transparency 72:18 82:16 146:2
transport 146:17 345:16
trauma 13:16 116:10 123:17,19 128:21,22 139:16 158:9 254:15 265:2 341:19 421:18
traumas 273:15
travel 144:5
treat 139:7 400:5
treated 281:20 350:21 419:9
treating 139:9
treatment 85:16 136:4 286:1 297:22
tremendous 219:12 312:13 396:21
tremendously 329:19
trend 284:12
trends 152:15 218:21
triage 6:16 53:4 54:10,10,17 56:10 64:8 130:14,21 242:1,4,21 243:15 243:18,19 244:12 245:21 286:21 287:6,13,14,14,18 287:20 288:3,20 289:1,14 291:1,6 292:4,6,15,21 293:13 300:14 318:19 337:1,7 357:18
triaged 55:12
triaging 288:6
tricky 392:19
tried 68:9 83:6 128:14 149:3 182:7 223:9 244:1 247:21 256:18

tries 83:9
trigger 56:14 169:6
triggered 313:11
triggers 82:7
trillion 64:14
triple 383:3
trolley 326:15
trouble 168:10 373:14 383:18
true 47:21 100:10 102:4 121:10 197:14 213:7 218:14 238:14 265:20 297:10 299:19 347:4 399:14 400:6 412:19
truly 111:5 113:20 243:13 285:19 287:17 298:16
trusts 276:6
truth 54:7 67:10,20 73:6 84:4
truthfully 49:18 52:7 67:13
try 16:3 40:18 41:1 47:11 66:2 68:6 79:10 82:1 87:7 107:22 165:18 209:12 217:14 219:16 226:18,20 226:20 227:3 249:18 251:9 295:22 304:12 338:4 392:22
trying 31:7 35:16 43:16 49:13 51:11 51:13 58:12 61:10 62:16 63:10 64:17 65:10 66:10,12,13 67:12 77:22 78:5 82:3 85:4 95:5 105:11,22 110:2 114:16 133:18 134:2 142:11 146:4,5 151:5,7 151:20 152:4 154:7 196:5 207:6 220:10 227:17 235:10 250:17 251:21 262:4 264:10 265:21 279:10,15 314:14 318:7 320:2 347:5 364:20 378:12 404:20 431:11
tsunami 310:6
turn 8:18 10:1 27:19 30:6 42:4 44:9 147:2 282:20 371:14 432:20
turns 99:16 101:8 194:5 232:11 235:19
tweaking 86:6
two 15:11 23:22 25:6 38:22 43:19 44:12 46:13 63:16 64:5,8 68:14 73:12 76:15 80:15 87:22 100:14 111:8,19 120:6 127:18 129:16 131:5 147:15 149:2 150:14 151:15 161:17 163:2 168:3 169:22 177:19 192:1 205:5 211:10,12,14,19 214:2,7 215:1,13 217:3,4 224:7 225:12 226:7 227:22 228:6,21 230:12,22 235:19 288:10,22 295:16 295:17,20 313:21 324:4,6 329:10 330:20 336:3,19 339:1 361:1 364:3 364:3,5,7,22 365:1 371:22 372:1 375:11 381:18 383:11 395:15 402:4 420:22 423:9 432:22
tying 370:6 385:13
Tylenol 286:2
type 45:10,22 72:14 151:17 221:21 341:19 362:4 374:22 427:18
types 45:18 54:17 149:8 230:16 249:21 336:7 427:5
typical 50:6 398:14
typically 73:3 93:13 223:20 234:19 324:21

