NATIONAL QUALITY FORUM

\+ + + + +

RISK ADJUSTMENT AND SOCIOECONOMIC STATUS OR SOCIODEMOGRAPHIC FACTORS EXPERT PANEL MEETING

\+ + + + +

THURSDAY

JANUARY 16, 2013

\+ + + + +

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., Kevin Fiscella and David Nerenz, Co-Chairs, presiding.

PRESENT:

KEVIN FISCELLA, MD, MPH, University of Rochester, Co-Chair
DAVID NERENZ, PhD, Henry Ford Health System, Co-Chair
JEAN ACCIUS, PhD, PMP, AARP
ALYCE ADAMS, PhD, MPP, Kaiser Permanente Division of Research
MARY BARGER, PhD, MPH, CNM, FACNM, American College of Nurse-Midwives
SUSANNAH BERNHEIM, MD, MHS, Yale-New Haven Hospital/Center for Outcomes Research Outcomes
MONICA BHAREL, MD, MPH, Boston Children's Hospital
MARY BETH CALLAHAN, ACSW, LCSW, Dallas Transplant Institute
LAWRENCE CASALINO, MD, PhD, Weill Cornell Medical College
ALYNA CHIEN, MD, MS, Boston Children's Hospital
MARSHALL CHIN, MD, MPH, University of Chicago*

MARK COHEN, PhD, American College of Surgeons
NANCY GARRETT, PhD, Hennepin County Medical
Center
NORBERT GOLDFIELD, MD, 3M HIS
ATUL GROVER, MD, PhD, FCCP, Association of
American Medical Colleges
DIONNE JIMENEZ, MPP, Service Employees
International Union
STEVE LIPSTEIN, MHA, BJC HealthCare
GENE NUCCIO, PhD, University of Colorado
Anschutz Medical Campus
SEAN O'BRIEN, PhD, Duke University Medical
Center
PAM OWENS, PhD, AHRQ
NINEZ PONCE, MPP, PhD, UCLA Center for Health
Policy Research
THU QUACH, PhD, MPH, Asian Health Services
TIA SAWHNEY, DrPH, FSA, MAAA, Illinois
Medicaid
NANCY SUGG, MD, MPH, University of Washington,
Harborview Medical Center
RACHEL WERNER, MD, PhD, University of
Pennsylvania

NQF STAFF:
TAROON AMIN
HELEN BURSTIN
ANN HAMMERSMITH
KAREN PACE
SUZANNE THEBERGE
LINDSEY TIGHE

* present by teleconference

A-G-E-N-D-A

Welcome, Goals, Review Agenda,
Recap of Day 1, Clarifications 4

Principles and Goals that Should be
Encompassed in the Recommendations 8

Public Comment 104

Breakout Groups to Discuss Potential
Recommendations

Report-out from Small Groups 147

Discussion of Top Recommendations - Working
Toward Consensus 198

Next Steps 278

1 P-R-O-C-E-E-D-I-N-G-S
2 8:33 a.m.
3 MS. PACE: Good morning. Thank
4 you all for coming back. Hope you had a nice
5 dinner and looking forward to more stimulating
6 discussion today. So I'm going to turn it
7 over to Kevin.
8 CO-CHAIR FISCELLA: Good morning
9 and welcome back. Do we have a revised agenda
10 here? I was just going to review the agenda
11 for the group first.
12 MS. PACE: Okay, right. I can say
13 it and then --
14 CO-CHAIR FISCELLA: Okay, go
15 ahead.
16 MS. PACE: So we're making some
17 adjustments today based on how far we got
18 yesterday and thinking about how to best use
19 our time with you today.
20 So what we're going to do is start
21 with kind of a straw man on the question of
22 whether to adjust for sociodemographic

1 factors. And Kevin will kind of lead us
2 through that and we'll kind of take the pulse
3 of where people are at.
4 And then Kevin is going to review
5 some key themes of what we heard from
6 yesterday and certainly have an opportunity to
7 add things to that, to just revisit our core
8 principles to see if there's anything that
9 emerged from yesterday that we need to add to
10 those.
11 We want to specifically then have
12 some discussion about the how question of
13 approaches because that's the section we
14 really didn't get to yesterday. So kind of
15 start -- we had some peripheral discussion but
16 the pros and cons of statistical risk modeling
17 versus stratification within an organization,
18 stratification by -- organizational
19 stratification.
20 We're going to then do some
21 breakouts but we'll -- I think right now, and
22 this may change depending on how our

1 discussion goes, but we'll have three breakout
2 groups. One to kind of tackle drafting some
3 recommendations specifically about the "what"
4 sociodemographic factors, some of the issues
5 about definition, what's existing today versus
6 future.
7 Have a group addressing kind of
8 the "how" question about approaches. Again,
9 statistical stratification, et cetera.
10 And then have a group talk about
11 recommendations related to some of the
12 contextual issues. Are there differences by
13 type of outcome? Are there differences by use
14 of the outcome performance measure to bring in
15 some -- have some discussion about that. So
16 we'll revisit that when we get to that point
17 but that's our thinking for now.
18 So Kevin, anything to add to that?
19 CO-CHAIR FISCELLA: No, no, I
20 think that's a nice summary.
21 MS. PACE: Okay.
22 MEMBER CASALINO: Karen, quick

1 question.

2 MS. PACE: Yes?

3 MEMBER CASALINO: If the group

4 were to decide that the door should be open

5 regardless of whether it has to be walked

6 through or not does it make any sense to have

7 any discussion at some point about what are

8 the kind of things that NQF would like to see

9 addressed by people saying yes, we think we

10 should, or no, we think we shouldn't add some

11 kind of SES adjustment for this measure? So

12 what kind of things should proponents of a

13 measure bring forward --

14 MS. PACE: Yes.

15 MEMBER CASALINO: -- if they want

16 to do it.

17 MS. PACE: Absolutely. And that's

18 a good, absolutely good point. And I know it

19 came up a couple of times yesterday that if we

20 go down this path we have to be more specific

21 about measure developers, what their

22 expectations are going to be, and also

1 guidance for our committees and members about
2 how to evaluate that.
3 So we can either think about that
4 as a separate group or in the kind of "how"
5 approaches. It might go best with that group.
6 But make sure that we keep that in mind when
7 we start talking about these breakout groups
8 and what the charge will be. Thank you.
9 CO-CHAIR FISCELLA: You're
10 probably wondering where David is. He had a
11 last-minute snafu with MedPAC and has to be at
12 MedPAC this morning. He'll join us later this
13 afternoon.
14 I want to encourage those who
15 haven't spoken very much yesterday to really
16 speak up and share their perspectives. That's
17 the point of assembling such a diverse group
18 is really to hear from everybody. So, please
19 weigh in.
20 So, what we would like to do is to
21 have a little more discussion around these
22 three options. I think our sense from the

1 group is that we're really down to the two or
2 three. Certainly if people see it differently
3 feel free to voice that.
4 But seeing if -- where the group
5 comes down on whether the door should be just
6 opened or whether we are actually saying you
7 really should enter. So let's begin that
8 discussion.
9 MS. PACE: So I guess one thing we
10 could do is, I mean certainly I think we want
11 to see if there's any other options we need to
12 consider here. But then maybe we need to just
13 do a straw poll and see where we're at. Does
14 that make sense?
15 CO-CHAIR FISCELLA: Yes, I agree.
16 I think we wanted to have a little discussion
17 and then actually do a straw poll vote. But
18 I know it's early in the morning.
19 MEMBER CALLAHAN: Kevin, this is
20 Mary Beth on the phone.
21 CO-CHAIR FISCELLA: Yes.
22 MEMBER CALLAHAN: Please tell me

1 if I'm out of order at this point in time.
2 But this is perhaps crystal clear in everyone
3 else's mind, but I wonder if it's all or
4 nothing.
5 And you know, our -- from what I
6 understand, and again I may be off course here
7 so please help me get back on course.
8 But socioeconomic status is kind
9 of differently by different organizations.
10 And I know our charge says socioeconomic
11 status or other sociodemographic factors. But
12 that's pretty vague. And that may not be
13 causing anyone else any problems, but I don't
14 know if we have kind of a boundary -- and we
15 may not want a boundary. That may be
16 purposeful.
17 But if we even have a hold on what
18 we as a group are talking about as
19 socioeconomic status and then what the other
20 socioeconomic factors are. And I don't know
21 if that would be helpful.
22 And then the second point is is it

1 an all or nothing. So, perhaps that's crystal
2 clear to everyone else but it would help me to
3 just kind of garner that. Thanks.
4 CO-CHAIR FISCELLA: I think that's
5 a great question to pose.
6 I think in terms of the all or
7 nothing, as I understand the way Larry framed
8 the question -- Larry can correct me since he
9 posed it this way -- is that the "should"
10 means the onus would be on the measure
11 developer to argue why a socioeconomic status
12 shouldn't be in a measure or not based on a
13 variety of considerations, the published
14 literature, empirical considerations, concerns
15 for unintended consequences, et cetera.
16 So, it wouldn't mean -- so the
17 "should" doesn't mean you would always have to
18 consider sociodemographic factors here. Am I
19 stating it correctly, Larry?
20 MEMBER CASALINO: Yes, Kevin, I
21 mean you're stating it as I stated it
22 yesterday, as I was thinking of it until 30

1 seconds ago. But actually as you talked it
2 did occur to me that this third possibility,
3 it could be posed in different ways.
4 It could be you need to address
5 whether the measure, some SES measures should
6 be in or not, and here's the kind of ways to
7 address it. That's kind of the way I've been
8 thinking about it.
9 But I suppose there could be an
10 option which would be the expectation is that
11 you will address it unless you kind of show to
12 us why you shouldn't. And I'm not arguing for
13 that, but that is slightly different than just
14 saying you have to address it but we don't
15 have a prior about whether -- whether the
16 default is that it's going to be in or the
17 default is going to be out.
18 MEMBER GOLDFIELD: So, I
19 highlighted this yesterday I think as another
20 approach which comes of the heritage of how we
21 develop our models.
22 I think there can be and I believe

1 there should be a recommendation that we are
2 absolutely committed to looking at SES. And
3 I think there should be a recommendation at a
4 federal level what we're doing at a state
5 level which is to say that there should be a
6 recommendation that CMS collect -- and for me
7 the poster child example is homelessness which
8 I've already highlighted -- that a well-
9 collected database in one state or in one
10 program. And that developers then can test
11 that.
12 Because I think part of the
13 problem that we had, or the challenge that we
14 had yesterday, there were all these different
15 research studies that did or didn't show, and
16 there were discussions was it valid or not
17 valid. So the way we look at the world as
18 developers, let's collect a data element
19 validly, consistently in a good database in as
20 expeditious manner as possible. And I
21 highlighted yesterday you could do this for 6
22 months in a state.

1 And then NQF could encourage as
2 part of the preamble to look at these issues.
3 And part of that would be a recommendation to
4 collect it in a consistent manner. So that
5 would be another option I think.
6 MEMBER NUCCIO: I was wondering if
7 number 3 might be phrased a little bit
8 different. Instead of "must be considered"
9 have it "should be considered."
10 That is, the idea would be that --
11 and I'm thinking of this having gone in front
12 of the review boards for measures, from the
13 perspective of the person sitting on the
14 review board they're going to say did you
15 consider SES. I can easily hear that being
16 said.
17 And the developer should be able
18 to say yes, we did, and here's what we thought
19 about it, and here's what we investigated, and
20 we decided we didn't want to do it.
21 And that should be an acceptable
22 answer from the perspective of -- at least in

1 my opinion should be an acceptable answer from
2 NQF, that it's still up to the developer to
3 decide whether or not for the particular
4 purpose that they're working on that some
5 sociodemographic should be in there.
6 But if you say "should be
7 considered" then the requirement from the
8 developer's perspective is that in fact they
9 investigate it as opposed to leave it as an
10 unknown. And so I would argue that we should
11 put that as a requirement for the developer,
12 that they should consider but there's no
13 expectation that they do include that
14 information if it's not appropriate.
15 I mean there may be measures, I
16 mean functional measures may not be at all
17 appropriate in some circumstances as I
18 discussed with a few of you guys last night.
19 MEMBER LIPSTEIN: Since I'm not
20 familiar with developer and review panels, why
21 should the developer have that much
22 discretion? Because isn't there developer

1 bias involved? So why, if we make a
2 requirement that you must evaluate it, you
3 don't have to adopt it but you must evaluate
4 it, why would we want to give developers that
5 much discretion and that much authority?
6 What's the advantage?
7 MEMBER NUCCIO: We are saying they
8 should consider it. And I just, maybe I don't
9 like the word "must." They would be required
10 to investigate whether or not there's a
11 rationale, conceptual, clinical, you know, for
12 why a sociodemographic variable would relate
13 to this particular outcome.
14 And they should have an answer,
15 but it should always be up to the developer
16 whether or not -- and from my perspective it
17 should be up to the developer because they're
18 the expert on that measure.
19 The folks sitting on the panel
20 come from a whole variety of backgrounds. And
21 so you might be bringing a hospice example
22 measure. And there may be hospital people,

1 and there may be nursing home people, but
2 there may not be -- there may only be one
3 hospice person on a panel of whatever, 10 or
4 12.
5 MS. PACE: Right. And I think
6 this may be a place to just interject a little
7 bit more about the NQF measure submission and
8 evaluation process for those who haven't been
9 involved.
10 We have specific criteria which we
11 mentioned yesterday, some around risk
12 adjustment, and we have specific standard
13 questions that we ask the developer to provide
14 information and analyses on for the steering
15 committee to review.
16 So this is actually consistent
17 with our approach to risk adjustment of
18 outcomes in general. So, our approach is that
19 generally outcome measures need to be risk-
20 adjusted, but a developer could, based on the
21 particular type of outcome, come in and say
22 this measure doesn't need to be risk-adjusted

1 because of X, Y and Z.
2 The evidence is that every patient
3 should be able to achieve this regardless of
4 other factors. Or our analysis showed X, Y,
5 Z. So, there are unintended consequences,
6 whatever.
7 But the little nuance here is that
8 the developer comes in with their best
9 approach and it is reviewed by a steering
10 committee and then a larger audience. So,
11 just because the developer reached a
12 conclusion doesn't mean that everyone would
13 agree with that conclusion and that's where
14 the whole process is about, you know, to have
15 discussion. Given the data and the analysis
16 and the rationale and the evidence do we reach
17 consensus that that was the right approach.
18 MEMBER LIPSTEIN: Is there only
19 one developer per measure?
20 MS. PACE: It tends to be one but
21 oftentimes there are multiple working on one
22 measure.

1 The complicated thing is when we
2 have multiple measure developers working on
3 basically the same measure but taking
4 different approaches. And then we have
5 discussions about competing measures and which
6 approach would be the better approach.
7 MEMBER CHIN: This is Marshall. I
8 think that we're starting to get back to the
9 challenge of the "for what purposes," sort of
10 like what Alyna talked about yesterday.
11 I can imagine that the measure
12 developer, unless there's clear instructions
13 about why there is the possibility of risk
14 adjustment for socioeconomic status could
15 think different things.
16 I think actually like one of the
17 three breakout groups is going to be the
18 context one, same issue, that we have to find
19 a relatively concise way to guide both the
20 developers as well as I guess the various
21 review committees.
22 So, in particular the developer

1 shouldn't have to reinvent the wheel each
2 time. So, thinking through this process.
3 Because I can imagine them
4 thinking well, you know, coming to different
5 conclusions about whether they need to risk-
6 adjust depending upon what in their mind is
7 the purpose for risk adjustment.
8 So this is an issue that I think
9 we're going to have to have a fairly nuanced,
10 potentially a tree-type diagram talking about
11 the different purposes of risk adjustment and
12 under what scenarios we want the developer to
13 think about this question about do they need
14 to risk-adjust.
15 Because otherwise then we get sort
16 of quite a bit of randomness from different
17 developers about whether they decide to
18 address it or not depending upon what is their
19 perspective or their understanding of why this
20 question is even in there.
21 MS. PACE: And again, I'll just
22 mention that our current process is that

1 measures that are submitted to NQF are under
2 the intended purpose of being used in
3 accountability applications as well as being
4 useful for improvement.
5 So, that context in terms of
6 measures being submitted for NQF for
7 endorsement is accountability applications.
8 And that's why we basically say risk-adjust
9 unless you can show us that it doesn't need to
10 be.
11 CO-CHAIR FISCELLA: But just to
12 follow up on Marshall's comment. Potentially
13 that could be part of the task group is that
14 sort of guidance to developers in terms of how
15 to make that consideration.
16 MEMBER GROVER: I was thinking
17 last night about -- I didn't dream about it,
18 but I had to think about it last night when I
19 went home. The slide that had usual
20 considerations for selecting risk factors, and
21 really thinking about it in the context of if
22 SES or other demographic factors are, in fact,

1 risk factors why wouldn't you count them the
2 same way you would diabetes or hypertension,
3 et cetera?
4 So, I think I come pretty strongly
5 down on the side of saying that if -- you
6 ought to be risk-adjusting for
7 sociodemographic factors unless there's a
8 clear reason why that they don't apply, such
9 as process measures.
10 So, if you say the time to
11 administration of antibiotics, or that kind of
12 thing, fine. We get that doesn't apply.
13 And to think about what those
14 factors are. I think we all would agree that
15 income is a significant issue here. Now, you
16 can't always collect that at the individual
17 basis and so where we can't using the best
18 Census tract information, hopefully not going
19 beyond the Census zip codes would be good.
20 I think we would agree that
21 homelessness adds another level of variability
22 there that can't just be captured in income.

1 And I think the discussion around
2 race yesterday was pretty powerful. And the
3 fact that I think in most cases it is picking
4 up the same thing as socioeconomic status.
5 But if we have issues like
6 perinatal outcomes where clearly we can't find
7 those differences based upon SES alone then we
8 ought to consider race.
9 So I think that you ought to go
10 towards option 3 saying that you have to at
11 least consider it, explain what the effects
12 are. And I would actually say go one step
13 further, that NQF ought to have a role as it's
14 implemented, particularly in payment policy
15 decisions.
16 Because I was very struck
17 yesterday by the MSPB discussion and the
18 developer that was on the phone. In reality,
19 MSPB is going to be somewhere hovering around
20 1 and if you're below 1 you're better than if
21 you're above 1.
22 But when CMS assigns the MSPB to

1 the value-based purchasing equation 25 percent
2 of VBP is going to be related to efficiency by
3 Fiscal Year 2016.
4 There's only one efficiency
5 measure and it's MSPB. And it gives it a
6 score of 1 to 10. So even if you are only off
7 by 0.14 or 0.05 it can make a big difference
8 in your score.
9 And I also feel like there's not
10 enough questions being asked about, well, who
11 is penalized, who are the providers, who are
12 the patients potentially being penalized if
13 you implement this measure in this way.
14 And again, as a hypothetical
15 example, 263 hospitals go down by a quintile
16 in the MSPB adjustment if you adjust for
17 Medicaid eligibility, right? Two hundred and
18 sixty-three hospitals, a tiny amount.
19 That's about the number of major
20 teaching hospitals in this country. That is
21 -- those hospitals, our teaching hospitals
22 deliver 20 percent of all the clinical care in

1 the country. So you might want to say, well,
2 it's only going to affect 263 hospitals.
3 But if it turns out that's
4 actually 20 percent of all the care being
5 delivered, that makes a huge difference.
6 And so I think there ought to be
7 consideration not only in the development of
8 the measure but in trying to urge CMS or other
9 payers, whoever is going to use this measure,
10 to think about whether the implementation is
11 going as it should.
12 CO-CHAIR FISCELLA: That could be
13 covered under the third work group under
14 contextual factors that we discussed.
15 But just to be sure, Atul, are you
16 suggesting a fourth, stronger option that the
17 group should consider here?
18 MEMBER GROVER: If you say it
19 always must be considered, you know, I'm a
20 little uncertain saying, you know, you give
21 all the power to the measure developers to say
22 one, two, three groups of individuals to say

1 that they're going to be the final arbiter of
2 whether or not sociodemographic factors ought
3 to be considered.
4 That makes me a little uneasy, but
5 at the same time I would think that going
6 through the NQF process if there is, first of
7 all, the ability to say yes, we can consider
8 these factors, and that you have to at least
9 present evidence to the NQF that you have and
10 provide a rationale and justification for why
11 in the end those are inapplicable, I could
12 live with that.
13 MEMBER OWENS: Can I add -- just,
14 it's building on Karen's comment and actually
15 Mary Beth's comment, so a couple of comments
16 before. But Atul, you actually came back
17 around to it.
18 Which is on the NQF process one of
19 the things that will need to be deliberated is
20 is this the appropriate SES measure or
21 construct. Because we haven't defined what
22 SES is. The things that we threw out are

1 actually quite disparate in what they're
2 representing from a concept standpoint.
3 And so you could envision a
4 measure developer that picks an SES developer
5 that picks an SES variable that in fact does
6 nothing, right? But that is not necessarily
7 what is intended.
8 So you've got to -- it's going to
9 have some implications for the review
10 committees. You're going to have to have
11 experts that understand socioeconomic status
12 and what that concept is as well as how it's
13 measured.
14 And there's going to have to be
15 deliberation about is this the appropriate
16 measure and is it appropriately used from a
17 methodologic standpoint, no different than the
18 other risk adjustments that we put in the
19 measure. So it's building on what you said
20 but trying to connect a few dots.
21 MEMBER SUGG: So I agree with most
22 of what's been said so far. I guess I just

1 fall on the I would like to be a little more
2 guiding in the developers as they develop it.
3 I'd really like to say if you are
4 doing this for public reporting then you must
5 look at socioeconomic status and give a viable
6 reason why you do not think it belongs in
7 there, as opposed to consider it. But really
8 a much more directed, we recognize that this
9 is important, especially in these particular
10 uses of these quality measures.
11 So I would favor 3 but with a
12 little more definitive statements about this
13 needs to very much be considered in these
14 particular instances.
15 MEMBER BERNHEIM: I just want to
16 go back to some of the very earliest
17 conversations we had yesterday because again
18 I think there are more than one way to
19 accomplish what this committee is interested
20 in.
21 And I want to remind people about
22 that first pathway that Kevin presented and