U

UC-Irvine 16:9
UHC 21:11,14 297:1,3
UK 162:18 223:12 260:9 268:6 269:13 275:13 276:21 278:13,16 280:8 283:19 284:7
ultimate 192:22
ultimately 90:20 109:4 240:11 251:15 263:2 387:7
ultra-busy 133:19
unable 376:9
unadjusted 6:11 241:15 242:14 249:4 261:3,10,16 265:18 266:15 267:2 268:3 295:17,20 296:6
unclear 97:16 154:11 222:14
uncomfortable 124:12 134:10 144:22 331:7
undergoing 393:22
underlined 102:14
underlining 413:16
understand 23:20 40:15 49:2 85:21 101:17 145:12,19 204:12 205:16 206:1 209:13 233:16 257:12 287:1 295:22 336:6 339:18 347:14 359:4,5
understandable 197:3 249:2 408:19
understanding 43:15 56:16 169:19 203:9 207:13 257:16 260:18 261:8,9 281:11 295:8 296:1 343:22 344:13,13 371:12
understood 112:5 113:2,6 237:4 276:4 346:21
undue 269:12
unfiltered 265:18
unfortunately 42:11 47:20 64:13 138:15 314:16 400:15
unheard 140:3
unified 109:17 343:19
uniform 194:19
uniformly 267:7
unintended 39:8 40:3 162:17 259:13 283:14
unique 12:6 114:14 258:11 347:21 378:15
unit 27:7 49:20 52:18 72:15 75:8 88:20 90:4 131:21 159:18 178:4 210:2 269:6 273:18,19,20,21 275:16,20 277:5 277:16 278:5 282:6,10 283:2 285:7,15,17,18,21 314:15 411:14,22 412:1
United 82:11
units 216:10,11 269:2 272:18,22 273:10,22
universal 136:15 224:3
universally 202:8
university 2:3,5,9 2:11,14,15,20,21 2:23,23 9:6 13:3 14:7 15:6 17:7 18:18 20:1 21:11 22:22 23:11 28:11 115:19 116:3,13 297:21
unlimited 180:13 345:20
unmentioned 235:15
unnecessary 277:12
unplanned 144:13 145:17 146:6 172:14 418:10 419:4,8,13
unrealistic 368:20
unreliable 37:22
unscheduled 183:19 190:17
unusual 140:4 397:10
update 181:19 183:22
updated 34:20 39:1 40:14 91:4
upfront 292:9
upside 270:15
upstairs 149:19 169:9 206:18 207:1 208:10

221:6,10 271:7 274:6 317:17,17
uptake 71:17 128:17
urban 256:9 422:4
urgent 183:19 190:17
URL 91:5
usability 34:19 38:21 408:13 409:2,16
use 34:19,21 35:4 38:21 89:3 103:8 106:3 111:13,14 114:9 136:21 150:19 179:20 180:7 185:1 199:9 199:12 200:8 202:6 204:16 205:2,4 221:16 223:9,20 226:20 241:19 243:19 244:11 247:9,16 261:20 276:21 285:7 293:13 294:4 295:12 299:2 336:22 343:9 349:12 350:6,19 373:8 380:5 381:2 387:19 389:5 392:17 402:20 409:16,19 420:2 425:9 426:8,12,17 428:12 431:9
useful 40:20 41:10 62:2 79:22 100:5 100:6 101:4 104:16 105:1 106:18 114:20 141:16 150:7 174:19 215:7 232:16 299:10 306:3 320:6 323:21 325:4
useless 296:3
uses 24:3 40:16
182:3 242:2 244:3
usual 117:20 149:3 424:16
usually 17:17 88:14 353:18 409:10 430:2
utility 91:17 310:20 357:16
utilization 285:15 295:9
utilize 304:4,5
U.S 90:11 131:20 153:20 223:14 275:14 276:19 277:22

V

VA 350:6
vacated 356:3
vacating 356:6
valid 37:22 103:19 106:4 197:18 199:9,12 248:11 404:6 407:13
validated 185:6 199:3 242:18 255:12 256:1
validation 110:21 199:12
validity 5:22 34:12 34:16 37:5,16 68:19 91:16 142:7 196:19 197:11 198:4,9 220:11 324:12 364:11 377:21 378:2,3,9 401:19 402:1,5,9 404:19 405:5,13 405:18 407:5
valuable 113:20 217:18 236:1 329:11,19 371:4 371:18 373:11,20
value 155:21 156:9 157:11 216:16 217:12 220:6 236:18 252:10,11 293:11 299:10,13 310:20 311:4 347:11 371:9 372:11 416:8
values 299:3
value-added 238:20 259:8
variability 262:5
variable 176:6,11 363:13 405:4
variables 258:16 306:22 416:4,8
variation 33:21 127:22 244:8 333:17 348:11 349:12 374:18 376:7,22 420:1,4 420:7
variations 416:18 417:12
varied 225:11
varies 89:13 290:11
variety 209:15,22 430:5
various 28:10 192:17 201:14 229:13 275:19 333:6 408:20 414:16 420:11
vary 89:21 298:9
varying 107:2
vectoring 45:15
vehicle 345:22
vein 77:6
Venkatash 2:23 7:10 20:10,11 68:11 69:22 158:15 199:18 260:13 294:19 297:6 310:15 320:11 335:9 370:22 371:2 375:3,13 378:21 388:1 390:13 401:6,11,21 407:3 408:11 410:2,19 413:7,15 414:17 425:15 428:1 433:14
Venn 126:3 135:7 165:11 167:22
vent 73:11,12,17
versa 194:8
version 91:4 137:19 224:6 241:14 242:14 255:9,13
versus 6:19 45:16 45:17 62:1 92:11 125:5 132:17 140:17 141:11 147:16 148:16 155:4 169:5 179:6 181:9 209:4 215:14 228:6 230:12 238:22 256:11 274:17 278:13 282:3 287:8 295:17 297:13 298:18,18 321:8 344:3 351:17 354:14 357:9,9 358:17 406:19 414:11,15 415:9
versus-passive 201:9
vertical 354:8
Veterans 76:12
vetoed 205:6
vetted 400:1
vice 4:23 13:14 21:10 30:12 52:14 194:8
victim 314:16
view 171:14 186:8
viewed 310:11
views 423:8
Virginia 77:19 424:9
virtually 251:13
visibility 167:13,14
visible 240:1
visit 217:15 244:15 248:2,3 258:1,7
visits 128:12 212:20 213:9
voice 17:17 55:5
volume 161:12 241:7 244:15 248:21 254:13 256:10 257:7 258:2,7,17 266:11 298:4
volumes 162:4
volume-stratified 244:3
voluntary 301:3
volunteer 18:20 46:21
volunteers 46:20
voted 269:11

W

wagon 62:14
wait 130:15,19 163:16 180:16 326:15
waiting 51:16 163:15,20 192:6,7 228:19,22 229:10 234:20 241:10 306:6 398:10 408:21
waiting-for-the 220:5
waits 130:20
waiver 82:12 84:5
waivers 82:14 83:18,21 84:3,9
walk 54:13 57:9 62:12 433:7
walked 25:6
walking-wounded 55:8
walks 291:12
wall 47:12 50:16 53:22 68:3
waning 169:13
want 25:10 26:3,11 26:17,22 27:13