1 some of the risks that are involved in just
2 putting this into the model because you lose
3 information.
4 And again I want to go back to
5 this idea that if the goal is to be able to
6 account for the fact that some providers maybe
7 should have different expectations set or
8 should have different payment levels set risk
9 adjustment isn't the only option.
10 And do we want in this guidance to
11 explicitly talk about the advantages and
12 disadvantages of putting a risk adjustment
13 variable in. It's going to be the best one
14 they have but it may well not be exactly the
15 right one and then the measure just stands
16 with that risk adjustment variable in and
17 there's a lot less information for everyone,
18 including patients which we have not mentioned
19 enough in this room.
20 But these measures are intended to
21 improve quality for patients but also give
22 patients information. Versus suggesting the

1 developers need to look at a measure that's
2 unadjusted but how the different strata of
3 hospitals perform and consider whether or not
4 those strata of hospitals with a non-risk
5 adjusted measure should be treated differently
6 in reporting or accountability practices.
7 And so I just want to keep
8 bringing us back to that because I do think
9 that there's a loss of information when we
10 risk-adjust. And if we just sort of throw it
11 all into the risk adjustment bucket without
12 going back to that concept we may not land
13 where we want to.
14 CO-CHAIR FISCELLA: When we're
15 talking about risk adjustment we're using it
16 in the broad sense of including stratification
17 as a type of risk adjustment.
18 MEMBER BERNHEIM: Okay, so can I
19 just say one last thing on that? Because
20 again, when people say risk adjustment and
21 stratification are the same thing they usually
22 mean if you stratify and calculate the measure

1 separately in two different strata, because
2 then you really are setting different
3 standards in the same way you are with risk
4 adjustment.
5 When I'm talking about it I mean
6 more the way MedPAC talked about it which is
7 that you calculate the measure, you're really
8 not risk-adjusting. It's not the same thing.
9 You're calculating the measure across -- Karen
10 looks like I'm saying something wrong. So can
11 you?
12 MS. PACE: No, no, I just -- I
13 agree we need to get the language right. I
14 think in the broader context of if you're
15 talking about accounting for differences in
16 the sociodemographic factor, if you kind of
17 think of that as the broadest way of thinking
18 of adjustment then stratifying organizations
19 for comparison groups in a sense is
20 accomplishing that.
21 If we can come up with some better
22 terminology for that, or whether you think

1 that that shouldn't be on the table and that's
2 strictly an implementation issue. I think the
3 way we were going is that that would be a
4 method of organizing the data to achieve some
5 of the purposes we're talking about. But how
6 we term that is another thing.
7 And conceivably that could be part
8 of the specifications, even though that would
9 happen after the kind of clinical risk
10 adjustment.
11 And the other thing I just want to
12 mention is that we don't in any way think that
13 this is a recommendation that would stand
14 alone. We will be asking you specifically to
15 make recommendations about approach.
16 So if this group decides that the
17 approach is, you know, clinical risk
18 adjustment and then using whatever term we use
19 for it to put providers in comparison groups,
20 that can be a recommendation.
21 So I just, you know, and I don't
22 know if there's a better way to do it, of

1 talking about these individually, but this is
2 not intended to be a stand-alone. There will
3 be other recommendations out of these other
4 questions.
5 MEMBER CHIN: This is Marshall. I
6 think that's a great comment you just made.
7 It somewhat makes me think about one of
8 Larry's first comments yesterday where I think
9 very early on he sort of made a summary where
10 I think that's probably where it would be
11 headed, where it was looking at stratified
12 data, but within strata, this stratification.
13 So you don't give the poor the bad hospitals
14 within a given strata a free pass.
15 But in some ways it's a level of
16 complexity that does get this issue of do you
17 do things through these individual, each
18 individual measure that people are submitting
19 and being approval and having some complicated
20 language about. When do you have strata, when
21 do you have more of a risk adjustment formula
22 versus just a global approach at NQF towards

1 how do you address issues of equity and
2 disparity.
3 So for example, I can imagine sort
4 of separate from the measurement review
5 process that there are formal recommendations.
6 This is why I can't ask for formal
7 recommendations. That NQF says well, to
8 address equity issues we recommend that -- we
9 want to make sure that we don't penalize the
10 under-resourced hospitals but we don't want to
11 give people a free pass. Therefore, we're
12 recommending that you look at it these two
13 ways or three ways.
14 I mean, people have mentioned
15 unadjusted, stratified and then sort of risk-
16 adjusted within strata.
17 And so I guess the question for
18 NQF staff. When it starts to get to that
19 level of complexity just like in the prior
20 comment talking both strata as well as
21 potential risk adjustment beyond
22 stratification is that sort of a separate

1 process where there's sort of a general
2 recommendation about how NQF recommends
3 approaching risk stratification? Or does that
4 all need to be built into what we're talking
5 about now so that all these concepts if we
6 decide to go this way are brought into what an
7 individual developer needs to think about and
8 be approved for when they submit an individual
9 measure for review?
10 MS. PACE: I think we're open to
11 either approach. And the question is how
12 confident we are that a specific directive
13 will really be applicable across the types of
14 outcomes, settings and uses versus more laying
15 out principles in terms of things that need to
16 be done, analyzed and presented.
17 But that's why we're having these
18 discussions of if there's a strong thinking
19 and rationale that a particular approach is
20 the way to go then we need to make that
21 recommendation and put it out there for
22 comment and see what others think about it.

1 So we're open to either way, more
2 directive and more open. And I think our
3 discussions with you will lead us in one
4 direction or another.
5 MEMBER BERNHEIM: The one thing I
6 will say is that from the perspective of
7 developers and steering committees and NQF I
8 actually think if you're opening the door it's
9 much better to do 3. I think you have to give
10 people a way to say this is why we're not
11 doing it. But I think it gives a committee
12 more information.
13 And this is already in the NQF
14 application. I mean, nobody's really
15 discussed this, but just so people know, we
16 are expected when we submit things to talk
17 about the evidence in the literature of
18 disparities in this area and any data that we
19 have, and discuss why or why not the measure
20 is stratified. That's already in the NQF
21 application. So in some ways this would just
22 be strengthening that.

1 And I think having guidance that's
2 not so restrictive that nobody can ever get a
3 measure through but that's consistent, so that
4 each measure developer is expected to come and
5 say we thought about SES, we considered these
6 variables because they're the right variables,
7 or because they're whatever, and we didn't
8 consider these, and here's what we saw and
9 here's what we decided.
10 The committee who's trying to
11 decide has much more information. So, despite
12 my talk about stratification and whatever
13 else, I feel like if -- I think the only thing
14 that makes sense if you're not doing 1 is 3.
15 Because otherwise I think you just
16 get committees that have some information from
17 some developers than others, and it's just too
18 hard for the committee members.
19 MEMBER GOLDFIELD: Could I just
20 respond specifically. I just want to say for
21 the record that I'm opposed to reliance on
22 risk stratification. But it depends on the

1 socioeconomic variable in question.

2 So there are certain socioeconomic

3 variables, and again, I'll say again,

4 homelessness for me is a clinical

5 characteristic, period. There's no ifs, ands

6 or buts.

7 And I believe NQF should encourage

8 in as strong terms as possible that there are

9 variables that we should be able to vote on

10 that pass the smell test, and the clinical

11 test, and whatever other test we want. That

12 should be part of the risk stratification,

13 period. That should be part of the risk

14 adjustment, I'm sorry.

15 There are other measures that we

16 may not feel as strongly about that could be

17 part of the risk stratification. My concern

18 in my risk stratification is that for me it

19 just becomes politicization. Because there

20 are many, many, many different ways of doing

21 risk stratification. I as a clinician, I as

22 somebody who works with these patients, I as

1 a developer believe that there are some
2 socioeconomic variables that are -- must be
3 part of risk adjustment and NQF should step up
4 to the plate on that.
5 CO-CHAIR FISCELLA: Let me just
6 interject here for a moment. We're going to
7 have broader discussion around the methods and
8 the pros and cons of risk stratification, but
9 we want to stay a bit more focused on the
10 question really at hand here on this really
11 straw man poll around the different options.
12 And unless you have just a very
13 brief clarifying point we'd like to try to
14 stay in order. Dionne, is yours up? Are you
15 next?
16 MEMBER JIMENEZ: Well, it's either
17 Sean or I.
18 CO-CHAIR FISCELLA: Yes, we're
19 just going in order so go ahead.
20 MEMBER JIMENEZ: Well, I had sort
21 of a clarifying question around for measure
22 developers in terms of knowing what

1 accountability -- when they're developing a
2 measure do they know what accountability
3 application their measure might be used for?
4 So, I mean it's obvious that the
5 Medicare spending per beneficiary is going to
6 be used for value-based purchasing program,
7 readmission --
8 CO-CHAIR FISCELLA: Can you try to
9 talk into your mike?
10 MEMBER JIMENEZ: Oh, sorry. So,
11 we know like certain measures might be used
12 for certain types of accountability
13 applications, but do measure developers know
14 that in advance going in? Because I think
15 that's an important clarifying question to me.
16 I'm definitely leaning more towards number 3
17 but we definitely want to see an SES
18 adjustment when it might be used for a payment
19 program, but it may not necessarily -- we may
20 not necessarily say you must do this for
21 patient reporting. So that's one thing I was
22 curious about.

1 MS. PACE: So, a lot of times they
2 do because CMS may have contracted with the
3 developer to develop a measure for a specific
4 program use. But, again I'm going to
5 challenge that assumption that you would do
6 things differently public reporting versus
7 payment in terms of if we think about in the
8 general sense of is it a reliable and valid
9 indicator of performance why would it be
10 different for public reporting versus pay-for-
11 performance.
12 Now, obviously there's a lot of
13 things that once you have a computed measure
14 what's done to it in a policy way in terms of
15 how that's going to be used and what weight is
16 going to be assigned to it for rewards or
17 penalties is another issue.
18 But if we talk about baseline do
19 you have a reliable and valid indicator of
20 performance is there really a difference
21 whether you're publicly reporting it where
22 people are making conclusions, or making

1 conclusions in another context. So, there
2 could very well be but I'm just going to
3 continue to challenge people to give us a
4 specific rationale why they would be different
5 so we can make sure that we logically move
6 down that path.
7 MEMBER O'BRIEN: So, when it comes
8 to having "must" statements about
9 methodological considerations for the design
10 of the measures I personally come down pretty
11 hard on wanting to avoid the "must"
12 statements.
13 I'd just make a comment that a
14 "must" statement was kind of what led this
15 group to be convened in the first place with
16 regard to the statement about always avoiding
17 inclusion of the sociodemographic factors.
18 And I just feel like I can
19 guarantee that you cannot possibly anticipate
20 all of the scenarios, considerations and
21 perspectives that would lead you to adopt a
22 different viewpoint.

1 And NQF convened a panel on
2 disparities and cultural competency recently.
3 And in that room there wasn't really
4 consensus. The idea being if you could
5 identify a variable that is a sociodemographic
6 variable, but if you knew somehow that its
7 impact on outcomes was purely what we're
8 calling biological, at that point it's just
9 obvious to everyone that you would want to
10 adjust for that variable.
11 And the answer is no, there is not
12 consensus in that group. Different groups of
13 patients that require different levels of
14 resources to achieve the same outcome, you
15 don't just necessarily want to accept that
16 just because you have such-and-such a
17 characteristic, we're just willing to accept
18 worse outcomes for you.
19 Out of issues of fairness and
20 justice sometimes you do more to achieve equal
21 results even if it requires more resources.
22 So I just don't think you can anticipate all

1 the scenarios.

2 So my personal flavor, how I'd

3 think about wordings and recommendations is

4 I'd separate out statements about, like advice

5 to developers about the issues they should be

6 considering and how to think about them.

7 And the "must" statements might be

8 what are they expected to provide in their

9 submission materials to NQF.

10 And the "must" statements that I

11 would include would be basically you need to

12 include discussion of these issues. So I'd

13 say something like -- I started jotting down,

14 I didn't really finish, but something in the

15 flavor of when performance measures are being

16 developed developers should describe the

17 proposed use and/or interpretation of the

18 measure, and they should ensure that the risk

19 adjustment is appropriate to support the

20 intended use for interpretation, and that

21 considerations for covariate selection should

22 include X, Y and Z where X, Y and Z are all

1 the ones that were on Karen's very nice slide
2 yesterday.
3 And that special consideration
4 should be given to sociodemographic factors.
5 And the potential for disparities and intended
6 and unintended consequences.
7 And then basically just insist
8 that developers include a discussion of their
9 philosophy and what they thought about when
10 deciding whether or not to include or not
11 include adjustment sociodemographic factors.
12 MEMBER ACCIUS: Thank you very
13 much. I think this conversation is very
14 insightful and fascinating.
15 I fall along the lines of "must"
16 in part because what the language, at least
17 the options state up here is that you must
18 consider it. It doesn't necessarily translate
19 that you must include it, that it has to be a
20 part of a consideration.
21 I worry that if we back away from
22 that language then it becomes quite murky and

1 confusing as to what the difference between
2 option 2 and option 3 is. And I guess it gets
3 back to Steve's point in terms of the amount
4 of discretion.
5 So, I think that that is something
6 that I am trying to reconcile in terms of
7 listening to this conversation. Because again
8 it gets back to what type of incentives, or
9 what type of messaging are we signaling to
10 developers.
11 And again, "must" and "should"
12 have different implications.
13 MEMBER CASALINO: To me I think
14 there's a lot of agreement in the room at this
15 point but we still have some lack of clarity
16 about language.
17 So to me the "must" statement
18 means what you just said. You must consider
19 it. It doesn't mean you must include SES
20 adjustment necessarily, and it certainly
21 doesn't mean, going back to Susannah's first
22 point, it certainly doesn't mean you must

1 include it and here is how you must include
2 it. You must include it as a variable in a
3 statistical model. I certainly wouldn't be
4 for that.
5 So, if that's true then and the
6 committee agrees on this then it seems to me
7 that one task today. I forget what the three
8 groups were supposed to be, but it seems to me
9 one clear task would be what is the guidance
10 that NQF would give to its review committees
11 and to developers about the kind of things
12 that ought to be considered in developing a
13 measure, and whether or not SES ought to be
14 included. So that to me would be one topic
15 for discussion.
16 But the other topic for
17 discussion. I'm only thinking of two and I
18 may be forgetting a third. We'll go back to
19 what Marshall said which is the potential use
20 of a measure. And I think we're all not
21 exactly on the same page in our understanding
22 about that either.

1 So, for example, when Karen says -
2 - Karen said why should there be any
3 difference between p-for-p and pay-for-
4 performance in a measure, I think I agree that
5 for the measure itself you might not want to
6 have a difference. But for the use of the
7 measure it's pretty clear to me that you
8 would. And along the lines, that's probably
9 the first thing I said yesterday which
10 Marshall was referring to.
11 So to me, there could be another
12 committee if NQF would be willing to consider
13 basically putting out guidance about -- which
14 is separate from measure development I think.
15 And maybe this is something that NQF hasn't
16 done, wouldn't be willing to do. But to weigh
17 in on considerations about how these things
18 might best be used in different kind of
19 situations. That would be a different kind of
20 process that I think is very important to the
21 group here and that a lot of our discussion
22 yesterday, especially in the earlier part of

1 the day, was about that.

2 Because we all see I think that

3 you really can't entirely separate the two.

4 And I would be unhappy, I think some other

5 people would too, if we just talk about

6 measure development and not at all about how

7 they're used. But you may not be willing to

8 do that. But that could be another group.

9 And I forget what the third would

10 be.

11 MS. PACE: Right. And actually

12 that would fit into our group about context.

13 And maybe we need to frame that about

14 implementation guidance. Because that's --

15 you're talking about once you have that

16 performance measure and it's the best

17 estimation of quality then how does it get

18 implemented in these various programs, the

19 uses, whether it's pay-for-performance.

20 MEMBER CASALINO: And is that

21 guidance, Karen, then for the developer to

22 make suggestions about how to use their

1 measure? Or is it guidance -- the developer
2 doesn't have to deal with it at all and it's
3 guidance for CMS for how they ought to do
4 things?
5 MS. PACE: Right. And I think
6 what I'm saying is that this group can make
7 some recommendations.
8 I'll just say in our current
9 process that NQF kind of has a line between
10 the measure and then its ultimate use. We
11 don't have a lot of control over that.
12 But that's not to say that we
13 can't offer some guidance about appropriate
14 use or implementation. And Helen, I don't
15 know if you want to add anymore about that.
16 But that's definitely a lot of discussion at
17 NQF about what NQF's role should be in that
18 realm, how that gets done.
19 It really does seem to be separate
20 from the measure development and maybe not the
21 responsibility of the measure developer.
22 Maybe this is something that comes out through

1 the steering committee discussion and
2 evaluation. It certainly is a topic in the
3 MAP.
4 DR. BURSTIN: As we begin thinking
5 about how we're going to better potentially
6 integrate what we do on endorsement and the
7 selection process at the MAP you could
8 logically see, for example, a handoff where
9 right after the decision around the scientific
10 validity of the measure a group then considers
11 its intended use and implementation. Again,
12 that's work to do this year.
13 And in fact, this has been a great
14 discussion because it really gives us a lot of
15 impetus to start thinking through how to best
16 do that without losing what's unique and
17 important about both.
18 MEMBER CHIN: So, this is
19 Marshall. I think again we're visiting some
20 issues that keep on coming up. That happened
21 in the disparities group from a few years ago,
22 it happens in the MAP, it's happening over the

1 past couple of days.
2 The problem is if you just look at
3 one isolated part. So for example, if we just
4 looked at measure development apart from
5 implementation then you don't necessarily make
6 coherent decisions.
7 Because an answer if something is
8 an appropriate case for adjustment will
9 probably depend upon its implementation.
10 So I guess I'm concerned -- again,
11 this is a question for NQF. If you keep on
12 compartmentalizing we're not going to come up
13 with sort of necessarily a logical overall
14 approach to equity. And so, I've heard again
15 -- there is this opening for us to think about
16 things in a more holistic way.
17 And unless there is an alternative
18 that you guys have planned about how you're
19 going to tie this together so it's coherent I
20 would suggest that this committee try to be as
21 holistic as we can be.
22 DR. BURSTIN: And, Marshall, I

1 think you're absolutely right there needs to
2 be some sort of trans-NQF approach to how we
3 handle issues of equity. I agree completely.
4 And I think that over time the integration is
5 certainly the goal.
6 But just a little reality check.
7 Measures that come into us for endorsement
8 aren't necessarily about to be implemented.
9 So we don't always in fact know how a measure
10 will be implemented at the time it's going
11 through its scientific review. So sometimes
12 it's going to have to be two-stage.
13 But certainly, and this is what
14 we've seen from the committees who have
15 reviewed the readmission measures and the cost
16 measures, it is hard to, for example,
17 sequester a committee from the realities of
18 what we know is happening in the real world
19 and say don't consider how it's going to be
20 used when they all know for some high-profile
21 measures exactly how it's going to be used.
22 So I think there are ways we can

1 try to integrate it when that information is
2 known and create sort of a stepwise
3 progression when it's not known at the time.
4 But all valid points, Marshall.
5 MEMBER CASALINO: If I may,
6 Marshall, may I ask specifically what are the
7 implications of what you just said? I don't
8 think you're saying that the developer ought
9 to also recommend how the measure would be
10 used. Or were you saying that? What is the
11 implication practically of what you just said?
12 MEMBER CHIN: So, for example, if
13 -- and it seems like from what I've heard the
14 past couple of days this is the most feasible
15 way to do it under the current situation.
16 That within the realm of the
17 committee you could do things that one of the
18 prior two or three speakers mentioned of
19 saying, well you know, being very explicit
20 guidance for developers.
21 Well, we want to think about like
22 if it was going to be used for a risk

1 adjustment formula do you need to adjust for
2 SES and what variables are valid.
3 Or if you were thinking of a
4 stratified approach where you'd be comparing
5 it against comparable groups, well you know,
6 what would be the approach. Again, I don't
7 know if those are great examples.
8 But thinking through the different
9 scenarios, the kind of ones that we've talked
10 about over the past couple of days. And then
11 thinking about does it make sense then for the
12 developer to be able to respond to the use of
13 their tool. Does it need to be risk-adjusted
14 for this scenario, that scenario. If you pick
15 the two or three most common ones.
16 Because otherwise as Helen said if
17 you leave it, you don't do that, then you have
18 just some general statement about well, do you
19 risk-adjust or not. And then when it comes up
20 for implementation later on and the two or
21 three most common things come up it could very
22 well be different answers to whether and how

1 you risk-adjust depending upon the context.
2 MEMBER SAWHNEY: Context is very
3 important and I don't know how to
4 operationalize what I'm about to say but to
5 put some more context into the discussion.
6 I recognize that the pathways for
7 SES impacting outcomes. And I recognize the
8 difficulties faced by the practitioners, et
9 cetera. And I'm all for methods that
10 compensate the practitioners more for the
11 challenges they face.
12 But I also might have a
13 distinction in this room in that I've had to
14 represent my organization when we've been
15 picketed. And I am having a bit of trouble
16 envisioning how to explain to the picketers
17 that because of risk adjustment there's
18 implicitly a different standard of care for
19 them because they're poor than there is for
20 rich people. That there's a different measure
21 of quality.
22 So, whereas I'm all for risk-

1 adjusting compensation I'm not for risk-
2 adjusting -- stratification I'm okay with, but
3 risk-adjusting where you make the difference
4 disappear, quality measures that we put out
5 and therefore implies that, you know, if the
6 provider doesn't do as well it's okay if
7 they're serving poor people.
8 MEMBER LIPSTEIN: I think, Karen -
9 - I want to emphasize what Karen said. Making
10 a nuanced distinction between public reporting
11 and pay-for-performance for accountability is
12 a hard thing to do in the public right now.
13 And I think one of the things that
14 changes this dialogue among the measure
15 developers is once upon a time measure
16 development was all about quality improvement
17 and setting benchmarks and standards for
18 accountability.
19 But now it really does determine
20 federal government funds flow, taxpayer
21 dollars. Which means what you do as measure
22 developers has to be much more subjected to a