30:6 33:18,19
34:3,21 35:20
36:12,20 37:11
38:2,11,16,18
39:18 40:4,18
41:14,22 42:9
44:12 59:17 61:19
84:12 85:1 92:2
95:18,21 98:13
105:7 108:3 109:3
109:14 113:16
120:12,16 121:17
121:20 124:5
141:14 146:1
150:13,22 153:19
155:2,4 160:5
166:17 170:9
171:7 172:2
178:22 179:5
184:2,4 185:20
186:11 188:13
189:15 191:3,6,8
191:16 193:19
195:12 197:20
202:1,4 204:10,14
212:10 215:19
217:15,16 225:1,6
227:3 229:7,15
234:6 238:7
240:21 241:17
244:19 252:13,14
254:2 257:15
260:7 262:16,21
263:21 266:4
275:9 277:11
282:11,12 283:10
283:11 286:11,15
291:17 292:3
296:21 303:7,9,18
304:11,22 312:20
321:12,15,22
327:20 329:9
330:4 332:17
335:4,17 336:6,20
345:9 346:6,8
349:5 351:5,7
362:14 367:19
378:8,17 381:12
390:8 391:10
392:13 395:4
397:4 399:19
401:4 406:14,17
412:22 420:14
422:8,13 423:18
424:1 425:19
426:17 427:17
433:1
wanted 30:5 42:19
43:7 119:20 120:1
120:20 121:19
153:18 163:5
164:7 184:6
186:10,19 189:5
189:14 196:11
216:16 237:4
250:19 257:20
264:14 268:15
269:2 282:17,18
290:13 307:6
318:4 321:1,3
326:1 331:20
340:20 343:5
346:18 356:18
357:11 367:22
368:3 370:4
406:11 409:7
426:1 427:1
431:22 432:6
433:9
wanting 142:4
wants 432:14
ward 270:13
wards 271:18 274:6
Washington 1:20
2:10,13 22:22
23:10 89:17
wasn't 60:16 79:6
116:14 141:1
158:4 198:12
211:15 231:9
270:4 289:14
297:4 355:22
356:9 398:13
watch 247:6 290:8
watercooler 416:21
wax 180:12
waxing 169:13
way 9:3 32:5 41:2,5
41:14 70:15 71:5
79:8 80:20 84:7
84:15 85:11 87:15
88:13,16 91:21
97:12 98:17,21
99:4,12 102:20
104:5,15 105:16
113:2,7,11,17
115:9 119:16
125:7,8,11 126:17
127:17 132:9,11
134:10 136:1
137:20 138:3
140:12 151:4
153:21 156:3
159:9,15 162:6
176:13 179:9
180:1,21 185:13
191:5 193:3 197:2
202:14 205:9,22
208:19 211:4
218:18 220:21
224:3 232:1
238:12 241:16
252:3 260:3
266:14 267:9
269:13 270:5
275:22 276:4
282:15,16 283:6
284:2 286:9
293:15 294:15
296:18 304:17
306:22 309:9,11
309:18 312:1,9,19
313:14 314:8
318:12 329:3
330:10 332:14
337:11 338:7,10
346:20 351:15
353:8 359:18
365:14 367:15
368:5,21 369:2,10
369:17,19 373:14
380:9 386:12,13
386:15 389:11
391:4 396:3 399:5
407:9,18 408:12
411:7 425:3 427:5
429:14
ways 68:15 78:9
85:8 86:9 95:11
95:12 97:6 140:16
141:4 142:14
175:13 179:7
184:14 185:4
192:2 197:19
211:8 223:13
257:17 283:17
300:10 306:21
323:16 347:13
391:5 403:22
404:21 412:9
414:7,16 417:11
424:4 430:5
weak 312:13
weaknesses 96:18
wean 73:13
weaning 73:11
weave 67:13,14,15
Weber 2:23 14:5,5
80:7 129:21 179:3
216:15 237:2
251:19 259:4
268:7 272:14
273:7 276:2 277:1
278:15 279:1,5
282:4 284:6 285:8
285:14 286:8
294:1 307:15
316:9 326:7 351:5
352:17 353:1
Weber's 84:13
website 182:13
WEDNESDAY
1:12
weeds 205:18
403:19
week 20:3 56:22
57:2 104:9 251:13
274:19
weeks 73:12 382:18
432:22
week's 149:6
weigh-in 189:15
weird 135:22
142:18
welcome 4:4,7 8:4
8:11 9:2
well-connected
340:7
well-designed
226:13
well-established
135:21 234:16
well-formed 77:18
77:20,21
went 104:20 112:4
122:7,7 188:20,21
241:6 268:10
269:7 276:11,17
322:6,6 398:8
weren't 139:14
270:11
Wes 2:8 16:5 78:7
113:15 124:7
204:9 207:17
215:18 234:5
239:3,19 265:12
279:12 291:9
309:3 329:7 346:6
350:12 383:7
410:8 424:11
431:5
west 144:8
We'll 72:9
whatnot 163:19
420:12
wheels 62:14
274:16 354:21
whichever 336:10
white 15:15 63:18
65:12,16 66:8
68:13 69:17
421:14,15
white-space 65:10
wide 32:14 35:1
263:15 333:17