1 public process. Because the public is paying
2 those taxes and they want to know how their
3 dollars are being distributed.
4 And so I come back to while, Jean,
5 I'm not taking anything away from the
6 expertise of measure developers they can't
7 have the kind of discretion that you're
8 advocating for in the "should" category.
9 Because their biases, where they
10 come from, whether it's from Colorado, or from
11 New Haven, or from wherever, the sky where
12 Marshall is --
13 (Laughter)
14 MEMBER LIPSTEIN: -- that -- you
15 all have biases that come about from your
16 local practice environment. The exam room
17 that you're in, the exam room that you're in.
18 And what I tried to say yesterday
19 is the exam room in Denver and the exam room
20 in the Mississippi delta are very different
21 exam rooms with very different kinds of
22 support mechanisms, especially to take care of

1 people who don't have a local tax base as I
2 brought up yesterday.
3 So I'm in the "must consider"
4 category if we're going to move off the status
5 quo because I believe that what measure
6 developers do has to be embraced so that it
7 will actually influence and change
8 practitioner behavior. Because that's what
9 we're trying to do. We all want to improve
10 the outcome for the patient.
11 And there are some people who
12 believe that socioeconomic risk adjustment
13 will mask disparities in health outcomes, and
14 there are some people that believe that it is
15 so misdirecting, the absence of that is so
16 misdirecting of public resources that as to
17 adversely affect patient outcomes.
18 So not only do I think it's a
19 "must consider" but I also think it has to be
20 considered by the measure developer with a
21 public input process.
22 And the public input process is I

1 want to be able to go to Jean and say Jean,
2 here are the socioeconomic variables I would
3 like you to consider. You can reject them
4 when you go to your panel to report but I'd
5 like you to at least consider them because I
6 believe this is the relevant SES variable.
7 If you pick a variable that isn't
8 embraced by the provider community it will be
9 hard to change practitioner behavior. And
10 ultimately changing practitioner behavior to
11 improve outcomes is what we're trying to
12 accomplish through accountability.
13 MEMBER NUCCIO: If I might. I
14 don't disagree with what you're saying. Maybe
15 my objection was not with the word "must" but
16 "must include" as opposed to "must consider."
17 That as a good researcher one
18 ought to consider I think as Atul mentioned
19 everything that's under the sun that could be
20 related. The question is how it gets
21 represented within the model and if
22 stratification is even a possibility, whether

1 you look at within a national set of values or
2 within an organization it really is an
3 important thing to consider.
4 But I guess -- I don't want to say
5 that I'm for number 2 because I'm not. I am
6 definitely for number 3. I just think that I
7 don't want to imply or have the review
8 committees imply that, well, it is always in
9 there.
10 Because there are, aside from
11 process measures I think there are other
12 measures or other contexts for measures that
13 don't make sense to risk-adjust.
14 An example I gave the other day
15 was if hospitals had a functional measure for
16 taking meds or management of medication there
17 is no management of medication in hospitals.
18 You're going to take it.
19 In the home health setting there
20 is management of medications because it's
21 highly variable and it probably is much more
22 likely related to sociodemographic kinds of

1 things and whether or not you have a
2 caregiver.
3 So, certainly I think it's
4 incumbent on the developer to demonstrate
5 through a series of methodological, you know,
6 here's how we've considered it in a scientific
7 way approach. And say it makes sense to
8 include it. We checked it out, it adds zero
9 to the information. And other than for making
10 sure that providers understand that yes, we
11 are considering that, you know, so they like
12 that, there's no scientific reason for
13 including it.
14 MEMBER LIPSTEIN: And just the
15 last clarifying point, Kevin, is Tia said
16 something about different quality measures for
17 poor people versus rich people.
18 Actually, I think one of my bigger
19 concerns right now are the disparities between
20 poor people in Louisiana and poor people in
21 Massachusetts, or poor people in Missouri
22 versus poor people in California. Because the

1 working poor in California are covered up to
2 138 percent of federal poverty. That's not
3 going to be true across the country.
4 I think one of the things we need
5 to do is to broaden our definition of
6 disparities not between -- well, between the
7 rich and the poor, but between the poor and
8 the poor in different parts of the country.
9 CO-CHAIR FISCELLA: Helen has a
10 comment and then we're going to do two more
11 comments on this side and then just do the
12 straw poll. A lot of the questions are
13 getting into the issue of how which we're
14 going to address next. So, Helen?
15 DR. BURSTIN: So, just a quick
16 comment. And I think some of this is the
17 sense that we shouldn't leave it up to the
18 developers.
19 I mean, really the whole point of
20 NQF is there is a very detailed process. The
21 developers around this table know it all too
22 well.

1 A measure comes in, it gets
2 reviewed by a steering committee, it goes out
3 for comment. It comes back to the steering
4 committee. It goes out for a vote. It comes
5 back to the consensus committee. It goes to
6 the board. It comes for appeals. So there
7 are so many checks and balances along the path
8 that I don't want it to feel like it's
9 completely up to the developer.
10 So in some ways I think what we
11 just heard from Jean around should be
12 considered with justification in the context
13 of the overall process is probably what I
14 think you're talking about.
15 But I don't want you to feel like
16 it's just the developer's say-so, we're good
17 and we move on. It is an exhaustive process
18 to follow. And we heard certainly one of the
19 reasons for this meeting was how many comments
20 we got on these measures about the lack of SES
21 adjustment as being the motivation for making
22 sure that this issue gets addressed.

1 MS. PACE: And one other comment,
2 and the developers can add to this, but most
3 of the developers we see measures coming from
4 have their own process where they do get input
5 from providers and patients as they're
6 developing the measure.
7 So that would be an opportunity
8 for providers to say well, you know, please
9 look at these particular factors. I mean,
10 they do that with the clinical things
11 obviously and this could be included in that
12 process as well.
13 So, I don't know, Jean and Sean
14 and Susannah if you want to agree that that's
15 part of your process?
16 MEMBER BERNHEIM: It's a huge part
17 of it. I mean, when you develop measures for
18 CMS there's a many-hundred page measure
19 management system manual. We have a technical
20 expert panel. We explicitly have criteria
21 that we have to have members from hospitals
22 that look different than ours on our technical

1 expert panel. We have a public comment
2 process. We have a lot of steps in place to
3 make sure that we're getting a lot of
4 representation from outside. It's a big part
5 of it. Before it comes to NQF.
6 CO-CHAIR FISCELLA: We're going to
7 take two more questions from this side and
8 then we're going to just do the -- and this is
9 really just to get a sense of where -- it's
10 not binding, right, as Karen has said.
11 Please. But to get a sense of where people
12 are before we move on. Monica?
13 MEMBER BHAREL: Thank you. This
14 is just a clarifying thing. This discussion
15 about the measure develop is very helpful for
16 those of us who don't do it. And reassuring
17 about the multiple steps.
18 So, Susannah mentioned something
19 about the current criteria. This question
20 about what the current criteria is.
21 So I'm just -- this is a total
22 clarification from NQF. So, I'm looking at

1 the disparities section. And it says
2 something about if disparities in care have
3 been identified measure specifications,
4 scoring analysis allow for identification of
5 disparities through stratification of results.
6 Then there's examples, race, ethnicity,
7 socioeconomic status, gender.
8 And I just wonder, could you just
9 help me understand? So in number 3, we're
10 then talking about risk stratification. And
11 this suggests that people, if disparities are
12 identified, should be looking at. Could you
13 just clarify that for me so I make sure I
14 understand as we move forward?
15 MS. PACE: Right. Well, and
16 that's part of the notes to our criteria which
17 is basically currently directing developers to
18 not include them in the statistical risk
19 models, but to -- that we should stratify to
20 identify those disparities.
21 But, the recommendations that come
22 out of this panel may change, will probably

1 change that language. So, that is the current
2 -- and you've heard people say well, we did it
3 this way because of that NQF guidance.
4 MEMBER BHAREL: And so just to
5 clarify. So, one of the outcomes that could
6 happen from this is that we decide -- I'm not
7 saying I'm for this, I'm just trying to
8 understand it -- that we continue to risk-
9 stratify. And that's not a change then from
10 what's happening now?
11 MS. PACE: Correct, right. And
12 that's what, you know, as Kevin said, we want
13 to get into more discussion of the hows. And
14 we may have some shoulds or should nots, but
15 yes, that's definitely a possibility.
16 MEMBER CASALINO: So, I wasn't
17 aware of that. That was interesting to hear.
18 I think before we've always still
19 had to know what does "must consider" mean.
20 To me, "must consider" means tell us whether
21 SES is relevant or not, right? So if it's
22 discharge counseling when someone leaves the

1 hospital, the patient is a passive recipient
2 to that in a sense. Someone could argue not
3 relevant, okay. So, first question is it
4 relevant or not.
5 The second question is if relevant
6 how do you propose dealing with it. We're not
7 telling them, we're not saying you must put it
8 in as a variable in an equation, but tell us
9 how you propose to do it. Is that what we
10 mean by "must consider" those two steps?
11 Number one, relevant or not. Number two, if
12 relevant, how dealt with.
13 In the measure. We're not talking
14 about how dealt with in how users would use it
15 for pay-for-performance or public reporting
16 necessarily.
17 Is that an accurate understanding
18 of what we would be voting on?
19 MEMBER SAWHNEY: I would add a
20 third and that's just feasible. So you could
21 have something that you feel is very relevant
22 that's just not feasible.

1 MS. PACE: So, basically, and
2 again, we can come back and wordsmith this,
3 but it's really kind of along the lines of
4 what our current approach is, that they would
5 need to consider it, meaning they would need
6 to examine it.
7 They would then need to present
8 rationale, evidence, analysis to justify
9 either including or excluding. So, we can
10 wordsmith that but I think the general concept
11 is that there has to be some thought first
12 about whether these things apply and then
13 actually doing some investigation into it and
14 presenting that for a committee's review.
15 And we can get into the details of
16 that. That's what we want to get into later
17 in terms of what would the expectations of the
18 developer be. How would we guide committees
19 to review that.
20 MEMBER CALLAHAN: Just for those
21 of us -- this is Mary Beth -- who are visual,
22 is there a slide that you all are referring to

1 that stated what a few persons ago said?
2 MS. PACE: Right. It was actually
3 one that we presented yesterday morning about
4 the NQF measure evaluation. We can --
5 MEMBER CALLAHAN: And who
6 presented that? Was it Karen?
7 MS. PACE: Yes.
8 MEMBER CALLAHAN: All right,
9 thanks. And whomever said something about X,
10 Y -- we would assess the person and it would
11 be a passive assessment. Can that be
12 clarified again? Would that be passive in the
13 sense of the information that was gained from
14 the person upon check-in?
15 MEMBER CASALINO: I just meant to
16 me one criterion -- so in a way we have three
17 topics I think. Should SES be considered or
18 not, number one, and guidance need to be given
19 to developers and committees about that.
20 Two, if it should be how should it
21 be considered as a measure, and guidance needs
22 to be given for that.

1 And three is once you have the
2 measure whether NQF wants to put out not for
3 that particular measure necessarily, but more
4 generally ideas about how measures might be
5 used in accountability. So those would be the
6 three things.
7 But in terms of the, you know,
8 whether it ought to be considered or not, when
9 I said passive I just mean, again, what I said
10 yesterday. If it's something for which the
11 patient must take some action other than
12 passively listening or letting someone give
13 them -- well, let's just put it that way.
14 Then I would argue it needs to be risk-
15 adjusted.
16 And that's why I would say I don't
17 think central line infections need to be risk-
18 adjusted or discharge counseling for patients
19 needs to be risk-adjusted for SES, but I do
20 think mammography rates, pap smear rates,
21 things where the patient has to go and get the
22 mammogram, for example, although process

1 measures I would argue very strongly need to
2 be risk-adjusted. So that's what I meant by
3 passive.
4 MEMBER GROVER: I would just add
5 anything that is dependent upon a patient's
6 behavior or their resources.
7 MEMBER CASALINO: Right.
8 MEMBER SUGG: I'll try to be brief
9 but I wanted to respond to a couple of things.
10 I feel like I have come back full circle.
11 So, there are times we want to
12 look at disparities. And when you look at
13 disparities in my mind you do not want to
14 adjust for socioeconomic standards because you
15 want to see what the disparities are. And
16 then you begin the process of looking, well,
17 why do these exist. And you ask further
18 questions.
19 NQF is about performance measures.
20 And so we do need to adjust for those
21 measures.
22 And getting back to Tia's concern

1 about are we expecting lower quality service
2 for people who are poor I think we need to re-
3 frame what those scores when we adjust for
4 them mean.
5 Does it mean that we expect lower
6 quality for care? No. What it means is that
7 there are things outside of the physician's
8 control that account for that lower quality
9 score.
10 And is that okay? No, it's not
11 okay. It's not okay that kids can't read at
12 third grade. But that is beyond the scope of
13 what a physician can do to improve quality.
14 So I think it's sort of looking at
15 that in a different way and saying -- it's not
16 saying that we're expecting a different
17 quality of healthcare, it's saying that there
18 are things that physicians cannot do anything
19 about that will affect people's health scores
20 in those situations.
21 And then to get back to is there a
22 difference in performance between public

1 reporting and payment, and I would say
2 absolutely.
3 And this is how I view that
4 differently. Payment will -- so for me the
5 overriding principle in many ways is we should
6 not do anything that is going to increase
7 disparity.
8 Paying differently and not looking
9 at socioeconomic standards will increase
10 disparity. We know that.
11 But a lot of times those payments
12 are more sort of organizational-based or
13 bigger, you know, bigger institutions that can
14 make up that difference perhaps with grants,
15 or perhaps with their teaching, or in some
16 other way.
17 So physicians will not feel that
18 necessarily right away and it may be something
19 that they're willing to kind of go for a few
20 years accepting until things change a little
21 bit.
22 When you publicly report on a

1 physician's individual quality score, that is
2 very different and that will more quickly
3 drive physicians out of serving underserved
4 people.
5 And the way that it will be used
6 is insurance companies will look at an
7 individual physician's score and say you will
8 not be a preferred provider. You will not be
9 in our network.
10 Or, an employer will pull up an
11 individual's physician score and say we're not
12 going to hire you because your scores have
13 been much less than the standard. And so
14 there are consequences to that that are
15 different.
16 So I very much feel like how these
17 scores are used are very important. And that
18 there are times that you say these have to be
19 socioeconomically adjusted or you're going to
20 unfairly penalize physicians and drive people
21 out of serving underserved.
22 MS. PACE: Right. But the two

1 examples you gave for public reporting and for
2 pay-for-performance, you're saying in both
3 instances to account for differences in
4 socioeconomic status. Maybe for different
5 reasons but you're still saying that those
6 need to be accounted for.
7 MEMBER SUGG: Right. I mean, I
8 would say in both those instances I would
9 still vote yes, these need to be accounted
10 for.
11 MS. PACE: Right.
12 MEMBER SUGG: And it shouldn't
13 necessarily be optional.
14 I'm just saying though that I
15 think there is a difference in how quickly
16 you're going to see an increase in disparity
17 for especially measures that are used
18 specifically to look at public reporting about
19 individual physician behavior.
20 MEMBER BERNHEIM: I think you
21 named something that's really important in
22 there that captures a lot of it. And I just

1 want to follow on it.
2 There was a question on one of the
3 slides yesterday that we never actually talked
4 about but that I thought was really important
5 which was what would you do in a circumstance
6 where adequate resources would ensure similar
7 outcomes. And I think that's a really
8 important question.
9 Because in some cases what you're
10 saying is we think the differences by
11 socioeconomic status are due to things that
12 healthcare systems, I wouldn't just say
13 physicians or the body that's being measured,
14 incentivized, cannot do anything about. That
15 they are really outside of a pathway that
16 involves disease and quality.
17 And those are cases, and this goes
18 back to sort of my most simplistic slide,
19 where you want to risk-adjust.
20 In other cases we feel like that's
21 not happening. I think the blood infections
22 is a great example where you wouldn't want to

1 risk-adjust.

2 But I think one of the hardest
3 questions, and I think it needs to be thought
4 about is what about situations where with
5 adequate resources you could ensure equal
6 outcomes, right? Because then, I mean that
7 answers to some extent your question, Karen.

8 Then I would say you may want to
9 know without risk adjustment that a place
10 isn't reaching standards that you could reach,
11 outcomes that you could reach. But you
12 certainly wouldn't want to further under-
13 resource this, right?

14 The center of Kevin's slide was
15 this concept that with this particular issue,
16 with socioeconomic status unlike any other
17 issues we have this disconnect where a lot of
18 us believe that there are increased needs and
19 these are the services that you least want to
20 under-fund.

21 And so I think in the context of
22 socioeconomic disparities you have a different

1 argument than in most cases that you might
2 want to sort of measure performance
3 differently than you apply payments.
4 I think that it's a hard question
5 if you think you could do it but they don't
6 have the resources whether you adjust or not.
7 But I certainly think it makes an argument for
8 considering a quality measure different than
9 a payment.
10 MS. PACE: Right. But I'm not
11 talking about like setting a payment rate for
12 services, like capitation. What I'm talking
13 about is using it in a pay-for-performance
14 context.
15 MEMBER BERNHEIM: Okay, so I would
16 say the same thing though, right?
17 MEMBER GOLDFIELD: I just have to
18 say I disagree. Because for me at the end of
19 the day they're all tied together.
20 CO-CHAIR FISCELLA: We want to
21 take a pause here and just see where folks are
22 here on the question at hand. We're going to

1 -- all of these threads are going to be
2 followed up and be continued so you'll have
3 ample opportunity to raise your questions and
4 concerns and express your views.
5 So, let's just do a straw poll.
6 It's absolutely non-binding. Okay. The first
7 is is there anybody in the room who is
8 interested in maintaining the status quo?
9 Raise their hand.
10 (Show of hands)
11 CO-CHAIR FISCELLA: The second
12 option is should it be up to the developer.
13 And this means that they could choose to bring
14 up the issue of SES or not. Not even bring it
15 up and consider it at all. It would be up to
16 their total discretion. Do we have any hands
17 for option number 2?
18 (Show of hands)
19 CO-CHAIR FISCELLA: And the third
20 option --
21 MEMBER O'BRIEN: Does option
22 number 2 include must be discussed?

1 CO-CHAIR FISCELLA: No, it does
2 not. Any hands for option number 2?
3 And now option number 3 is must or
4 should. I'm not sure I completely understood
5 the -- but that starts to get into I think a
6 bit of the wordsmithing that will come later.
7 So I'll say must/should be considered. Hands
8 for that?
9 (Show of hands)
10 MEMBER CALLAHAN: Mary Beth's hand
11 is up.
12 MEMBER CHIN: Marshall.
13 MS. PACE: The difference is must
14 be considered does not mean must be in the
15 adjustment. Okay, so you're suggesting a
16 fourth option. What's the difference between
17 "must" and "should"?
18 MEMBER WERNER: One is stronger
19 than the other. "Must" is much stronger.
20 MEMBER GROVER: If you want to use
21 regulatory language it's it will be considered
22 versus it may be considered.

1 CO-CHAIR FISCELLA: I'm going to
2 suggest a re-vote on what it actually says,
3 "must be considered." A vote of hands on
4 "must be considered."
5 (Show of hands)
6 CO-CHAIR FISCELLA: Okay.
7 MS. PACE: And who did -- because
8 we can't see. Those against that language,
9 "must be considered."
10 MEMBER CALLAHAN: Mary Beth is
11 against it.
12 MS. PACE: Okay.
13 MEMBER CHIN: For clarity, the
14 "must" means it must be considered, but then
15 if it's not appropriate then it doesn't need
16 to be considered.
17 CO-CHAIR FISCELLA: That is
18 correct.
19 MEMBER CALLAHAN: Is there going
20 to be a fourth option?
21 MS. PACE: No.
22 MEMBER CALLAHAN: Oh, so we're not

1 doing "will" or "may" as the options? Is that
2 correct?
3 MEMBER CHIN: Marshall's a yes.
4 MEMBER SAWHNEY: I think there is
5 a fourth option and that is once we -- if we
6 endorse the third option then the fourth
7 option becomes is there an obligation of the
8 developer and the NQF to consider and give
9 guidance as to appropriate use.
10 MEMBER LIPSTEIN: Following up on
11 3 I think there's two categories that come
12 next. One is guidance provided to developers
13 and one is guidance provided to implementers.
14 And those are both things that are still up
15 for discussion, correct?
16 MEMBER CALLAHAN: This is Mary
17 Beth. I go back to 3 and I'm a yes.
18 MEMBER CASALINO: Building on what
19 Steve said, yes, it's an open question that we
20 haven't really gotten into, and this might not
21 be the right time, whether developers must --
22 if they consider SES, they decide it's

1 relevant, must they then also -- and they
2 decide how to do the measure, must they also
3 provide some suggested guidance to
4 implementers? Or not? We haven't really
5 discussed that.
6 And then we all had discussed a
7 little bit whether NQF might put out more
8 general guidance, not measure-by-measure
9 guidance presumably.
10 MS. PACE: Right. So we will get
11 to those. So maybe for now we can say that
12 there seems to be pretty good consensus that
13 we have to must consider. We can talk about
14 that language, but the idea is that there has
15 to be some conscious effort put into
16 considering looking at the issue of including
17 sociodemographic factors.
18 And that would have to be
19 presented with the measure submission. And we
20 can -- we'll get into what the expectations
21 for developers are. That's part of what we're
22 going to work toward today. Is that okay?