willing 109:12 135:16 136:9
willingness 147:20 148:13
wind 180:8 429:16
window 182:21 261:5 338:12
wish 274:20
Women's 20:22
wonder 71:14 72:12 109:22 128:1,6 142:20,21 160:18 352:14 357:5,15 392:9,20 396:18
wondering 63:17 63:18 79:1 108:10 150:14 151:3 197:12 205:13 356:22 394:10
wonders 382:16
Wood 20:12 22:17
word 152:2 229:7 254:5
words 102:12 249:19 285:16 337:6
wordy 74:2
work 11:4 12:7 14:8 15:14 17:7,8 17:10 18:8 20:2,5 20:19 22:4 23:3 28:15 29:12 30:18 34:7 35:22 36:6 40:13 41:8 43:22 49:11,14 60:22 76:11 84:16 87:1 87:4,20 89:12 90:9 97:18 102:3 103:2 105:6 106:14 112:12 114:14 127:21 128:20 133:3 144:15 149:7 150:16 151:8 152:17 153:10 174:8 181:20 182:11,17 183:6 192:15 194:2 209:19 219:16 236:6 253:6 272:6 272:6 273:16 287:5 290:18 294:10,14 297:20 324:17 345:2 351:16 368:21 370:2 380:17 387:8,11 411:6,9 413:1 416:18 423:6 425:7 426:15,19 427:1 427:10,11,15,18
workable 412:17
worked 14:2 19:3 85:5 111:21 112:15 251:5 272:1
working 9:5 13:2 15:21 32:19 105:9 131:15 132:4 135:3 157:18 158:7 175:16 182:12 235:6 265:14 328:5 334:3 350:10 369:12,19
workload 396:20
works 84:4 88:8 89:14 104:19 134:5 178:1 263:19 276:4 344:2 363:8
workup 217:9,17 253:10 286:12,17
workups 219:10 286:14
world 28:22,22 38:14 94:17 96:8 97:22 102:5,17 106:15 109:13,15 118:22 121:5 127:4 195:11 254:6 266:7 364:10 392:16 393:5 396:1 409:10 429:4
worlds 29:2 120:6
worried 96:5 115:10 230:3 410:1
worry 139:15 178:11 421:14,20
worse 250:5
worst 262:17 299:16
worth 34:6,8 110:2 171:21 173:1 227:2 236:22 279:15 280:21 281:11 320:19 326:12 334:2 352:4 361:16 379:5 388:2 397:15 401:7 403:16 407:11,12
worthwhile 251:9
worthy 149:21
wouldn't 208:17 244:19 262:15 271:4 283:18 302:14 303:7 356:20 374:12 393:13 402:16 403:4 404:5
Wow 228:22
wrap 106:11 432:6
wrapped 221:8 230:6,13
wraps 296:12
wrestle 102:17
write 223:17 284:1 340:16 353:18 370:8
writes 54:8
written 123:6 169:5 242:13 266:15 303:7 317:21 356:1,2
wrong 104:21 151:4 214:8 256:12 341:22
wrong-side 394:15 398:22
wrote 307:16

X

X 155:4,5 293:18
X-axis 141:6

Y

Yale 2:23 20:13
yeah 404:4,4
year 9:8 13:8 20:17 46:10 62:10 161:19 219:3 256:4 372:1 431:1
years 9:7 12:12 16:11 24:5 29:15 33:2,4 36:5 45:3 50:15 58:2 92:15 101:5 149:2 161:17 173:21 191:21 205:1 219:7,8,19,22 227:9 237:16 288:22 314:14 426:7
York 60:9 101:14 142:2,3
Young 20:22
Y-axis 141:7

Z

Z 29:8
Zealand 131:16,18 278:4 284:11
zero 229:20 285:11

$

$1.5 66:3
$1.8 66:3
$2.1 66:3
$2.5 64:14
$200 65:4
$350 64:13,18 67:7 431:8
$60,000 65:3,5