1 CO-CHAIR FISCELLA: Yes. And just
2 to clarify, I think I heard Mary Beth say she
3 changed her vote from -- to 3. And do we have
4 one dissension? Is that right?
5 MEMBER O'BRIEN: It's in the
6 category of expectations and wording, so I
7 guess I can say yes for now but I'll have more
8 to say later.
9 MS. PACE: All right. And Nancy,
10 do you want to make any comments?
11 MEMBER GARRETT: So, I don't know
12 if this is in the category of language or not,
13 but I think it's conceptually different. I
14 mean, what I would propose is that we say
15 adjustment should be included unless there are
16 conceptual and empirical considerations not to
17 include it.
18 And to me that's different, to say
19 it should be included than it should be
20 considered.
21 And I just wanted to say, kind of
22 follow up on Norbert's point that the states

1 are going to do this anyway. I got back to my
2 email last night and I had a draft legislation
3 to review, to respond to today by noon that
4 we're going to be moving -- proposing. It's
5 called legislation to establish risk
6 adjustment based on social determinants of
7 health for the Minnesota State Quality
8 Reporting System. And so I think we need to
9 take a strong stance.
10 DR. BURSTIN: It might be really
11 interesting for the group to actually see that
12 if you'd be willing to share the legislation?
13 Okay, thanks.
14 CO-CHAIR FISCELLA: But just to
15 clarify what you're saying, Nancy, is that you
16 agree with "must" but it really needs to be
17 stronger in your view, the language behind
18 that needs to be stronger.
19 MEMBER CALLAHAN: And this is Mary
20 Beth. I don't know who was speaking but I
21 just want to point out that the language from
22 that state was social determinant which is

1 really a little different than socioeconomic
2 status. So I just want to point out that I
3 think everyone knows this but the language has
4 to be kind of a little bit more specific I
5 think.
6 MS. PACE: So this is just to move
7 us on after this discussion. So, why don't we
8 -- why don't we do a quick review of the
9 themes and then take a break. And then we'll
10 come back and have some more focused
11 discussion about the "how" before we go into
12 our breakout groups. So why don't we quickly
13 go through those slides. Suzanne, you want to
14 move us through?
15 CO-CHAIR FISCELLA: Sure. So,
16 what we wanted to do is review some of the
17 themes we heard and then briefly give folks a
18 chance to add if there were themes here that
19 we missed.
20 And we've already heard this
21 morning the issue about payment and the issue
22 of how to address this. And this has come up

1 in a number of different contexts. So the
2 issue of payment and need, and level playing
3 fields, and how that might be addressed
4 through different mechanisms.
5 In terms of disparities adjusting
6 for sociodemographic factors could potentially
7 mask disparities. Potentially addressing
8 disparities, we heard that again this morning.
9 Not adjusting for sociodemographic
10 factors could lead to invalid inferences and
11 reputational harm to those serving socially
12 disadvantaged patients including those with
13 low SES. We heard that reiterated again this
14 morning.
15 Much concern about implementation
16 for rewards and penalties. And how to frame
17 that, whether that should be -- whether that
18 needs to be an overarching issue that a number
19 of you have again raised this morning. The
20 issues of penalizing providers, a lack of
21 resources and not wanting to protect bad
22 apples. And again the important role of NQF

1 in terms of providing implementation guidance
2 particularly around this issue.
3 We talked about a variety of
4 potential sociodemographic factors. A number
5 were raised. We didn't hone in on any in
6 particular but these included income again
7 brought up this morning, English language
8 proficiency, homelessness among some others.
9 The pathways are not understood.
10 They may be more indicative of more difficult-
11 to-measure factors.
12 Sociodemographic factors may not
13 influence all outcomes. Race does not
14 typically represent biologic difference, not
15 necessarily genetic but in some circumstances
16 must be represented, something that's
17 unmeasured. And low birth weight came up as
18 an example.
19 Alternative measures for
20 sociodemographic factors included housing
21 vacancy rate, for example, the Census tract
22 level and differences in levels of tax support

1 for different healthcare organizations in
2 different regions of the country as well as
3 organizational -- the case mix essentially of
4 the population being served by different
5 organizations. So percent low-income or other
6 measures of sociodemographic.
7 The potential benefit and burden.
8 The challenges in collecting some of this data
9 in routine care. The limitations of use of
10 Medicaid status at least as it currently
11 exists due to variation in eligibility by
12 state and level of payment for those services.
13 There was discussion around the
14 use of geocoded or area-based measures of SES
15 including Census tract which is reliable and
16 well studied, but requires geocoding of
17 patient addresses. And some people raised the
18 question of whether there were HIPAA
19 challenges here.
20 Others mentioned that in some
21 cases Census tract, there may be substantial
22 variability in SES and uncertainty as to

1 whether these comparisons should be based on
2 national references, or based within states
3 due to heterogeneity within the context of
4 what SES means in different regions. Next
5 slide.
6 SES may serve as a proxy for
7 unmeasured disease severity and/or factors
8 that impair access and adherence.
9 Consideration might be given to use of direct
10 measures of some of these factors.
11 And again, examples were
12 homelessness. And potential examples also
13 included I think self-reported health status
14 I think was mentioned in one context as well
15 as low health literacy.
16 So these were the themes that we
17 as a group -- oh, we have some more? And
18 consideration for selecting clinical risk
19 factors apply to sociodemographic factors. So
20 the question was why would we handle
21 sociodemographic factors or have a higher
22 threshold for inclusion than we do to standard

1 case mix, clinical case mix factors. Why
2 would we not view them the same.
3 Allow data and empirical analysis
4 to drive decisions I think in terms of
5 measurement development. And some analysis to
6 indicate marginal benefit over clinical
7 factors and whether that would be a
8 justification to include or not due to the
9 extra burden.
10 It was also mentioned even if
11 there's no empirical advantage for adjusting
12 it may be important for acceptance and face
13 validity. In other words, providers may be
14 more willing to accept outcome measures if
15 they feel they are adjusted even if the actual
16 difference is small.
17 And measure developers need clear
18 expectations and committees need clear
19 guidance on how to evaluate the incorporation
20 or not of these factors in quality metrics.
21 And then areas needing more
22 discussion. What we really didn't touch on is

1 the implications for different settings or
2 different types of providers. Relevance to
3 other outcomes, cost, experience with care,
4 clinical measures. And other perspectives
5 from patients, consumers and purchasers.
6 So, the use of these may differ by
7 the quality metric and outcome that's being
8 studied. In some cases it might be relevant
9 to process measures in other cases. And
10 members have given examples where it does not
11 appear that it would have any relevance.
12 Do not include in statistical
13 model. The purpose is to identify disparities
14 and work on improvements on the issue of
15 masking and adjust for sociodemographic
16 factors for accountability uses.
17 What would be the reason to
18 consider differences by type of
19 accountability, public reporting, pay-for-
20 performance. And we had some discussion again
21 about that theme this morning.
22 Now, we're not suggesting

1 obviously that there's consensus around these.
2 These are just themes that came up. But why
3 don't we just take a couple of minutes and see
4 if people want to just add to themes that we
5 think were missed.
6 MEMBER LIPSTEIN: Page 4. On this
7 one, the disparities, there were two factors
8 shown. And the second bullet feels like it's
9 very provider-centric relating to invalid
10 inferences and reputational harm about those
11 who serve the disadvantaged patient.
12 The other theme we raised
13 yesterday was whether or not accountability
14 measures have unintended consequences of
15 discouraging providers from serving vulnerable
16 patient populations.
17 And so that would actually be as
18 important to me as the second bullet. Could
19 you go to number 7, page 7 now?
20 Under the risk factors that we
21 talked about -- that's page 8. That's why I'm
22 having trouble.

1 Oh, the point I wanted to bring up
2 on this slide is there's a major initiative at
3 NIH now. And I forget the acronym. Somebody
4 may know it. PROMIS? And what does it stand
5 for?
6 DR. BURSTIN: Patient-Reported
7 Outcomes Measurement Information System.
8 MEMBER LIPSTEIN: Right. And so
9 the use of that data set. Because this was
10 under future data. The use of that data set
11 may be relevant here and might end up under
12 one of our key themes for future data. Thank
13 you.
14 CO-CHAIR FISCELLA: Great point.
15 MEMBER BERNHEIM: My statisticians
16 always remind us not to let purely empirical
17 analyses drive things. And what's missing
18 from here is there needs to be a clinical
19 conceptual consideration as well.
20 MEMBER LIPSTEIN: Thank you.
21 MEMBER OWENS: So, just adding to
22 the things that we really haven't gotten to in

1 terms of discussion. And that is some
2 developers come in knowing where it's going to
3 be implemented. They're funded by CMS, for
4 instance, and they'll be used for a CMS
5 program.
6 Our quality indicators, for
7 instance, are not necessarily geared for a CMS
8 program. And in fact, not necessarily geared
9 for an accountability program.
10 Now, we've got sort of a pink
11 elephant in the room in that people love the
12 fact that it's NQF-endorsed but are not
13 actually applying it to an accountability
14 program but they want to say it's NQF-
15 endorsed. That's sort of, you know, that
16 makes it valid.
17 And then in those circumstances
18 for that use it's actually a different set of
19 questions. I mean, the same type of questions
20 but maybe different answers.
21 And so I just, you know, as NQF is
22 thinking about implementation is it going to

1 keep it's "and accountability" in its mission.
2 Because that for us is huge, right?
3 Because the message, that piece of
4 the message, that NQF is about quality
5 improvement or performance improvement and
6 accountability, that's what that endorsement
7 means, is completely lost.
8 DR. BURSTIN: I think that's part
9 of the logic of thinking through fit for
10 endorsement, of having some sort of
11 differentiation to allow you to say this
12 measure is great, use it for performance
13 improvement, it provides really good
14 benchmarking information. We would need the
15 following things to have it really evolve to
16 being used for other uses. So people don't
17 get misinformation, providers aren't
18 misclassified, et cetera.
19 MEMBER OWENS: Right. And so one
20 of the things that obviously our QIs are used
21 a lot for is healthcare planning, right?
22 Healthcare planning. You look at national

1 healthcare, where a fund is going to go, where
2 are things targeted to. The NHQR, NHDR look
3 specifically at where do we need to put more
4 money, more dollars. But it's not an
5 accountability program.
6 MS. PACE: Some of your measures
7 are picked up by states and used for
8 accountability.
9 MEMBER OWENS: It's not that
10 they're not used for accountability, it's that
11 they're not necessarily used for
12 accountability. But people still want to see
13 the NQF seal of approval.
14 MS. PACE: Right.
15 CO-CHAIR FISCELLA: Looks like we
16 have one last comment.
17 MEMBER SAWHNEY: We've discussed a
18 number of SES variables and they were buried
19 in the list, income, race, ethnicity, LEP,
20 homelessness.
21 One we haven't discussed that I
22 would like us to spend a few minutes on at

1 some point is education because -- for two
2 things.
3 First of all, it's not the same as
4 but it's highly correlated with income. And
5 if we were going to ask providers to in a
6 clinic setting collect more information
7 education is one that's readily collected and
8 people are usually honest about it.
9 And even in limited English
10 proficiency situations if you have someone
11 who's highly educated in their native language
12 that's a totally different person than someone
13 who's not.
14 MEMBER PONCE: I just want to --
15 can I comment directly on that? So I agree in
16 terms of if another criteria was shifting
17 population health. Publications, one in
18 particular by Galea that does a systematic
19 review that shows that in terms of mortality
20 education is number one in shifting population
21 health.
22 MEMBER QUACH: Can I just comment

1 that my understanding is when you say SES that
2 you should be considering not just income but
3 education and all the other factors.
4 I want to throw out there when we
5 start considering the different factors that
6 we think about summary measures as well.
7 Otherwise, we're always going to be arguing
8 well, this one's worse, or this one's better
9 than the other.
10 I don't think we should be arguing
11 which populations are more disadvantaged in
12 some ways. I really want us to consider the
13 different barriers out there that affect
14 health.
15 CO-CHAIR FISCELLA: Susannah, did
16 you have a question? Okay.
17 MS. PACE: Is it time for public
18 comment? We had it on the agenda for 10:35.
19 Do you want to do that before break? Okay,
20 let's go ahead with public comment. Operator,
21 will you open the lines? And those who want
22 to comment can come up.

1 OPERATOR: At this time if you'd
2 like to ask a question or have a comment
3 please press *1 on your telephone keypad.
4 We'll pause just a moment to compile the Q&A
5 roster.
6 MR. SHAW: Hi, I'm John Shaw from
7 Next Wave in Albany. And I wanted to speak to
8 two issues relative to transparency.
9 One is the longstanding issue of
10 do we risk-adjust or not that's come up a
11 number of times and taken a lot of discussion
12 time.
13 I'm not sure I've heard anybody
14 support masking disparities. Maybe I'm
15 missing something, but I think the sense of
16 the group was nobody wants to mask
17 disparities.
18 So, perhaps a simplifying straw
19 poll would be if that's the case then we can
20 take that off the table with the implication
21 that it may mean reporting both risk-adjusted
22 and raw statistics.

1 And the second one is relative to
2 some of the drivers. And we heard the real
3 driver in a lot of the desire for risk
4 adjustment is basically financial equity.
5 That if it costs more to achieve the same
6 outcome in a particular population then we
7 want to risk-adjust for it.
8 However, one of the useful
9 information pieces in this area is how much
10 more does it take and who's paying for it. So
11 a transparency issue might be considered for
12 guidance, particularly either at the measure
13 developer level or during the endorsement
14 process.
15 If there's evidence that things
16 like for readmissions following up in the
17 community with visits to the patient really
18 reduces readmissions a lot. We heard that and
19 we heard that in NQF discussions in the MAP.
20 And following through on that we
21 found the successful programs were able to do
22 that with grant funding. So, source, and

1 about $1,300 per patient cost.
2 So it would be useful in framing
3 what the real impact is to get some sense of
4 what are the sources. Is it the local taxing
5 authority, or a grant program, or someone else
6 in a neighborhood that's taken it up, and how
7 much. Thanks.
8 MR. HAUGHTON: Hi, John Haughton.
9 I'm the medical information officer for
10 Covisint.
11 My comments are on the risk
12 adjustment. And specifically if you think --
13 potentially if you think about it, of how to
14 say here's a measure that's measuring
15 something specific as process or outcome.
16 That's one dimension of data. And then the
17 risk adjustment is another dimension.
18 If ultimately the risk adjustment
19 for many purposes ends up being able to have
20 a clear sense of what expected is. So you can
21 look at an expected-to-observed ratio or the
22 other way around then you potentially could --

1 as you're defining the measures you could
2 start with a slate that has no risk adjustment
3 and then as data comes in to say risk
4 adjustment matters if you have as part of the
5 measure definition an update-able element to
6 say risk adjustment should be used for a
7 particular purpose then you would know that
8 the risk-adjusted benchmark ends up being the
9 only one available.
10 So if you think of -- I think the
11 bottom line of what I'm trying to say is if
12 you can separate out the current state of
13 definitions which is working really, really
14 well but add the capability to update it needs
15 risk adjustment, and then whoever is the
16 keeper of the measure that has endorsed it
17 could say yes, it needs risk adjustment. And
18 that could become an attribute of the measure
19 versus having to be intrinsic in it.
20 Because the risk adjustment may be
21 use the CMS HCC model or the CDPS in Medicaid
22 and that works well enough. Or use

1 sociodemographic factors, or education, or a
2 number of wonderful things that were talked
3 about here.
4 So I think the bottom line of my
5 comment is a mechanical suggestion of keep
6 what you have and then add this extra piece
7 that the measure owner could update. And then
8 that way your measures could track very
9 quickly as information comes from the field to
10 give expected versus observed.
11 MS. PACE: Operator, would you
12 check one more time if anyone on the line?
13 OPERATOR: We have no questions or
14 comments from the public at this time.
15 MS. PACE: Okay, thank you. So,
16 10-minute break and reconvene at 10:30.
17 (Whereupon, the above-entitled
18 matter went off the record at 10:17 a.m. and
19 resumed at 10:36 a.m.)
20 CO-CHAIR FISCELLA: We're going to
21 reconvene. Please have a seat.
22 Let me just briefly review the

1 agenda before lunch. We're going to take one
2 more straw poll and then we're going to have
3 some discussion on the "how" up to 11,
4 although recognizing that this will be a focus
5 of one of the workgroups we're going to cut
6 off discussion at 11 o'clock and then break
7 into the three groups.
8 So several members came up and
9 asked that we have a straw poll on really
10 breaking out the third option into what's
11 currently considered that the measure
12 developer should consider these factors and
13 present a rationale with a fourth option being
14 essentially it should be done whenever
15 feasible. So, in essence just do it if at all
16 possible.
17 When data were lacking for a
18 particular measure perhaps. I mean it's
19 essentially do it. I mean there's always
20 caveats, and there's always things that are
21 going to come up. And I'm sure members here
22 can think about what they may be.

1 But in essence it's just do it as
2 a routine versus have the measure -- put the
3 onus on the measure developer to present a
4 rationale for not doing it perhaps with some
5 additional encouragement to do it.
6 MEMBER CASALINO: But I'm sorry,
7 what is it? If it must consider it then I
8 think it's always feasible to consider it. If
9 they can say well, there's not good enough
10 data, blah blah blah.
11 So do you mean -- is that what you
12 mean? I hate to -- I'm sounding Clinton-esque
13 here.
14 (Laughter)
15 MEMBER CASALINO: What's feasible?
16 I mean it's always feasible to consider. It
17 may not be feasible to do X, Y, or Z.
18 CO-CHAIR FISCELLA: So Nancy was
19 one of the people who brought this up. And
20 perhaps you could even -- could you just
21 paraphrase if you're not permitted to give us
22 the official language the -- paraphrase what's

1 in the intent of this legislation which would
2 be in essence what you're suggesting.
3 MEMBER GARRETT: So, the
4 legislation that we're going to be kicking
5 around in Minnesota, not that this is approved
6 yet or anything, but there's a lot of energy
7 around this.
8 It's called Legislation to
9 Establish Risk Adjustment Based on Social
10 Determinants of Health. And it says that to
11 ensure that measures used for public
12 reporting, payment methods, performance
13 requirements, or payment incentives for
14 providers or health plans are adjusted for
15 patient characteristics identified under
16 clause 6 which has detail on what that means
17 that have an impact on provider and health
18 plan quality and cost.
19 So it's a strong statement in the
20 sense that SES and sociodemographics should be
21 included. And so that's kind of the question
22 is do we want to be a bit stronger than saying

1 must be considered and say should be included.
2 MEMBER SAWHNEY: Should we
3 differentiate between process and outcome?
4 MEMBER GARRETT: I think we're
5 just talking about outcome measures here.
6 That's the scope, right?
7 MS. PACE: Primarily, yes.
8 MEMBER WERNER: So, this idea that
9 we should create a stronger statement I think
10 in some cases is very appealing, but I think
11 it really depends on the use. And I think we
12 haven't really come to clarity about that.
13 So it's come up a few times. Are
14 we talking about the use of performance
15 measurements in financial incentives, or are
16 we talking about them for sort of feedback
17 purposes. And I think that the implications
18 for adjustment are much different and the
19 strength of the statement that we make about
20 it is different depending on that.
21 MEMBER CASALINO: I don't see how
22 you can get stronger than must consider.

1 Where the devil is going to hit the details or
2 whatever is going to be the how instructions
3 of what they're supposed to do.
4 I mean that's going to matter a
5 lot, what they're supposed to do. But to say
6 they've got to consider it.
7 MEMBER WERNER: So, I would say
8 that if these measures are being tied to
9 financial incentives, and by financial
10 incentives I mean both public reporting and
11 pay-for-performance, that they should be risk-
12 adjusted. And I think --
13 MS. PACE: No, they're always
14 going to be -- risk-adjusted including
15 sociodemographic. So, I guess this will come
16 out in some of our further discussions
17 We I think need to do a quick
18 straw poll. If you can't support it now
19 because it requires more context and
20 discussion then don't support it now. We just
21 wanted to do a quick straw poll on that and
22 we'll come back to it.

1 So the question is changing to
2 number 3 to instead of "must be considered" my
3 understanding is the option is that outcome
4 performance measures risk adjustment should
5 include sociodemographic factors. So, it's a
6 different approach. Am I right in what you're
7 saying?
8 MEMBER NUCCIO: So, must be
9 considered versus must be included.
10 MS. PACE: So, right. The
11 additional option we'll write in here is "must
12 be included" instead of "must be considered."
13 MEMBER CHIEN: So, I like that
14 we're writing higher-strength statements now
15 that we've decided almost pretty much
16 unanimously that 1 and 2 don't matter.
17 But I'm wondering whether or not
18 we need to be continuing with either/or type
19 language or a gradient.
20 Because what I heard Rachel say
21 was that it still, it depends what you're
22 using it for. It is less important to use

1 strong language if we're saying you're using
2 it for internal quality improvement purposes
3 as opposed to within Hospital Compare.
4 And I want to know if there's an
5 ability to have a gradation in option 4.
6 MS. PACE: So just, again,
7 context. NQF endorses measures that are going
8 to be used and intended to be used in
9 accountability applications. So if it's
10 strictly used for quality improvement it
11 doesn't need to be risk-adjusted. It can be
12 used in the way that's most informative for
13 quality improvement.
14 And we can have more discussion
15 about this but we can come back to it. It's
16 basically the request is to get a vote on
17 whether people would support stronger
18 language.
19 CO-CHAIR FISCELLA: All cases of
20 accountability.
21 MEMBER CALLAHAN: I can't hear.
22 MEMBER CASALINO: But I think that

1 if we were to say "must be included" as
2 opposed to "must be considered" -- if we say
3 "must be considered" we don't have to qualify
4 anything and all the qualifications can come
5 in on what consider it means, what you
6 actually have to do, right?
7 But if we say "must be included"
8 then we're saying you must include SES when
9 you have a measurement for central line
10 infections, for example. And I don't think we
11 want to do that.
12 So I would say "must be
13 considered" and then when we tell them what to
14 do we say things like -- people have said it
15 different ways. If the patient has to do
16 something then you better very strongly
17 consider including it, for example.
18 And then there's the use cases
19 about how it's going to be used. And we
20 haven't really gotten to whether the developer
21 should be coming up with suggestions about
22 that, or NQF is going to do it, or both.

1 MEMBER WERNER: SO I think that
2 just to follow up on what Larry is saying is
3 there's a more nuanced approach which is
4 somewhere between 3 and 4 which I think a lot
5 of us are struggling with, right? And so I'm
6 finding it very hard to think about voting on
7 4 when there are so many caveats.
8 MS. PACE: Right. But I think
9 what Larry's describing is really what number
10 3 is because 3 needs guidance which is what
11 we're going to get to in terms of which
12 factors, which approaches, if there are
13 specific recommendations, what the developers
14 need to submit to show that they considered it
15 and how they made -- so none of these would
16 stand alone without the additional
17 recommendations and guidance that we're trying
18 to get to.
19 MEMBER WERNER: So just to
20 clarify, under 3 we would say for central line
21 infections we do not think that you should
22 risk-adjust for sociodemographic --

1 MS. PACE: No, we're not going to
2 get to specific things like that, but it would
3 be -- "must be considered" would include the
4 rationale, why you wouldn't consider it for
5 central line infections. I mean, unless the
6 group can come up with these kind of hard and
7 fast things.
8 MEMBER LIPSTEIN: Instead of doing
9 that now, and since Nancy proposed this maybe
10 she'd consider "must be included unless NQF
11 guidance indicates otherwise." Could you
12 handle that?
13 MEMBER GARRETT: I don't think
14 that's NQF's call.
15 MEMBER LIPSTEIN: Oh, whose call
16 is it? Unless Nancy indicates otherwise.
17 (Laughter)
18 MEMBER GARRETT: I mean, I think
19 what maybe you're trying to get at, unless
20 there's empirical or conceptual reasons why it
21 doesn't make sense. I could live with that.
22 MEMBER SUGG: I think that's where

1 I would come down too, that you do it and if
2 there's a reason it shouldn't be done you have
3 to give your compelling reason as to why it
4 shouldn't be done. But the bottom line is for
5 performance measures you do do this and then
6 you go from there.
7 And then back to the quality
8 improvement. Again, I think much like when I
9 order a blood test, things I can use it for,
10 things I can't, you have to say these measures
11 are for performance in an accountability way.
12 These are not intended for quality
13 improvement.
14 So that people then if somebody
15 tries to use it for quality improvement you
16 can say no, you are using this outside of the
17 realm of where it was developed.
18 CO-CHAIR FISCELLA: Well, let me
19 ask those who suggested this be brought to the
20 floor. Is the -- would it be acceptable to
21 say this should be done with some caveats
22 which starts to overlap with what Larry is

1 showing? Or what do you want the vote to be
2 held on?
3 MEMBER GOLDFIELD: Well, again,
4 the poster child example of where we don't
5 want it to, like I agree with Susannah, is
6 central line infections. So, I mean I think
7 we're all in agreement on that.
8 CO-CHAIR FISCELLA: Good.
9 MEMBER GOLDFIELD: So from that,
10 that homelessness should be included, must be
11 included, period. And then central line
12 infections clearly on the face validity do not
13 need to be included. Then how does that fit
14 into a fourth option which the third option I
15 saw as being less strong.
16 MEMBER WERNER: So, number 4 could
17 be "should be included unless there are
18 conceptual and empirical considerations not
19 to."
20 MEMBER PONCE: Why can't we do
21 both? Sorry, I've had my card up for awhile.
22 CO-CHAIR FISCELLA: Go ahead,

1 sorry, I'm sorry.
2 MEMBER PONCE: So for the "must be
3 included" why can't we have both? So for
4 central line infections it might show that
5 whether you do it without the sociodemographic
6 factors and with it absolutely doesn't matter.
7 And then it informs us that it doesn't really
8 matter.
9 So why can't you just include it,
10 I mean have these two approaches and have it
11 both?
12 MEMBER GROVER: I actually --
13 that's what I was going to suggest, but also
14 the addition to say that if it does turn out
15 that in Black patients it's higher, well, you
16 want to know that. And you wouldn't
17 necessarily then adjust for it, but you
18 wouldn't want to know.
19 MEMBER GARRETT: Which would be a
20 conceptual reason not to include it. So I
21 think that fits with the wording, yes.
22 CO-CHAIR FISCELLA: So, are you

1 guys comfortable with where it's at or do you
2 want to have a specific vote?
3 MS. PACE: I don't think there's
4 agreement.
5 CO-CHAIR FISCELLA: "Must be
6 considered" doesn't mean will always result in
7 adjustment. Approach must be justified.
8 Four, "must be included unless there are
9 empirical or conceptual reasons not to."
10 Let's have a quick vote on those two options.
11 Number 3, hands up. "Must be
12 considered" doesn't mean always would result
13 in adjustment. Can someone count, please?
14 (Show of hands)
15 MS. PACE: Marshall?
16 MEMBER CHIN: Yes on the current 3
17 about "must be considered."
18 MS. PACE: Okay. And Mary Beth?
19 MEMBER CALLAHAN: I'm going to go
20 with 4.
21 MS. PACE: Okay. So we have 10
22 for number 3 and then number 4 -- number 4?

1 I'm sorry.
2 (Show of hands)
3 CO-CHAIR FISCELLA: I think the
4 chair breaks the vote.
5 MEMBER GROVER: You know, the
6 truth is practically speaking they should wind
7 up the same. It's just really 4 gives
8 stronger emphasis to it I think and makes it
9 seem like a bigger deal. But they should wind
10 up exactly the same way I think.
11 MEMBER OWENS: So, with the way I
12 read the second bullet approach must be
13 justified, I would say approach to not risk-
14 adjust must be justified. Right? So then
15 they're essentially the same.
16 MS. PACE: So, this is really kind
17 of wordsmithing. I think we're pretty much in
18 agreement. And I just understand that we
19 actually had a miscount on the first one, that
20 it was actually 11 on the first one and I
21 think 11 on the second one.
22 So, I think we will come back to

1 this and we can think about the best wording
2 for it. But I think we need to try to move
3 on.
4 CO-CHAIR FISCELLA: Yes, I agree.
5 So we began to delve into the issue of how.
6 And we've had some strong views expressed in
7 terms of full risk adjustment versus
8 stratification.
9 And we'd like to take the next,
10 what do we have, 15 minutes, maybe 15 minutes
11 if we're going to have enough time for the
12 workgroups to begin hashing out really -- and
13 I think really presenting a rationale in terms
14 of why you're proposing a particular approach
15 or not. Maybe we can put that slide up?
16 MS. PACE: Yes. Go ahead to the
17 next one.
18 CO-CHAIR FISCELLA: So,
19 statistical really means just throwing all the
20 variables into the model, but then also, I
21 think many people have mentioned this,
22 presenting it with and without that

1 adjustment.

2 The stratification within

3 organizations so that like organizations are

4 being compared. No, I'm sorry.

5 Stratification within organizations means

6 comparing comparable groups within that --

7 across organizations. And organization

8 stratification means comparing by

9 organizations who are similar in terms of

10 sociodemographic populations.

11 MS. PACE: Great. So just -- and

12 sorry, we should have brought in this slide

13 from yesterday. But the stratification within

14 an organization is where you would have maybe

15 the five quintiles within each organization's

16 reports versus, as Kevin said, the

17 organizational stratification as kind of the

18 MedPAC approach of stratifying the

19 organizations to identify like peer groups for

20 comparisons.

21 So, this is just based on some of

22 the discussion we had yesterday. We'd like to

1 have a brief discussion about pros and cons,
2 or perhaps bring up other methods. But we're
3 going to have one of the breakout groups
4 really delve into this a little closer. But
5 this would give everybody a chance to make a
6 few comments for consideration of that group.
7 CO-CHAIR FISCELLA: The one caveat
8 I would add before we go around is these are
9 not necessarily mutually exclusive. One
10 could, in fact, produce a report that did all
11 of this.
12 MEMBER CASALINO: Kevin, may I
13 just make -- I think discussing these in the
14 abstract is going to be frustrating because I
15 think we're each going to have a different
16 case in mind.
17 I really think that we should just
18 try discussing these kind of one case at a
19 time. And I actually think this could be
20 instructions for developers as well.
21 So the cases could be, for
22 example, you're a big hospital, big

1 accountable care organization, individual
2 physician, for example. Because these have
3 very different implications. There are things
4 you could do potentially with a big hospital
5 you can't do with an individual physician.
6 But if we're not specifying which case we're
7 talking about when we're talking we're going
8 to be arguing about things we don't need to
9 argue about.
10 So I would pick out at least a
11 couple of very contrasting cases, say big
12 hospital, individual physician, although there
13 are other cases that are important, and
14 address one at a time in the context of the
15 discussion about these different methods here.
16 CO-CHAIR FISCELLA: I would make
17 sure that comes up in the work group that's
18 going to focus on this, on those issues.
19 Because that's going to be the task of the
20 work group, to develop that level of
21 specificity.
22 Do I have a right-hand bias here?

1 Try to make your comments succinct, please.
2 So we can get more through.
3 MEMBER LIPSTEIN: Was the
4 implication that I haven't been succinct up to
5 now?
6 (Laughter)
7 MEMBER LIPSTEIN: No, my concern
8 on stratification within organizations. So,
9 Larry just mentioned big hospitals. So I take
10 the four big hospitals that I've worked for,
11 Mass General, Johns Hopkins, University of
12 Chicago and now Barnes-Jewish and they're all
13 in different parts of the country.
14 Now, let's imagine that they all
15 have the same percentage of Medicaid patients
16 and the same kind of DSH variables. In
17 Baltimore the absence of a city hospital is
18 different than Boston which has a publicly
19 funded hospital. In Chicago the presence of
20 Cook County is different than St. Louis which
21 doesn't have a publicly funded hospital.
22 So, you need to be careful with

1 stratification to recognize that different
2 hospitals exist in different parts of the
3 country.
4 I brought this up yesterday. It's
5 the point about the local tax base. The
6 presence or absence of local tax support for
7 a regional safety net is very determinative,
8 that's the theory, of health outcomes.
9 And so stratification that doesn't
10 recognize those differences across the country
11 because we're just using the MEDPAR data set
12 is going to be problematic.
13 MEMBER GARRETT: So, I have a
14 number of concerns about stratification. One
15 of them is by definition when you define
16 strata there's going to be variance within
17 that. And so you're not dealing with
18 continuous variables as continuous variables,
19 you're sort of artificially putting into
20 categories and I think that's a problem.
21 The size of this data can be a
22 problem. So in Minnesota we've been talking

1 about potentially doing stratification by
2 hospitals as a way of dealing with differences
3 in SES across our hospitals.
4 And there's two hospitals that are
5 safety net hospitals that would end up in one
6 strata, and those two hospitals have really
7 different patient mixes. So we don't really
8 feel like even that is a fair comparison. So
9 it's unclear that that really helps.
10 It's a little bit different when
11 you're talking about a national scale. But
12 remember these measures are used in so many
13 different ways and NQF measures are used at
14 the local level. So I think we always have to
15 keep that in mind.
16 And then there's complexity. So
17 we're talking here. You know, the
18 readmissions example was nice because we were
19 using one SES variable and putting them into
20 10 strata.
21 But potentially you're talking
22 about stratifying by race, by ethnicity, by

1 language, by income, and the amount of tables,
2 just you're talking about adding hundreds of
3 pages to reports, or sophisticated
4 dashboarding applications to be able to deal
5 with all these different permutations.
6 And so when you're talking about
7 public reporting, I mean really can a consumer
8 handle more than one number per provider per
9 measure. Does it lose meaning because there
10 are so many of those different variations? So
11 I think those are some of the things.
12 And then also with the current NQF
13 process it feels like stratification in many
14 ways is kind of out of the scope of the
15 process. You know, NQF doesn't know all the
16 possible uses of the measures when they're
17 released out into the world.
18 And so even if the process says it
19 should be stratified in this way how do you
20 know that that actually happens? It's more
21 like a library of measures that's kind of
22 checked out with the methods along with it.

1 So what I propose instead is the
2 idea of having two measures, one that's
3 adjusted, that can be adjusted for all the
4 different complex factors with a statistical
5 model, and one that's not.
6 And so an example that's kind of
7 related is that there's a measure of total
8 cost, a per-member per-month measure that
9 Health Partners brought forward. And there's
10 two versions of that measure. One of them has
11 price included and the other one has price
12 removed.
13 So you can use those two measures
14 together, and in fact they're usually used
15 together in the applications in shared savings
16 programs. And it's very useful because you
17 can see, okay, here's how I'm doing from a
18 total cost perspective which does include
19 contracted rates. And here's how I'm doing
20 from strictly a utilization perspective. And
21 so are there ways we could guide developing
22 two measures in tandem, one that could be

1 adjusted and one that's unadjusted. Maybe
2 that's a way to kind of address this.
3 MEMBER GOLDFIELD: I just want to
4 add a fourth category which is to say
5 categorical assignment without statistical
6 data. So it happens all the time. In 1982,
7 for example, when DRGs were first implemented
8 the data was weak. And in fact, certain of
9 the DRGs with complications had actual lower
10 payment rate than those without complications.
11 And Rich said, don't worry, next year it will
12 work itself out because the data will be more
13 precise.
14 Similarly with, for example,
15 readmissions we've artificially assigned
16 certain socioeconomic variables for those
17 institutions that have that additional data to
18 a higher level of severity. And so that's a
19 fourth category.
20 MEMBER CHIEN: I move we not try
21 and choose between these methods but give them
22 as examples of ways that you can approach this

1 issue. And then it's up to whoever is running
2 the actual program and implementing it to use
3 what the developer has done as a jumping-off
4 point.
5 MEMBER NUCCIO: And I'll just
6 second that point, that you can make a case
7 for the use of any of these.
8 I'd also like to make the point
9 that within statistical modeling you can
10 create strata and create different prediction
11 models for varying levels of severity, for
12 example, and aggregate those into a single
13 national model. So there's a way of splitting
14 the statistical model into a stratified
15 approach.
16 If you have, for example, a
17 functional measure where the patient is in a
18 somewhat less disability kind of state.
19 Bathing, for example, if you're trying to
20 improve the patient's ability to self-bathe.
21 If you split that into where the patient can,
22 in fact, work with assistive devices as

1 opposed to those patients who need another
2 person around to help them out you get two
3 different models of how -- what clinical
4 factors are related to improving the outcome.
5 So, what we do is we split the
6 dependent measure based on severity and have
7 a more severe model and a less severe model.
8 MEMBER ADAMS: Just to add to
9 that, I agree. And I actually think the
10 sociodemographic variables, I worry that we're
11 trusting statistics a little too much in terms
12 of the standard models may not be enough if
13 we're talking about distributional
14 differences.
15 So, for example, you could have
16 extremes. If you're talking about dual
17 enrollment, for example, dual eligible
18 populations, et cetera, real extremes in the
19 population in terms of which organizations see
20 whom. And standard statistical adjustment is
21 not going to take care of that, that level of
22 selection.

1 So I agree, it's probably going to
2 have to be a little bit more sophisticated.
3 I'm not saying we shouldn't do it. I'm just
4 saying on the cause it's not just mass
5 disparities, but there are also limitations to
6 our ability to address that level of selection
7 with the standard models that we have.
8 MEMBER GROVER: I just wanted to
9 say -- so, I want to suggest that these are
10 all things worth exploring but not necessarily
11 things that have to be decided with this
12 group.
13 Because I think you might run into
14 times when it may make more sense to do the
15 individual risk statistical adjustment, other
16 times when it makes more sense to do
17 stratification, and sometimes when you want to
18 do both where you get some information at the
19 individual level around income, or education,
20 or occupation, but then you want to adjust for
21 the neighborhood.
22 So, I think it really will depend

1 upon what measures you're looking at. And I
2 think you shouldn't necessarily hamstring the
3 people who are going to develop measures or
4 implement from the get-go.
5 CO-CHAIR FISCELLA: Okay, last
6 one.
7 MEMBER PONCE: I think we still
8 are in the realm of discovery so that's why we
9 do want to have some options. But I want to
10 put a vote in with Nancy's argument about
11 having both, by showing both the risk
12 adjustment without the sociodemographic
13 factors and with.
14 And I think that actually is
15 instructive. I don't quite understand the
16 masking of disparities. It actually might be
17 instructive if rankings change when you have
18 the adjustments.
19 It also is more flexible in
20 accounting for the really most vulnerable
21 types of patients where it's not just about
22 income but it's also about income and

1 education and a multitude of sociodemographic
2 factors which would not be facile in a
3 stratification.
4 MS. PACE: So now the fun part.
5 We're kind of readjusting how we're going to
6 do breakouts.
7 We're going to do three breakouts.
8 We're going to have one breakout group focus
9 on sociodemographic factors. And start
10 thinking about some specific recommendations
11 that you might want to bring back to the
12 larger group.
13 These are just some ideas of
14 things that you might want to touch on, but
15 your group will need to kind of see where you
16 want to go with this. Definition, what
17 factors, is it always the same ones that
18 everyone has to consider. This issue of
19 existing data versus potentially future data.
20 And that group is going to meet
21 over on this other side of our conference
22 room.

1 Okay, next one. The second
2 breakout group are approaches to how to do
3 this. And start thinking about specific
4 recommendations. And a continuation of the
5 discussion we just had.
6 And let me just clarify. This
7 group doesn't have to come up with a
8 recommendation to pick one. Their
9 recommendation could very well be, you know,
10 these are the considerations for choosing one,
11 or totally leave it open but that's what
12 they're going to grapple with.
13 I mean, it could be here because
14 this is where we also want to have this group
15 kind of tackle the question of what would be
16 expected of developers. So all those kinds of
17 conditional things. And also how we might
18 evaluate whatever the developer submits.
19 And then the next group. Oh, and
20 that group is going to -- we're thinking that
21 may be a smaller group. We have a smaller
22 conference room which Suzanne and I will be

1 going to that one. And also Marshall and Mary
2 Beth because of our phone arrangements, that's
3 the group that you'll be in by phone.
4 And then the third one is about
5 some of the contextual things we've been
6 talking about. Are there differences by type
7 of outcome, particularly by use that many have
8 brought up. What's the rationale for the
9 differences.
10 I don't know, process measures
11 have popped up a couple of times in
12 discussion. Our project was specifically
13 about outcome performance measures, but you
14 may want to address that.
15 And particularly, and this may be
16 where you want to spend your time, is this
17 question of guidance for implementation and
18 use. And some thoughts or recommendations
19 around that in terms of what NQF's role should
20 be, how that guidance would be developed. So
21 we'll leave that to you to mull over.
22 And that group is going to stay

1 here on this side of the conference room. So,
2 and let's see.
3 So, in terms of staff, Taroon,
4 Helen and Lindsey will stay on this side with
5 the contextual group. Kevin and Karen Johnson
6 are going to work with the sociodemographic
7 factor group on that side. And then me and
8 Suzanne will work with the approaches group in
9 9 Temp. Yes?
10 MEMBER CASALINO: Karen, just two
11 questions or clarifications. One is it seems
12 to me at least that the question of should
13 process measures be considered in some cases,
14 say. To me the third group if I understood
15 correctly is more about what should NQF say if
16 NQF is going to say anything about how
17 measures ought to be used, for pay-for-
18 performance, for public reporting should it be
19 different. That's one question for the third
20 group.
21 And the other question for the
22 third group is should it just be NQF who says

1 that say in general, or for a specific
2 measure, and/or should developers be expected
3 to say something about that. To me that would
4 be the third group.
5 But the process measure, yes or
6 no, or sometimes and when, to me that's a
7 criterion for what ought developers address
8 and so I would put it in the second group.
9 MS. PACE: Okay, good point.
10 We'll definitely switch that. Thank you.
11 CO-CHAIR FISCELLA: Let me just
12 check with Marshall and Mary Beth. Due to
13 logistical problems you have to be in the same
14 group which creates an issue.
15 But do either of you have strong
16 preferences in which group to go into given
17 that you have to be in a bloc? We arbitrarily
18 assigned you to the second one but it could be
19 the third or the first.
20 MEMBER CALLAHAN: This is Mary
21 Beth. I definitely think I would be better in
22 the first, but I'll do whatever is necessary.