1

1 1:1 170:14 183:5 187:18 263:4 311:15 373:1 401:17 432:9
1,000 58:6
10 4:12 6:24 75:1 113:18 206:9 215:3 219:22 306:7,19 307:13 307:16 315:3 321:17
10-bed 253:13
10-hour 215:15
10-to-20-percent 114:21
10:30 122:7
10:54 122:8
100 65:14 70:13 83:10 93:1
100-bed 253:15
1030 1:20
104 5:12
105 336:9
106 336:9
11 306:19 317:11
11:57 188:20
110-percent 333:19
1135 82:12 83:18 83:20 84:3,5,8,9
12 100:16 326:16 326:21
12-hour 326:15
12:48 188:21 189:2
1200 247:8
122 5:13
13 100:17
15 46:6 97:21 279:4
15th 1:20
15-minute 321:13
16-percent 161:21
1600 396:3
1600-bed 396:2
17 1:13
18 116:12
187 5:15
188 5:13
190 5:17,19

196 5:22,24
197 5:20
1986 135:5

2

2 2:1 113:19 129:11 129:11 132:17 170:15 220:14 291:8 311:15 401:17
2.5 395:11,15
2:56 322:6
20 50:4,5 51:10 61:7 68:3 69:16 71:16 72:5 73:21 74:2,6 104:3 109:3,6 110:11 113:18 119:17 129:11,12 132:17 213:16 267:12 375:10 376:13 382:21 383:20 384:11,13 400:3 400:17,22 404:3 405:17
20,000-visits-per... 244:4
20-percent 52:9,19 53:16 376:9 382:22 399:18,20
20-some-odd 380:20
200 58:5 65:15 74:5 74:10
2003 111:22
2004 268:11
2006 53:3
2008 190:10 193:10 198:12 216:1 224:15 241:15 274:11
2009 101:8 161:21
2010 269:10
2011 46:6
2012 1:13 45:1 234:8
220 6:5,7
23 116:17 274:3
24 4:16,18 366:13
24-hour-plus 281:3
240 6:8
243 6:9
25 116:16 192:6
25-percent 161:20
267 6:10
268 6:14
27 4:20
272 395:11
286 6:15
288 6:17
297 6:18,20

3

3 3:7 275:20 290:5 290:6,7 291:8 311:15 342:10
3-percent 80:12,19
3:15 322:4
3:18 322:7
30 4:22 103:6 275:20 291:16
300 6:21
301 6:23
315 6:24,26
3200 396:5
322 7:4
343 7:6
371 7:8
374 7:12

4

4 4:1 147:2
4.9 53:13,18
4:30 117:17
40 103:6 246:20 295:17,20 383:20
400 58:5
42 4:12
425 7:15
43 5:4,6
431 7:19
432 7:22
44 5:7,8
45 116:21
48 274:3
495 206:8 216:4
496 206:8
497 206:8 208:5 216:5,16 225:17 228:15 284:20

5

5 5:1 80:12 268:16 268:19
5-percent 80:19
5:02 433:17
50 158:2 217:9,9 376:8
50-car 83:10
55-minute 202:2 212:2
58 5:10

6

6 6:1
60 158:2 247:1
60,000 128:12
60-percent 333:21

7

7 6:15 7:1 183:5,10 286:18
70 333:21
72 366:12

8

8 4:4,7,8 45:6 275:5
8:30 1:21
8:44 8:2
80 45:14 66:10,20 69:17 70:20,22 205:22 213:15
80-year-old 224:18
87 5:11

9

9 4:10 6:21 196:16 300:6,9 304:19 307:16 330:6
9th 1:19
90 45:14 51:1
90th 274:13,22 275:6 297:14 298:5,6 299:9 363:13
90-percent 417:5
90-second 429:20
95 220:1 268:16 269:20 284:10
95-percent 417:5
97 220:1
98 268:11,13 283:20
99th-percent 271:9

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Regionalized Emergency Medical Services Expert Panel Meeting

Before: NQF

Date: 10-17-12

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