1 MEMBER CHIN: I would prefer
2 either the second or the third.
3 MS. PACE: So let's leave them in
4 the second.
5 (Laughter)
6 MS. PACE: We'd have to move all
7 the rooms around.
8 CO-CHAIR FISCELLA: Okay.
9 MS. PACE: I'm sorry, we just have
10 a real technical limitation with where we have
11 a phone to do a conference call with you so I
12 apologize.
13 MEMBER CALLAHAN: No problem.
14 MS. PACE: And certainly the full
15 group is going to address all of these topics.
16 MEMBER CALLAHAN: Great, thank
17 you.
18 MS. THEBERGE: So, for the folks
19 who are here in person you are welcome to join
20 any of the groups and listen in on the
21 discussion.
22 For the folks that are on the

1 phone and the webinar, unfortunately due to
2 technological limitations we can't stream or
3 have a live conference call for this breakout
4 session so we'll have to have you rejoin us
5 after lunch.
6 We won't be disconnecting the
7 line, we'll just go on hold on the phone until
8 after lunch.
9 MS. PACE: So, the breakout groups
10 will reconvene back here at time of lunch to
11 get the lunch which will be at 12:30. So
12 we'll have until 12:30 for your breakout
13 discussions. And hope that you can come up
14 with some top recommendations to bring back to
15 the larger group for discussion.
16 And when you come back you'll grab
17 your lunch and we'll plan to start our
18 discussions no later than 1 but if everyone is
19 in place we may get started a little sooner.
20 The staff will handle that.
21 They'll be taking notes and create a
22 PowerPoint. That's exactly what we'll do,

1 thank you. Okay. All right.
2 Oh, no, we wanted you to self-
3 select. So we're hoping that -- and if we
4 have too many that come to 9 Temp we're going
5 to have to have people kind of move to another
6 group.
7 But for those who want to work on
8 the approaches if you would meet us by the
9 door here. If you want to work on use and
10 implementation guidance stay where you're at.
11 And if you want to work on sociodemographic
12 factors move behind us.
13 (Whereupon, the above-entitled
14 matter went off the record at 11:15 a.m. and
15 resumed at 1:19 p.m.)
16 CO-CHAIR FISCELLA: We're going to
17 go ahead and get started. We hope to finish
18 up at 3:30 and we want to leave time for
19 public comment as well.
20 The way we thought we would
21 structure this is to have each group report
22 out and then have a brief round of clarifying

1 questions. And then after that to have the
2 fuller discussion after everybody's heard all
3 of the reports and has the full context in
4 front of them for that discussion.
5 So we're going to begin with group
6 3 I believe.
7 MEMBER GROVER: Going backwards,
8 okay. So I'm just reporting out for the
9 group. I'm responsible only if you like them,
10 not responsible if you don't.
11 So the idea was what's the
12 context. Are there actually specific things
13 we want to recommend in terms of adjusting for
14 sociodemographic factors.
15 And the group consensus was that
16 individual measures, process and outcomes that
17 are submitted to NQF must include analysis of
18 the data to demonstrate relevance and impact
19 of sociodemographic variables on the risk
20 adjustment model and performance measure
21 score.
22 Now again, the analysis in the

1 measure submission must show why the
2 adjustment is not relevant if that's the case.
3 So again, going back to the CLABSI example, if
4 there's no patient-related factors or
5 resource-related factors that would affect the
6 outcome then that certainly could be the case
7 and those would be put aside.
8 But where they are relevant the
9 developer would submit recommendations
10 specific to the measure as to what
11 sociodemographic variables should be included
12 in the measure specification.
13 So if you wanted to drill down on
14 income and SES they might suggest, you know,
15 ideally you'd want individual income level but
16 all we have is Medicaid eligibility status.
17 But whatever they can come up with ought to be
18 part of the measure specifications itself.
19 And then the third part was where
20 we were -- it was a little tougher to kind of
21 think about how much guidance should there be
22 in terms of what to do with the measure and

1 how to implement where it might be useful.
2 And my understanding again, and
3 anybody that was in the discussion please feel
4 free if I'm misrepresenting this, is that NQF
5 has typically approved a measure and then just
6 bless it to go forth to the world where
7 they're using that for payment policy, or
8 quality improvement, or for anything else.
9 So we think that NQF has had
10 opportunities in the past where they have
11 talked about implementation guidance. And it
12 might be that this is a great measure for
13 quality improvement but really is not ready
14 for payment policy.
15 Some of the examples David
16 actually brought up was in terms of historical
17 data around cardiothoracic surgery performance
18 to say well yes, it's statistically
19 significant that these are different, but is
20 it really meaningful to use these for payment.
21 I think it also leaves open the
22 idea that if there are things that are not

1 available to be adjusted within the measure
2 itself, something like Steve's prior comments
3 around where you have to look at the tax base
4 and the infrastructure.
5 Well, maybe you can make
6 recommendations there that if you're going to
7 use this for payment purposes then you ought
8 to adjust for some other external factors that
9 may not be directly in the measure.
10 Again, that was sort of the
11 hardest thing I think for us as we were having
12 that discussion.
13 MEMBER CASALINO: Let me just add
14 a quick clarification.
15 One is I think we actually used --
16 in terms of the second bullet we actually used
17 the language, it was a little stronger than
18 what we voted on this morning maybe, which is
19 that the default position is that SES or
20 sociodemographic factors are relevant. And so
21 measure developers should have to show a
22 reasonable case that they're not relevant, or

1 should have to show how they're going to deal
2 with them.
3 And then the second point would
4 just be the third bullet, not just what
5 variables should be included but also how they
6 should be included. I think we all agree.
7 MEMBER GROVER: Let me just -- the
8 other thing I forgot to mention is I think we
9 had a feeling that in terms of reporting out
10 of the measures that it would be useful that
11 not only talk about what level, is it the
12 physician level, is it the hospital level, but
13 also reporting the raw or unadjusted data
14 somewhere as well as the adjusted at least for
15 the purposes of people who wanted to look at
16 that more deeply.
17 Well, I don't know that we
18 resolved truly unadjusted, or just unadjusted
19 for sociodemographic factors.
20 There was some -- I think, John,
21 you were talking about there might be a need
22 for consumer group advocates to want to have

1 access to that raw data. And that providers
2 themselves may want to know for quality
3 improvement purposes what the absolute
4 unadjusted raw data is.
5 MEMBER COHEN: I just have a
6 problem with the use of analysis of the data
7 in the first bullet and analysis in the first
8 sub-bullet. So that presumes that you have to
9 do it, an analysis of the data to demonstrate
10 that SES isn't important.
11 To me there are certain outcomes
12 that clearly don't involve this. So clearly
13 you don't want to involve this.
14 And to require a data analytic
15 step to demonstrate what is essentially a
16 logical argument, it just seems it's an
17 exercise in futility.
18 CO-CHAIR NERENZ: Just let me go
19 to Atul with this. Does the word "analysis"
20 on that first bullet imply all-out full data
21 analysis?
22 MEMBER COHEN: I would like

1 argument, either analysis or an argument
2 that's provided.
3 CO-CHAIR NERENZ: Yes, that's the
4 way I had read that bullet. So I just wanted
5 to -- between your question and the answer.
6 MEMBER SAWHNEY: In the language
7 of health researchers, and it's the same thing
8 as Mark was just saying. I think there's
9 importance to conceptual modeling. I mean,
10 you need to have a conceptual model reason for
11 -- the conceptual model needs to be examined
12 and the conceptual model in and of itself can
13 be reason to disallow it.
14 An example, screening for domestic
15 violence of pregnant women. The data may in
16 fact show -- I'm not saying it does, may in
17 fact show that lower-SES women get less
18 frequently screened. But there's no reason
19 why everyone shouldn't get screened.
20 MEMBER NUCCIO: Just a point of
21 clarification. The term in the second bullet,
22 the last two words, "measure specification."

1 Typically that as I understand within NQF's
2 terminology, that describes the numerator and
3 denonimator. And I'm not sure that that -- am
4 I being too restrictive?
5 MS. PACE: Yes, we would consider
6 the risk model part of the specifications.
7 MEMBER NUCCIO: Okay.
8 MS. PACE: Right.
9 CO-CHAIR FISCELLA: Other
10 clarifying comments or questions?
11 MEMBER CASALINO: I was in the
12 group as well. Just to be -- I want to see
13 though. We hadn't really discussed a point
14 that was raised by Mark about do you have to
15 analyze the data. So I just want to make sure
16 we are all clear about that.
17 So, if someone says -- has central
18 line infections, the conceptual model is, the
19 logical argument is that you don't need to
20 adjust for any sociodemographic factor for
21 that. I think we're saying that would be
22 acceptable, right?

1 But I do think that however NQF
2 winds up wording this or putting this out one
3 would want to take care that that door isn't
4 opened too wide. And people can wave their
5 hands around and say oh well, we don't need to
6 do it.
7 And for example, again I keep
8 coming back to this. But for me the poster
9 child example for that is oh no, it's a
10 process measure, we don't have to present any
11 data or any argument. We don't have to
12 consider SES, it's a process measure.
13 And the correlate to that is -- so
14 I think that needs to be made clear that this
15 door is narrow for lack of argument or data.
16 And I do think that a proactive
17 statement somewhere that in the past it's been
18 said that, you know, commonly believed that
19 process measures don't have to be -- you don't
20 have to worry about SES. But in fact if the
21 patient has to do something maybe you do have
22 to worry about it. That would be very helpful

1 I think.

2 Otherwise you're going to have
3 everybody coming to you and saying oh well,
4 it's a process model, we don't have to provide
5 any analysis of SES.

6 CO-CHAIR FISCELLA: One of the
7 other points we wanted to make was that if
8 something is statistically significant and SES
9 or sociodemographic factors do make a
10 difference the idea here would be you should
11 use them because even though you might say
12 well, it's a small difference like in the case
13 of readmissions, you never know how it's going
14 to get implemented. And so the default ought
15 to be adjust the measure.

16 So NQF should issue programmatic
17 guidance on how accountability programs,
18 reports result with respect to
19 sociodemographic variables.

20 So in public reporting showing the
21 measure both ways which is what I had
22 mentioned a couple of minutes ago since I

1 didn't know we had another slide.
2 And that again I think you want to
3 think about whether you want to have it be
4 completely not risk-adjusted versus risk-
5 adjusted for medical effects. I think we're
6 leaning more towards saying, you know, SES and
7 other demographic factors are part of risk
8 adjustment.
9 Pay-for-performance and value-
10 based purchasing. This is where we talked
11 about, you know, if possible NQF could make
12 some recommendations in some cases about,
13 well, should you be trying to use this
14 measurement in attainment versus improvement.
15 If you are using it for those
16 purposes do you want to use the risk-adjusted
17 or the non-risk adjusted. And I think this
18 was just more keeping things front of mind in
19 terms of how much of this is in the control of
20 the individual clinician or the provider.
21 Let's use, for example, a
22 physician who's got low rates of mammography.

1 If you're paying for improvement you'd want to
2 risk-adjust the population that that physician
3 is caring for because you would want to know
4 that they weren't just improving because
5 they're getting rid of all the poor people or
6 other disadvantage people within their
7 practice.
8 So just some thoughts there. I
9 don't know if anybody else, Larry?
10 MEMBER CASALINO: I think that --
11 I don't know if any of this slide is what NQF
12 wants to do.
13 I'd just make a small
14 clarification. I think for the second bullet
15 under pay-for-performance and VBP which is "or
16 a blend of absolute score," I think we
17 actually, we didn't discuss this in detail but
18 I think we meant "and." So you'd be doing
19 improvement and absolute and risk-adjusted and
20 absolute potentially.
21 Although the point was brought up
22 by Alyna that there's lots of other ways to do

1 it as well actually.
2 CO-CHAIR NERENZ: Just a quick
3 question and observation together.
4 In this domain we may conceivably
5 just to look to Karen and to Helen to tell us
6 when we've exceeded the bounds of our charge.
7 Because some of this has to do with how NQF
8 does its business in general and not strictly
9 about the issue of SES. And we may have some
10 thoughts about this.
11 But I think my own personal stance
12 is if you tell us, well, those are all nice
13 but that's not exactly what we asked you to
14 talk about we could say well, okay.
15 DR. BURSTIN: I think anything is
16 fair game at this point. Again, as you heard
17 from Chris and I yesterday, process is in
18 flux. If we can't fit it into the current
19 endorsement process it will build in our
20 strategic planning for the new one. So worry
21 not.
22 CO-CHAIR FISCELLA: Do we have

1 other clarifying questions around this? It
2 sounds like we do.
3 Yes, yes. This is just clarifying
4 so we can get everything out on the table
5 because we don't want to risk not having
6 enough time for all of the reports.
7 MEMBER CASALINO: We should add
8 that Taroon who's standing at the end of the
9 room here did a terrific job leading the
10 discussion. I think really good.
11 MS. PACE: This is for the
12 approach group. And Susannah said she would
13 be willing to present.
14 MEMBER BERNHEIM: I welcome the
15 group members and others to correct me if I'm
16 wrong. We found it a little hard to stay in
17 our own territory but we tried.
18 So one thing we thought in giving
19 guidance to developers is that they should
20 provide a conceptual description, a causal
21 pathway of how SES might influence outcomes
22 and that that should be informed by review of

1 the literature and content experts.

2 We made a particular note that we

3 should differentiate between patient-level

4 analyses and institutional-level analyses.

5 That we need to present the

6 variables that we considered when measures are

7 brought forward. And with a recommendation or

8 a "must" I guess in this case that there is

9 consideration for both patient-level,

10 provider-level and community variables.

11 There was some discussion in our

12 group about the issues around provider-level

13 variables and I don't think we came to a final

14 conclusion on that. But this was an effort to

15 make sure that there was a thorough

16 consideration of the kinds of variables that

17 might be relevant to the measure even if they

18 aren't all instantly available.

19 That there should be analytic work

20 that's done to show the effect of SES on the

21 performance score. So again, not a patient-

22 level analysis but at the performance score

1 level that you could see the measure with and
2 without it, that that would be sort of
3 baseline data.
4 I think Larry made a good point
5 earlier. This is probably all under the
6 circumstances where there's some sense that
7 there's relevance. So the previous group
8 established that there may be measures where
9 you just say conceptually this is irrelevant
10 and at that point -- you don't usually go down
11 this pathway but assuming that for most
12 measures you're going to go down this pathway,
13 or for a good percentage of measures.
14 And then we talked a lot about
15 sort of how do you evaluate whether in its own
16 appropriate risk adjustment variable. And we
17 talked about essentially following the same
18 considerations that we do for clinical
19 variables. So we talked about those a little
20 bit, about sort of the quality of the data and
21 its relationship with the outcome. And that's
22 already pretty well laid out by NQF so we did

1 not rewrite that here.
2 But we discussed are there any
3 particular considerations you want to have
4 when considering bringing an SES variable in.
5 And the group's recommendation was
6 that you look first at the impact of clinical
7 variables so that you're seeing whether or not
8 SES is adding information on top of the
9 clinical variables, that for most measures
10 that would be the approach that we would
11 recommend.
12 And that you would not say that
13 just because there are differences by SES you
14 necessarily would risk-adjust but that you
15 have to again consider the conceptual pathway
16 and particularly consider the possibility that
17 this is mediated by quality differences.
18 I think Tia just made an example
19 it was a process measure, not an outcome
20 measure, but that if you saw that all of the
21 poor providers were doing worse on a screening
22 measure you wouldn't necessarily risk-adjust

1 for that if you felt like it was a performance
2 issue.
3 Okay, we veered a little into
4 group 3. There was a feeling in the group
5 that there should be even more context for the
6 endorsement so that when the -- I think we
7 intended this that the developer would include
8 in the NQF application more information about
9 the indications for use, the data source
10 setting, patient population, level of
11 analysis.
12 This is in there to some extent
13 but there was sort of a sense in the group
14 that maybe there was a need for more
15 information so that the measure was more
16 narrowly defined as to what it had been
17 designed for.
18 Some of these are a little vague
19 so again, the group can weigh in if I'm
20 getting it right. But I think this next point
21 was people felt like it was complicated to try
22 to talk about a measure being both a

1 performance measure and a measure intended to
2 identify disparities. And so that we should
3 separate those concepts with more of a focus
4 in our group on performance measures.
5 But that if you were bringing a
6 measure forward that was mostly intended to
7 identify disparities, that that would be a
8 different concept. And it was hard to try to
9 be doing both in the same thing.
10 And this last one. We had a
11 really interesting discussion. I'm actually
12 going to use the example which was around
13 schools where one of the members of the group
14 had a school where there was scoring where
15 they were provided both the information about
16 how they were doing overall which was a 5 out
17 of 10, and how they were doing compared to
18 schools that had similar demographic
19 backgrounds, and they were a 9 out of 10.
20 And the sense was that -- and
21 they've moved now from a 5 to an 8. And the
22 sense was that the information about the 5 was

1 really important to inspire improvement, that
2 if they had just been given a 9 there might
3 have been complacency. And that the
4 information about the 9 was really important
5 to fairly evaluate given the demographic mix
6 of that school. So this is what -- that
7 intent is not to make everyone get an A was
8 trying to portray.
9 I think by the time we got near
10 the end of this discussion there was a pretty
11 strong feeling among the group that there is
12 a use for both an unadjusted measure, that
13 there should be information about the measure
14 on an unadjusted purpose, but that based on
15 the then implementation purpose you may want
16 to account for sociodemographic factors.
17 Now, this was written as clinical
18 adjustment only for public reporting and
19 accounting for sociodemographics in pay-for-
20 performance. This was at the very end of our
21 conversation. I'm not sure that this is
22 exactly where the group landed.

1 But conceptually the group came
2 back really to some of the conversations that
3 we had very early on which is that maybe
4 there's really a need in many cases to have
5 both pieces of information available.
6 MEMBER NUCCIO: Just a point of
7 clarification. If you go back to the first
8 slide. On the effect at the performance level
9 I think we were pretty clear that we wanted it
10 to look at the effect not just at the patient
11 level but also at the provider level. Given
12 that the metrics are typically used to sort
13 and shuffle providers that we should ask the
14 developer to consider that.
15 And also I think we were
16 reasonably clear that when we said unadjusted
17 we weren't really speaking unadjusted, we were
18 talking about adjusted for sociodemographics.
19 So that we would have a clinically adjusted
20 model and a model that would also incorporate
21 sociodemographics. Unless I'm mis-speaking.
22 MEMBER BERNHEIM: No, that's

1 right. And we should probably fix that.
2 MEMBER COHEN: I must say I
3 recall, and correct me, on the second slide I
4 thought the second bullet from the bottom was
5 report both for public reporting which is --
6 MS. PACE: Well, that was the
7 first group. The group that just presented
8 said they should both be reported.
9 Oh, I'm sorry. I see what you're
10 saying. You're right. I mean, I think
11 Susannah is right and I did this pretty
12 quickly here. So we can come back to that.
13 But I thought that -- I may have captured that
14 wrong.
15 MEMBER LIPSTEIN: What we were
16 trying to capture that when Susannah gets an
17 A it's a real A. When I get an A it's graded
18 on a curve.
19 (Laughter)
20 MEMBER LIPSTEIN: Which I thought
21 was completely fair.
22 But part of it is what we were

1 trying to get at is we just don't want me to
2 lose my inspiration to do better.
3 MS. PACE: Do you want to weigh in
4 on for public reporting? Do you want both?
5 Because I think this was your last statement,
6 and so I just -- it's what I ended up writing
7 down and it may not have reflected the group.
8 MEMBER LIPSTEIN: I actually was -
9 - we were just in our group, I think I was
10 informed, and maybe other members of our group
11 would be informed by the report of the
12 previous breakout group which talked about
13 another alternative to that which had to do
14 with a blended -- either a blended score of
15 partial unadjusted -- for clinical factors and
16 adjusted both ways, or a second alternative of
17 an adjusted figure but you also have to
18 improve.
19 So I think that this topic
20 overlaps, and correct me if I'm wrong, with
21 the recommendation of the other group. And we
22 ought to probably group those together.

1 Because I thought their recommendation has
2 some merit too.
3 CO-CHAIR NERENZ: I was also going
4 to ask about the second sub-bullet there from
5 the bottom. And it may be that -- the thing
6 is that the wording there doesn't quite
7 capture it. But I do think it's really
8 important.
9 Because when I saw it worded that
10 way my eyebrows sort of went up. I said that
11 doesn't sound like at least where we were
12 yesterday.
13 So to use the example of the
14 schools just to try to frame it, let's assume
15 that the 5 and the 8 are both sort of
16 clinically adjusted. I mean it's not -- but
17 just saying.
18 What I read that to say now is
19 that only the 5 would ever be publicly
20 reported. And that just surprises me. And I
21 suspect that that wording is not meant to mean
22 that.

1 MEMBER BERNHEIM: Yes, I think as
2 far as we got in the consensus is that it's
3 useful to have both. I don't think we got
4 quite to exactly how you would use each of
5 them.
6 MEMBER CHIN: So this is Marshall.
7 Another issue that we talked about that I
8 don't think we reached consensus but we
9 identified as an area that needs to be
10 addressed by the wider group is what to do
11 about -- saying about stratification versus
12 statistical adjustment.
13 And whether, if we do address that
14 whether it's better at the level of the
15 instructions to developer and review panel, or
16 more for implementers.
17 MEMBER ADAMS: Just along those
18 same lines that Marshall just mentioned. In
19 the second bullet point just the reason this
20 came up was that we have the table earlier
21 showing the different specific approaches and
22 the pros and cons. It felt like it had a dual

1 purpose of both identifying variance in
2 performance measures as well as identifying
3 disparities.
4 And so we thought that those be
5 separated, that we were really focusing on
6 accountability here, not on disparities. It
7 doesn't mean you can't have two different
8 aims, but each aim deserves its own approach.
9 And so we've decided, or talked
10 about anyway the issue of the approach that we
11 were talking about really is focused on the
12 first goal of performance measurement for
13 accountability, not sort of this additional
14 goal of disparities reduction.
15 MEMBER GOLDFIELD: I just have two
16 comments, questions. Can we go to the
17 previous slide for a second, please?
18 So we had a fair amount of
19 discussion with respect to clinical variables
20 about the issue of health status. And so I
21 for one in terms of the work that we've done,
22 we've documented the importance of health

1 status as collected by either OASIS or MDS or
2 the FIM.
3 And for example, in certain
4 outcomes pertaining to, for example, dual
5 eligibles there would be what I would call an
6 opportunity for improvement in risk adjustment
7 to incorporate health status.
8 The discussion that we had in the
9 next group is that health status is more of a
10 clinical variable.
11 And so I just want to highlight
12 that we often talk about clinical variables in
13 the absence of health status. And within
14 health status is both provider-derived and
15 patient-derived.
16 So for example, in New York
17 they're collecting patient-derived. The FIM
18 and so forth are provider-derived. I just
19 think that needs to be kind of incorporated.
20 Then if we go to the next slide.
21 So my only comment here is the issue of the A.
22 And there's a couple of different points here.

1 I'm not sure I followed all the
2 different clarifications but putting that
3 aside, one thing I tried to point out
4 yesterday is that if you do a, for example,
5 include a particular socioeconomic variable or
6 even some other variables such as a fill rate
7 for pharmaceuticals initially you might -- I
8 think what's so much fun frankly at the end of
9 the day of being a developer is that it's
10 dynamic. It's not static.
11 So you could use it for the first
12 year but then not use it in subsequent years
13 because there would be an expectation that at
14 some point they get their arms around the
15 issue. So I just want to say that.
16 And then secondly, one point that
17 I didn't highlight in the work that we do with
18 states is that the A so-called can be the top
19 quartile. I'll just take that as an example.
20 And the top quartile in the performance and
21 outcome measure is constantly moving. And so
22 we all want there to be perfection. So the A

1 hopefully is a higher A year after year. So
2 I just want to point that out.
3 MEMBER BERNHEIM: Just so people
4 know because there's a lot of questions about
5 what the NQF application actually looks like.
6 NQF requires that measures come back every
7 year. For 2 years it's just sort of for quick
8 updates and every third year it's
9 comprehensive reevaluating and you're re-
10 looking at your risk model.
11 So just on the lines of that these
12 can evolve. There's an absolute expectation
13 that these are evolving. Somebody has to own
14 this measure and keep it maintained.
15 CO-CHAIR FISCELLA: Let's go onto
16 the third report then.
17 MEMBER BHAREL: So, in our group
18 we have just one slide for you. So we went
19 through -- I just want to explain our process.
20 So we went through and looked at
21 the various definitions of thinking about what
22 needs to be included in the risk adjustment.

1 And we started at we thought the
2 narrowest definition was socioeconomic status
3 and then broadened that to include
4 sociodemographic and social determinants of
5 health.
6 And then we went through and in a
7 brainstorming fashion listed everything that
8 we thought could be of importance when risk-
9 adjusting in this realm. And that's what you
10 see in front of you.
11 And then from that what we did was
12 we listed, and in the interest of time we
13 won't go through each one with you, the pros
14 and cons of each in the area of existing data
15 and research on the effects that these have on
16 health outcomes as well as existing capacity
17 to capture data versus future capacity and the
18 like.
19 So what you see here, the top tier
20 are the ones which we could gain consensus on
21 where everyone felt that they should be top
22 tier. And the second tier, it's labeled as

1 such, but it's just other important things
2 that we found that we put in that category.
3 And we did not exclude anything.
4 Just two comments. This has been
5 made before, but very importantly, race and
6 ethnicity is listed but in no way is it as we
7 discussed yesterday at length to be a proxy
8 for SES. But just as it relates to certain
9 specific issues.
10 And then health status, as you see
11 it has a question mark. Norbert just brought
12 this up but we just ran out of time to speak
13 through it more as to what the functionality
14 piece has in comparison to other aspects of
15 health status that are already incorporated in
16 the clinical piece.
17 And then in terms of, you know, we
18 talked a little bit about current data
19 capacities and different pockets of data in
20 future but didn't get very far in that
21 conversation.
22 Members of the group, if you want

1 to add anything please do.

2 MEMBER GOLDFIELD: I think on

3 second tier we also wanted to include patient

4 activation. I think.

5 MEMBER BHAREL: Yes, I'm sorry. I

6 think there was some debate on that but we

7 talked a lot about patient activation as well.

8 CO-CHAIR FISCELLA: Okay. I

9 think, Dave, you got yours up first and we'll

10 go around clockwise.

11 CO-CHAIR NERENZ: Must be a speed

12 of light issue. I think I'm closer. I don't

13 think it was actually faster than the folks

14 over there. You maybe saw it faster.

15 CO-CHAIR FISCELLA: It's possible.

16 CO-CHAIR NERENZ: I like the list.

17 The word "neighborhood" here clearly has to

18 mean something more precise because everything

19 else strikes me as being a measure itself.

20 What is neighborhood?

21 MEMBER QUACH: Well, we had some

22 extensive discussion around that. We went

1 back and forth.
2 In terms of things like income and
3 education we did talk about I think for lack
4 of a better word maybe sort of the way it's
5 measured. Like, you know, Alyna presented on
6 the SES at a neighborhood level.
7 And so we were discussing do we go
8 and try to capture how area matters, where you
9 live matters in terms of you live in an area
10 that's really poor, versus just looking at
11 your income alone. So it's almost what I
12 would call a place-based kind of variable.
13 And we didn't specify all the
14 things that should go in there. Like there
15 was discussion around food deserts and lack of
16 access to certain things. So it's an all-
17 encompassing type of variable but it's
18 something that we wanted to throw out there to
19 consider.
20 CO-CHAIR NERENZ: Okay. Again, no
21 objection. I'm just thinking as we move, if
22 this list is going to be a list of variables

1 this one strikes me as being -- this is a
2 category. And that we may and should just
3 flesh out that category and then in the end
4 the list will be just variables.
5 So individual-level income is a
6 variable. Neighborhood-level income is a
7 different variable.
8 MEMBER QUACH: And I think we
9 probably should say this, that this list isn't
10 ready for prime-time just yet. We do need to
11 sort this out.
12 MEMBER BARGER: I would just say
13 that we were trying to get at there are
14 indexes where you can use Census data at the
15 Census tract level using various variables to
16 come up with characterization of where people
17 live. And so we just, you know, they exist.
18 MEMBER OWENS: I wondered if there
19 was any discussion about the definition of
20 three of the terms that we've been sort of
21 interchanging which is social determinants of
22 health, socioeconomic status and

1 sociodemographic variables.

2 And as we move forward and this

3 becomes more in terms of a report to NQF do we

4 need some conversation around that?

5 MEMBER BHAREL: So we spent the

6 majority of the initial time we spoke talking

7 about that. And we chose to use the

8 definitions in the initial packet that we got

9 which are on page 3 and 4.

10 And so the way we interpreted it

11 was everything that we were speaking about

12 comes under the heading of sociodemographic

13 factors. So we came to agreement that we

14 would use that during this discussion. And

15 it's probably good for this group as a larger

16 whole to either agree or disagree on that.

17 MEMBER CALLAHAN: Page 3 or 4 of

18 what initial packet?

19 MS. PACE: The briefing memo has

20 the definitions in it.

21 MEMBER CALLAHAN: The briefing

22 memo. Yes, I have it somewhere here.

1 MS. PACE: Okay.
2 MEMBER CHIEN: Thanks, Pam,
3 because I have a ditto on that one and I'm
4 glad that the group already resolved it.
5 I have a similar reaction to
6 David's about the list of characteristics
7 here. Because some of them look like very
8 specific in like neighborhoods very broad, and
9 I'm wondering about what we can do to refer
10 people to conceptual models that are about
11 social determinants and factors that are
12 actually modifiable in the healthcare system
13 as opposed to being so specific.
14 Because then I worry that if we
15 have something that is a list like that that
16 people will forget about the overall picture.
17 So I'm not sure if you had time to have that
18 kind of discussion.
19 And then I had just a tiny
20 reaction to what Norbert was trying to say
21 which is that when you start talking about
22 patient activation that doesn't sound like a

1 demographic characteristic to me anymore.
2 That starts sounding like a patient
3 characteristic.
4 MEMBER BHAREL: And part of the
5 reason, it came up at the end of our
6 discussion and we couldn't come to consensus.
7 What you just said were the two sides of it,
8 about the patient activation, the demographic.
9 So we can talk about that in the bigger group
10 if you like. We were probably split about
11 half and half.
12 MEMBER CHIEN: Just and there are
13 plenty of great conceptual models around
14 social determinants that are readily available
15 that I think it would be easy to include in
16 like a packet in the way the terms were.
17 And then there are also -- so
18 there are concepts around determinants of
19 health. But then there's also some good work
20 coming out about patient complexity.
21 So it really takes into account
22 what the healthcare system can actually do

1 which is another way that we could specify the
2 concepts without telling people what actual
3 measure -- what variables to use.
4 MEMBER BHAREL: So it's
5 interesting. I don't know that literature
6 well enough to comment on it, except to say in
7 our group when we were picking the items on
8 this list, and we encourage anybody to add
9 anything or challenge us on any of them
10 because it was really a brainstorming process.
11 But what we were trying to get our
12 hands on were things that are not readily
13 changeable in the healthcare system, at least
14 in the way it's set up today, that the
15 individual who is caring for the person in
16 that health system would not be able to
17 readily change. And that's kind of where this
18 list came from.
19 And some of them are very
20 traditional like income, education,
21 occupation. And some of them are more broad.
22 And really towards the end of our time we just

1 ran out of time but thought that this is just
2 a starting point and these definitely need to
3 be fleshed out and need to be more, there
4 needs to be data behind it and more
5 clarification, specific definitions. Are we
6 talking about an individual organization. And
7 this is really just a point to start the
8 conversation.
9 MEMBER NUCCIO: Did you have a
10 discussion of whether these variables were
11 measured at the patient level or the provider
12 level or community level?
13 MEMBER BHAREL: It's a great
14 question and that was the aim but we ran out
15 of time. So some of them as you're suggesting
16 I think are more applicable to the patient
17 level versus community level.
18 We spoke about it loosely but not
19 enough to give you a listing here.
20 MEMBER PONCE: Two comments. Just
21 I think this is a good list and I think it
22 gets at constructs.

1 And I'm hoping then the actual
2 measures also encompasses not just the levels
3 but also level measures versus stratification
4 measures. So again, that income could be
5 about income and equality. And that race is
6 not just percent race of minority race, for
7 example, but gets at racial -- residential
8 racial segregation.
9 My other comment on insurance
10 status is that may also, you know, in this new
11 world would have to be also fleshed out,
12 getting at subsidy exchange population.
13 MEMBER QUACH: Can I just add that
14 for the insurance we talked at length about
15 the different pieces of it, like the dual
16 eligible and such. So just, we didn't capture
17 it all in this list but it's in the notes as
18 well.
19 MEMBER BHAREL: And I'd have to
20 say, I mean even the first one, income, which
21 seems like gosh, that's so easy, that was a
22 long discussion. That is not easy. It's hard

1 to ask. It's hard to capture. It's
2 politically somewhat incorrect.
3 And so many of these factors would
4 need a great deal more conversation to know
5 what data is available so that it's not a data
6 burden for providers, but also how can we
7 capture things that are meaningful and yet we
8 can get at them. So I think much more
9 discussion.
10 MEMBER SAWHNEY: And we've talked
11 about individual versus neighborhood,
12 especially vis-a-vis income. The literature
13 would tend to support a family measure instead
14 of an individual measure because there are
15 non-working members of the family, stay-at-
16 home parents and such, and they are not
17 socially disadvantaged.
18 MEMBER GARRETT: Just a question.
19 Did you discuss at all health-related
20 behaviors that are highly correlated with
21 socioeconomic characteristics? Such as
22 smoking which is often considered an outcome

1 variable. But just wondering if you talked
2 about that at all.
3 MEMBER BHAREL: So we talked about
4 several things including substance use and
5 tobacco use didn't come up. But along those
6 lines, things that we felt were currently
7 covered in current risk models, we did not
8 include those in these models as well.
9 CO-CHAIR NERENZ: Just as a quick
10 general observation that follows directly on
11 this comment and it comes up I think on the
12 issue of activation.
13 There are a class of variables
14 that I might be willing to call attitudes and
15 behaviors that at least in my sense of the
16 semantics are not sociodemographic but they're
17 related.
18 So in the spirit of this I guess
19 we just need perhaps NQF staff guidance or
20 else collectively as a group, we just need to
21 know how to handle that. Do we talk about the
22 at all? Do we make mention in the report to

1 say yes, these exist, or they're important,
2 but they're not in the -- I'm sorry?
3 Well, smoking is a behavior.
4 Activation is an attitude. Okay? And we
5 could keep going. These are things that can
6 be measured at the individual level but we
7 could debate whether they're stable or are
8 they changeable.
9 I guess I just, and again this
10 just may be purely my semantic bias, I would
11 not start by including them in my mental
12 category of sociodemographic. I think they're
13 something different.
14 I just think they're closely
15 related. And I think we just may need some
16 guidance from those who gave us the charge how
17 do you want us to deal with them.
18 Do we want to have drag-out
19 debates about what the boundary is? Should we
20 just say that there are this closely related
21 set of things that are not in our charge? How
22 do you want us to deal with that?

1 MS. PACE: I don't think that
2 they're necessarily out of the -- I mean, our
3 original charge was really pretty focused on
4 socioeconomic status and we definitely
5 identified that that needed to be broader than
6 just socioeconomic status.
7 And obviously some of these
8 pathways that we talked about relate to
9 attitudes and behaviors. So I don't think
10 it's out of scope.
11 I guess the concern is what we're
12 going to do with these and what the
13 recommendations are. Because I'm starting to
14 now think about these discussions with measure
15 developers and giving them a totally
16 impossible task for things that there are no
17 data currently available.
18 So I think we definitely need to
19 think about them, but also think about present
20 versus future and some of those other
21 considerations we've talked about.
22 CO-CHAIR FISCELLA: I was just

1 going to weigh in here. I think as electronic
2 health records get better it's going to be --
3 and many of these behavioral elements, even
4 some of these attitudinal elements become
5 routinely collected in structured fields it's
6 not going to be that difficult to get them.
7 I think that's undoubtedly the wave of the
8 future.
9 And I think certainly including
10 behavioral risk factors in these models will
11 improve model performance.
12 The question I struggle a little
13 bit with is what's the implications for our
14 group in terms of sociodemographic factors.
15 And you know, what it means to adjust for the
16 BMI and smoking characteristics of the
17 population and what that does. Does that
18 improve incentives? Does that decrease
19 incentives to address these risk factors?
20 So given your guidance it sounds
21 like you're putting it back on us to decide.
22 MS. PACE: Well, and I guess it

1 gets complicated because some of these things.
2 We were trying to identify things that the
3 provider doesn't have any control over.
4 There's a whole lot of, you know,
5 patient activation is a lot of times related
6 to how the provider approaches and their
7 strategies for working with patients. So do
8 we consider that a risk factor?
9 I mean, we're getting much more
10 complicated when we start moving in that
11 direction. And where even though it is maybe
12 difficult to move there are, in fact,
13 interventions that have been studied and have
14 shown some effectiveness.
15 So I think that's where I'm having
16 some difficulty is getting off of the place.
17 You know, because then we really are
18 complicating risk adjustment with things that
19 really maybe are indicative of the quality of
20 care.
21 CO-CHAIR FISCELLA: I just want
22 to, as someone who brought up homelessness I

1 just want to highlight that there are several
2 managed care organizations that are getting
3 into the housing business to try to address
4 that.
5 And so I think the real question
6 at the end of the day is just taking
7 homelessness again as an example is that it
8 should be part of the risk adjustment, but at
9 the same time it is a factor such as some of
10 the other ones that I've mentioned that one
11 can have an impact on.
12 Probably the most important thing
13 I did for one of my diabetic patients in the
14 last month was help him get a job in terms of
15 his diabetes control. Unfortunately I'm not
16 very lucky in that way.
17 But so my point is that there's a
18 very, you know, we're expanding the boundaries
19 of what's expected of us. And in fact the
20 health system is in very interesting ways in
21 some ways trying to respond. And so I think
22 there are some variables that we can make an

1 impact.

2 But the point is again that these
3 variables that we're trying to struggle with
4 should be part of the risk adjustment. And
5 clearly some of them can be done on day one,
6 some on day three and not all of them, and
7 maybe some on day five, on year five. And
8 that's part of what I think will come out.

9 MEMBER OWENS: This is sort of an
10 in-the-weeds comment. In terms of what we
11 haven't talked about is one way to
12 operationalize SES and that is the disparity
13 within a neighborhood.

14 So at least in terms of a causal
15 pathway, it affecting health if there's a lot
16 of disparity of income you're more likely to
17 support outcomes as opposed to if there's
18 homogeneity, whether that be everybody's low-
19 income or everybody's high-income you're more
20 likely to see better outcomes in terms of
21 health. So we haven't really talked about the
22 relativeness of that.

1 The other thing I'd like to
2 highlight is some of you gave examples, and
3 particularly Steve, the relative poverty, what
4 does poverty mean in rural area of Alabama
5 versus what does poverty mean in New York
6 City. And so the regional differences in how
7 one defines it. And it's not just here's high
8 and low poverty.
9 MEMBER CHIEN: I think everyone
10 said basically some element of what I wanted
11 to say. But I also just wanted to self-
12 congratulate the group a little bit. Because
13 it's good to have these problems. Up until
14 now we've said oh, don't think about it so
15 that we kind of were operating with two hands
16 tied behind our backs.
17 And I think it's good to --
18 wherever we're starting to just have this
19 included so that we can have these kind of
20 discussions about well, are they in the risk
21 adjustment or are they actually a process
22 measure in and of themselves.

1 If you recognize that someone has
2 lost their job is it the physician's job to
3 make sure that you reconfigure the medication
4 so that they are as affordable as possible.
5 So I just -- go get them.
6 CO-CHAIR FISCELLA: I want to just
7 echo Alyna's comment. I think this is really
8 a daunting, daunting task. And I think given
9 90 minutes to bring folks together to grapple
10 with these very difficult issues, you know,
11 I'm impressed with what's been accomplished.
12 And we've gotten through the clarification
13 round. I think now we want to move onto
14 broader discussion to where we want to go with
15 these recommendations.
16 MS. PACE: Right. I guess what we
17 can, you know, and we'll have to take the
18 pulse here. I know people are starting to get
19 tired. Kind of have had a lot of brain
20 activity and really appreciate you. It's
21 great to see everybody still hanging in there.
22 So I know that there's a lot of passion for

1 this topic.

2 But I guess maybe if we could to

3 have some discussion of where we can actually

4 start thinking about recommendations, formal

5 recommendations that would come out.

6 I know you didn't really have time

7 to do that in the group and we've done the

8 best we can. So David, do you have an idea

9 how we might start thinking about that?

10 CO-CHAIR NERENZ: Well, I tend to

11 be a very optimistic person about our ability

12 to get from here to there.

13 MS. PACE: Great.

14 CO-CHAIR NERENZ: So, what we have

15 just looked at strikes me as a set of

16 recommendations. And if the task fell to me,

17 or if -- I would say could we then draft a

18 first pass written report I think, yes, it

19 could be done.

20 But what I was about -- the reason

21 I started leaning to the button, I just want

22 to ask does this set of three -- they're not

1 three sets of -- these three bundles. Taken
2 together do they represent what you have asked
3 us to do? Or is there something major that is
4 missing? Other than explanatory text, detail,
5 any resolution about -- because text can be
6 written about this, but it occurs to me that
7 the essence of what we have just seen strikes
8 me as the essence of what you have asked us to
9 do. Is that?
10 MS. PACE: No, I think you're
11 totally right. And I think it's, you know,
12 definitely this would be the start of a draft
13 that we would then come back to the group for
14 further clarification, refinements, et cetera.
15 So no, I think this is a great
16 place to be at this point in our discussions
17 in terms of what the recommendations look
18 like.
19 I guess maybe the question is
20 since we were just doing clarifying questions
21 if we go back through those and see if there
22 are any points of disagreement or conflict

1 that we need to resolve before we would draft
2 them as a recommendation. Maybe that would be
3 the best --
4 CO-CHAIR NERENZ: And that's sort
5 of what I was imagining that the next stage
6 here would be now in a more open sense are
7 there any points on any of these sets of
8 slides that someone says I simply cannot
9 accept that or I disagree.
10 Because if we can work through
11 that bit then we get as we look ahead through
12 the next set. We've got conference calls,
13 we've got circulation of draft materials.
14 That's all a fairly routine process.
15 MS. PACE: Right.
16 CO-CHAIR NERENZ: And people send
17 in comments about I don't like this word down
18 on the bottom of page 17. But that's natural,
19 that's inevitable.
20 But it would seem like the thing
21 here would be to say are there elements of
22 this post-lunch set of slides that anyone

1 would like to say I cannot support this. I
2 will not support this.
3 MEMBER CHIN: So David, this is
4 Marshall on the phone. We only got I guess
5 the first group of slides so I don't see all
6 the slides in front of me.
7 But the other way of thinking
8 about it is are the issues that were discussed
9 at the very beginning of the meeting
10 yesterday, have they been addressed or not.
11 This is the end result part.
12 And I still think that we haven't
13 -- we don't have the answers to the specific
14 practical issues that would come up.
15 So for example, what is the
16 guidance for instrument developers and the
17 review panels versus the implementers.
18 Or, the whole set of issues that
19 Kevin and again Larry in the very beginning
20 have outlined about how they might be used.
21 So all the issues about them, stratification
22 versus adjustment, paper improvement, all

1 those different things. I don't think they've
2 been clearly covered.
3 So that each of the individual
4 things may make sense, but in terms of the
5 practical things that come up I think there
6 probably are still holes.
7 CO-CHAIR FISCELLA: Marshall, did
8 you have a suggestion and a way to address
9 those concerns?
10 MEMBER CHIN: Well, maybe it's
11 complementary. I think that what we've done
12 so far over the course of today has been from
13 the ground up. So like looking forward.
14 Maybe the way to fill in the holes
15 is starting at the back and then working to
16 the middle point. So in other words, if
17 people came up -- what are the concerns that
18 people would have about how these instruments
19 might be used or misused.
20 And then thinking back, well, the
21 recommendations we've made have we covered
22 then what our recommendations are really

1 about, something like that.

2 So for example, again, it's come

3 up yet again that well it depends upon what

4 the instruments are going to be used for and

5 the purpose. So is it to basically make sure

6 that under resource settings the hospitals

7 don't get killed financially and is not

8 cherry-picking at all.

9 Our recommendation is do they --

10 are there unintended negative things that flow

11 from the general-ness of our recommendation

12 right now.

13 My guess is there's going to need

14 to be some more specificity regarding the

15 recommendations and some of the contextual

16 things. So I think that's what's probably

17 missing right now.

18 I mean, all the things, for

19 example, like people in the beginning that

20 raised yesterday some of the sort of

21 fundamental issues which are the classic ones.

22 So for example, you don't want to

1 adjust away disparities to whitewash the
2 situation. At the same time you don't want to
3 harm safety net providers.
4 Again, I think that we haven't in
5 the practical recommendations come up with a
6 recommendation that totally outline, that have
7 a specificity so that we avoid doing harm on
8 either of those different ends.
9 CO-CHAIR FISCELLA: Marshall, do
10 you think that in the discussion of each
11 recommendation that there's an explicit --
12 that those concerns are addressed in some form
13 or fashion, or there's some consideration of
14 those potential unintended consequences either
15 way? I'm trying to get at what the next step
16 would be.
17 MEMBER CHIN: I think you're
18 right, Kevin. I think over the course of the
19 couple of days the key issues have been
20 discussed.
21 But I think probably the next
22 step, if some wise people like you co-leaders

1 and some of the NQF staff try to come up with
2 a draft that was then sent back to us. I mean
3 that's one possibility.
4 But at least take for example like
5 in our breakout group we discussed a lot of
6 the issues. But then in terms of what comes
7 down to the recommendations we have one level
8 of that but there's a stickier, thornier set
9 of practical issues that come up that weren't
10 explicitly addressed and come to consensus to.
11 I think that's probably true of
12 the group as a whole so that even though the
13 issues have been discussed I haven't heard
14 explicit recommendations and explicit
15 consensus on those recommendations. So that's
16 what I think is missing.
17 And it may be hard to sort of hash
18 out as a group right now so maybe the best
19 thing is if a smaller group like you and David
20 and some of the NQF leaders come up with
21 another draft. But I do think that it has to
22 be addressed before I would feel comfortable

1 that we've done our job.

2 MS. PACE: Yes, absolutely. This

3 is not the end of your job, that's for sure.

4 (Laughter)

5 MS. PACE: But maybe, Marshall, to

6 get us started thinking of your concerns. If

7 we go back through the list and at least

8 identify if there are any that people can't

9 live with. If they see a clear hole of

10 something that wasn't addressed. So that we

11 can at least identify that.

12 Because I think it may be

13 something that has been discussed through the

14 day. But you know, we put together these

15 slides on the fly at a very quick. So I can

16 attest that they're not totally representative

17 and complete.

18 But maybe if we just start through

19 them again and just get people's thoughts on

20 potential problems or holes we can at least

21 start addressing that.

22 MEMBER SUGG: So, I wanted to go

1 back to the public reporting of both raw and
2 adjusted data. And I have some concerns about
3 that.
4 Because I think that we can look
5 at the data and a lot of people could look at
6 it and kind of understand how to
7 differentiate, how to use it. But I'm not
8 certain that my patient pulling the
9 performance scores up on the Web and seeing
10 two different performance scores, that they're
11 going to know how to differentiate that.
12 I also -- and I think it might
13 exacerbate that sense that oh, because I'm
14 poor my doctor doesn't have to score as well.
15 So I think it could be very misunderstood in
16 what we're presenting if we put it out there.
17 The other thing I'm concerned
18 about is managed care organizations or
19 insurers looking at that score and saying oh,
20 well you scored top notch on your adjusted
21 score, but you weren't so great on your
22 unadjusted. So you're different than this

1 other doc. So we will differentiate you in
2 that way, that it still could be used in a way
3 that it wasn't meant to be used.
4 So I feel like if we were
5 developing these scores for quality
6 performance measures and we feel that
7 socioeconomic adjustment is important and
8 right to do, that that should be the score
9 publicly put forward.
10 Although the raw score I think is
11 still important and should be something that
12 organizations and providers can have access
13 to, but maybe not in a publicly reported type
14 of way if that's possible. I don't know if
15 that's possible.
16 MS. PACE: And can I just ask a
17 question. And maybe Jean will weigh in on
18 this.
19 Typically when we have
20 conversations with consumer and patient
21 advocates one of their big concerns is
22 transparency. And so if the data exist why

1 not make it transparent.

2 I just think that we have to get

3 some input on that. But you're right, the

4 question of interpretability when you have two

5 scores. I mean it adds a lot of complexity.

6 Jean, I don't know if you have any

7 thoughts on that.

8 MEMBER ACCIUS: You're absolutely

9 correct in that regard. I mean, from the

10 consumer perspective we really want to know

11 exactly good information to help make good

12 decisions, and to understand the different

13 factors that went into that decision is

14 extremely important.

15 MEMBER CASALINO: I think this has

16 been a very, very good meeting. I mean, it's

17 a difficult subject in a big group and to make

18 the progress we've made. I mean, I could get

19 back on the Amtrak train this afternoon now

20 and feel content about what's been done.

21 But I think, I can think of -- in

22 terms of what Marshall said I can think of

1 three areas that could be more worked on at
2 some point.
3 One is I don't know how much work
4 this requires but from time to time the issue
5 has come up, and I don't think it's really
6 covered in the recommendations, that
7 developers, or maybe NQF is already doing
8 this, but developers ought to address the
9 specific case to which their measure is
10 devoted.
11 So is this a measure for -- of
12 hospital cardiac surgery or of individual
13 surgeon performance, right, or both. So it
14 should be specified. And then all dimensions
15 of the measure should address that specific
16 case. That would be one point.
17 The second point would be, as
18 again Marshall said earlier, there hasn't been
19 really a lot of discussion yet about
20 stratification versus risk adjustment,
21 statistical risk adjustment, in relation to
22 specific types of cases or in relationship to

1 how these things might be used in incentive
2 programs. You know, it probably would be
3 useful to have more of that at some point.
4 And the third and last thing I'll
5 mention is, and our group spent a lot of time
6 discussing this in a lively and polite way.
7 And I'm not sure we came to a resolution
8 really.
9 And that's the idea of should
10 anything be said about how measures -- one
11 addresses whether SES is relevant or not. If
12 it is then the measure developer says what
13 they're going to do about it to measure
14 whatever they're measuring.
15 But that's different than saying
16 how might this be appropriately used in an
17 incentive program.
18 And so what we discussed in our
19 group and didn't come to a resolution on I
20 don't think is you just stop at step 2 which
21 is this is how SES gets used in the measure
22 and you leave it at that.

1 And I think some of the group was
2 quite content with that and other people in
3 the group were saying maybe you should go
4 beyond. And so if you go beyond I think
5 there's four possibilities.
6 Well, one possibility is not to go
7 around and the other three would be developer
8 comes up with some recommendations for how the
9 measure could be used in public reporting
10 and/or in pay-for-performance and that's it.
11 NQF doesn't comment on those.
12 The second possibility would be
13 developer comes up with some things and the
14 NQF committee actually evaluates those. And
15 the question was raised well, how are they
16 going to evaluate those. And is NQF going to
17 get into the business then of endorsing for
18 each measure whether there's a good plan for
19 how it would be used as opposed to how it
20 would be measured.
21 And the third possibility would be
22 forget about going measure by measure, but NQF

1 could periodically perhaps help to try to
2 bring some order to a field where that's
3 completely chaotic right now, where each
4 program is kind of doing it in its own way and
5 make some reasoned recommendations with
6 arguments for and against advantages and
7 disadvantages of ways that measures might be
8 used in pay-for-performance and in public
9 reporting programs.
10 So again, I think that's a topic
11 that is not really covered in the current
12 recommendations.
13 CO-CHAIR FISCELLA: Other
14 comments? Nancy, you have yours up?
15 MEMBER GARRETT: So just on the
16 general theme of kind of looking through all
17 the recommendations are there any concerns or
18 things we would disagree with.
19 So I'm not sure I agree with the
20 idea of paying based on a blend of absolute
21 score and risk-adjusted score. I feel like
22 that's a pretty specific recommendation for us

1 to give. And if the risk-adjusted score is
2 really validly taking out the things that we
3 don't want to include I'm not sure that I
4 agree with a blend.
5 So I'm not sure if that was a
6 really solid recommendation out of the group
7 or that was more one of the thoughts. But I
8 wouldn't be comfortable with that being the
9 overall recommendation.
10 MEMBER GROVER: I think it was
11 more just an idea of the kind of thing that
12 NQF might be thinking about in terms of when
13 they issue any implementation guidance. I
14 don't know that -- I don't think it's a firm
15 recommendation, it's just an example of the
16 kind of thing they may want to weigh in on.
17 CO-CHAIR FISCELLA: I'm just
18 curious what the rationale was behind the
19 blended.
20 MEMBER CASALINO: This is for the
21 pay-for-performance. So, yes. I mean the
22 idea that I threw out actually yesterday was

1 that for pay-for-performance as opposed to
2 public reporting one might actually pay on a
3 2 by 2 table. And so you do an improvement
4 versus absolute score.
5 And whether these -- improvement
6 versus absolute score and then a similar blend
7 also of absolute score versus risk-adjusted
8 score. And the final dollar sum that the
9 organization or the individual received would
10 be some blending of those.
11 But I agree, I don't think our
12 group came -- we didn't spend very much time
13 discussing it. I don't think we came to any
14 consensus on it.
15 MS. PACE: And would that be an
16 example of what you were talking about before
17 about the specific implementation guidance?
18 Because that seems very specific in terms of
19 --
20 MEMBER CASALINO: Yes. So I mean,
21 the question is nothing whatsoever could
22 happen with this. Or if NQF encouraged

1 developers to come up with ideas some
2 developer might say that, be left at that.
3 Or the next possibility is
4 developers could be encouraged to come up with
5 ideas and NQF then would say, you know, the
6 measure approval wouldn't necessarily depend
7 on this, but if the idea is going to be put
8 out is that an NQF endorsement of the idea or
9 not.
10 Or, the fourth possibility is
11 forget about measure by measure, just give
12 some general advice. And I don't think the
13 general advice would necessarily be you ought
14 to do pay-for-performance using this 2 by 2.
15 More here's five different ways
16 that these -- given now that we're thinking
17 about SES, you know, this brings up anew the
18 question of how these incentive programs can
19 be devised. They can be devised this way,
20 this way, this way, or this way. And here's
21 advantages and disadvantages of each.
22 I think that would be a huge

1 contribution to the field. And NQF is in a
2 fairly good place to do something like that.
3 MEMBER GOLDFIELD: I'm not in
4 support of that. And the reason why I'm not
5 in support of that, we might work with say 100
6 payers on recommendations. We even have very
7 clear recommendations on how to implement the
8 work that we do.
9 And I'd say 50 percent of the time
10 they completely screw it up, I mean just
11 completely. And I can think of examples in
12 many states.
13 And then the other 50 percent of
14 the time well, it's sort of -- somebody
15 implemented. So the bottom line is these are
16 going to be implemented by the policymakers.
17 These are going to be implemented by the
18 payers. And I think this is really from my
19 perspective getting beyond the charge. So
20 that's my thought. It's getting beyond the
21 charge.
22 MEMBER BERNHEIM: So one quick

1 thing on that and then one other
2 clarification/recommendation.
3 I agree that sort of getting into
4 too much complicated detail about how the
5 payer should pay is maybe beyond where we are.
6 But the concept that the way this
7 should be applied as a performance score might
8 want to be somewhere in between risk-adjusted
9 and not is actually one that I've literally
10 had people on our time say I wish I could just
11 sort of halfway adjust for this.
12 And it comes out of these analyses
13 we've done where we see the differences
14 decrease a lot when we adjust for clinical
15 status but not go away altogether.
16 And then we've done some that I've
17 showed you, but we've also done some much more
18 complicated modeling where we've really tried
19 to parse out how much is driven by a hospital
20 versus a patient.
21 And we end up with these kind of
22 half and half. And the models are confusing.

1 And I don't think every measure developer
2 should try to do these complicated models.
3 But I think there are probably
4 measures where we say blood infections, no
5 risk adjustment at all. Some things where we
6 say we think you just fully risk-adjust
7 because we think the differences we're seeing
8 have nothing to do with providers and there's
9 nothing to do about it and this should be a
10 risk-adjusted measure.
11 But I do think that there's a
12 class of measures where the reason we get
13 stuck is we're sort of like I can't do this
14 right. Like I can't get it quite right.
15 And so the concept that you might,
16 this is really vague guidance, but here we go.
17 But that you might try to represent we think
18 there is -- that some of the differences based
19 on socioeconomic status are going to be able
20 to be dealt with by providers. And some of it
21 we think is residual and not. And so we're
22 not sure full risk-adjusted makes sense. Then

1 you leave it to CMS to deal with that.
2 But you could build in something
3 where we could add guidance that says we think
4 this was one of those middle ground ones.
5 Because I actually think that exists a fair
6 amount. It's not very quantitative.
7 You look like you want to say
8 something on that. Can I make one -- well no,
9 go ahead.
10 CO-CHAIR NERENZ: I was just going
11 to say that was very eloquently stated. We
12 ought to just cut and paste from the
13 transcript and put it in the report.
14 (Laughter)
15 MEMBER BERNHEIM: Yes, you could
16 leave it vague.
17 The one thing I was going to say
18 was just earlier to classifying. It's on a
19 totally different topic. But as much as I
20 appreciate the importance of some of the
21 behavior and attitude factors as potential
22 risk adjusters in certain measures I don't

1 think that they're sociodemographic. And I
2 think in the same way we're just like -- so I
3 would just take those off of our list.
4 And if we're going to give some
5 guidance that says sort of here's the range of
6 measures on first tier and second tier I
7 wouldn't get into behavior and attitude. I
8 just think it's too complicated.
9 MEMBER O'BRIEN: I missed the last
10 hour and I feel like that was a terrible hour
11 to miss and so I hate to repeat any comments
12 that were made.
13 But I just feel like decisions
14 about how to pay and whether to reward
15 improvement and whether to reward on a
16 relative scale among similar providers, that's
17 not risk adjustment. That's a different
18 question. I think it's confusing if we lump
19 them together.
20 I think it's fine for this group
21 to make recommendations about those issues
22 because I think some of the concerns that led

1 to the recommendation never to adjust for
2 sociodemographic factors were concerns about
3 things not being properly incentivized. And
4 so if we can think of alternative ways to
5 address those concerns I think that's
6 important to address.
7 But it's just conceptually very
8 different questions and it makes things more
9 complicated. So I think we should kind of put
10 those aside and come back to them, and focus
11 more on adjustment at the patient level and
12 not where the choice of benchmark should be.
13 MS. PACE: So can we just discuss
14 that a little bit more? So when we talk about
15 risk adjustment, what would you say is not in
16 there?
17 So the obvious, I think you're
18 saying that the kind of organizational
19 stratification is not really, typically, what
20 we're thinking about with risk adjustment.
21 What about stratifying within an organization
22 for, you know, like if you have different risk

1 groups and you report out --

2 MEMBER O'BRIEN: Yes, I think that

3 should be on the table, too. And I think it's

4 closer to risk adjustment, whether it is or

5 isn't, I'm not sure.

6 But, you know, the way I think

7 about that is, if you had all the data in the

8 world, what would be important to know would

9 be how a hospital performs on every category

10 patient, where a category isn't just what's

11 their rates, it's basically the 20 or 30

12 variables you have at your disposal to measure

13 their characteristics.

14 And so really the how well a

15 hospital does would be a, you know, if you

16 call X a variable that represents all of the

17 possible patient characteristics you can think

18 of, how a hospital does would be a function of

19 X. And you'd really like to know performance

20 at each level of X. And what we do implicitly

21 is we create these composite measures that

22 take your performance for lowest SES, middle

1 SES, high SES, and roll them into a big
2 composite measure.
3 And I think the question should
4 be, is it meaningful to report an overall
5 composite measure and what's the justification
6 reporting them all together, versus reporting
7 them out separately?
8 So I think I would put that in the
9 category of, you know, what questions you
10 would be asking and answering with the data,
11 rather than given a particular question, how
12 do you address that question methodologically?
13 CO-CHAIR NERENZ: If I could, I'm
14 just a little concerned that there was a
15 little bit talking past just here, and let me
16 try to paraphrase. I didn't think that Sean
17 was making quite the point that then you
18 responded to.
19 I thought what you were saying,
20 which I think seemed consistent with a lot of
21 the flow of the group, is that a specific
22 question, for example, like payment on the

1 basis of combination of actual, or this year's
2 rating improvement, is a bit outside of our
3 charge, because you could, that's a different
4 question from SES risk adjustment. It's a
5 matter of, you can assume the existence of an
6 adjusted measure and then you can discuss
7 whether that's the right way to pay on it, or
8 not.
9 Now your response back, I think,
10 on the issue of organizational stratification,
11 I would have thought, again, myself, that that
12 still can be on the table in terms of one of
13 many possible methods of adjustment. So I
14 sense --
15 MS. PACE: Well, that's what I was
16 trying --
17 CO-CHAIR NERENZ: -- there was a
18 little --
19 MS. PACE: No, that's why I was
20 trying to clarify, because I thought Sean was
21 saying that, from a traditional way of
22 thinking of a risk adjustment, that that's

1 outside of what people normally would call
2 risk adjustment and that's why I was trying to
3 clarify.
4 MEMBER O'BRIEN: I think it's just
5 a language issue, maybe.
6 MS. PACE: Okay.
7 MEMBER O'BRIEN: And just for
8 helpful communication.
9 CO-CHAIR NERENZ: You know, what's
10 the it then, in what you just said, that the
11 issue of whether you pay on a combination of
12 current and improvement, is one it. The issue
13 of whether you do organizational
14 stratification, as a method of adjustment, is
15 a different it.
16 MS. PACE: Exactly.
17 MS. PACE: Exactly. And I thought
18 Sean was talking about both.
19 MS. PACE: That he thought
20 recommendations about --
21 MEMBER O'BRIEN: I don't call
22 either of those risk adjustment. I mean, I

1 don't --

2 MS. PACE: Yes.

3 MEMBER O'BRIEN: I don't think of

4 those as issues related to risk adjustment.

5 I can see how you could, I mean, I know they

6 are very closely related, but the language I

7 use, is that's not how I describe it.

8 MS. PACE: Yes, we'll go ahead and

9 have public comment. And so, Operator, if you

10 want to open the lines and see if there are

11 any public comments.

12 OPERATOR: At this time, if you

13 would like to ask a question, please press

14 star 1 on your telephone keypad. We'll pause

15 for just a moment to compile the Q&A roster.

16 MR. SHAW: John Shaw from Next

17 Wave in Albany. And just sort of, at the end

18 of the day and keeping in mind, going through

19 similar discussions last week with the

20 Population Health and Wellbeing Committee,

21 there's a couple of viewpoints that I'm trying

22 to consolidate in my own mind to make sense

1 out of this.
2 I think first is, because of that
3 overlap, I would strongly recommend that NQF
4 do the best they can on incorporating both
5 voices into both sets of viewpoints.
6 I guess what struck me is, a lot
7 of what I heard last week was looking at these
8 issues from the population health community
9 perspective and sort of the broad base. And
10 much of the viewpoint here was more from a
11 healthcare delivery viewpoint, how does
12 healthcare delivery view population health?
13 And last week I heard population health
14 viewpoint on healthcare delivery, and they may
15 not always be the same.
16 With respect to two specific
17 issues here, I think there is a strong value
18 on reporting both the clinically-adjusted only
19 and adjusted for socioeconomic, or
20 sociodemographic, and do that both from the
21 perspective of both transparency and the fact
22 that healthcare does not and cannot address

1 all of the issues in there.
2 And this is where you can,
3 essentially, in the educational example, if
4 you report the raw figures, this is the room
5 for improvement by somebody, which may not be
6 healthcare delivery, but maybe the schools,
7 maybe environmental viewpoints, maybe
8 addressing food deserts and things like that.
9 So that gives you room for
10 improvement, but the adjustment for
11 socioeconomic status provides a level playing
12 field for payment within the healthcare
13 delivery system.
14 The second area is the class of
15 measures that are behavioral, or attitudinal,
16 in talking about tobacco use and things like
17 that. I think that has to be addressed in
18 both settings. However you want to call it,
19 it has to be addressed in both settings.
20 The addressing tobacco I can
21 relate to from being on the Lung Association
22 Board and seeing that you can make a

1 difference on smoking cessation and so on, but
2 it does have a bigger impact if you change
3 smoking rules in public spaces and things like
4 that. There's impacts from both sides, and
5 changing things that are behavioral in nature
6 is very difficult and essentially does drive
7 some of what we're trying to get at, in terms
8 of equity.
9 So do you want to encourage people
10 to avoid signing up smokers because you know
11 their outcomes are going to be worse and it
12 may not be easy for you to change their
13 behavior. So addressing that is appropriate.
14 And I think that's it. Thanks.
15 MALE PARTICIPANT: Thank you.
16 Thank you, John.
17 OPERATOR: There are no public
18 comments or questions at this time.
19 MS. PACE: Okay, thank you.
20 MR. SIGNER: Bill Signer with
21 Healthfirst. Yes, and I want to reiterate, I
22 think it's great what you're doing here. It

1 really is important, because these quality
2 standards do make a big impact on how things
3 get rated.
4 What I note is, and I understand
5 why and I think it's just fine that the focus
6 has been mostly on the hospitals and the
7 providers. And I understand that's an
8 important focus, a lot of these issues do
9 resinate in that area.
10 The concern I have is, when you're
11 looking at Medicare and you're looking at the
12 Medicare Advantage populations, that the same
13 criteria may not apply. And what I mean is,
14 things like income, language and education may
15 well apply, but things like insurance status,
16 clearly does not apply. Things like whether
17 people are on SSI may not be as good of an
18 indication, because most of these people are
19 on Medicare and Medicaid and then less likely
20 be on SSI. So I just want to make that
21 general point.
22 What I do want to point out is

1 that there are some criteria that are working
2 now. We're talking about socioeconomic
3 status. One of the things that strikes me the
4 most about the way it's applied, in terms of
5 MA, is there is actually a negative adjustment
6 to the plan if you have a high percentage of
7 low-income patients. A negative adjustment.
8 They put one in on the caps. So this is
9 really having a big impact. It really does
10 affect how you score and it's something that
11 we're very, very concerned about.
12 On the positive side, some of the
13 things we would like to point out that could
14 be looked at are improvements. Improvements
15 have been discussed here, it's a real big
16 issue.
17 A lot of these plans that are
18 focused on low-income folks have been
19 improving, but they're not getting to the
20 level that you want them to get to. If you
21 don't emphasize improvement more -- and now
22 it's about seven percent, we're saying it

1 should be more like 25 percent -- what's going
2 to happen is these plans are going to fall
3 away and say, why bother. Why bother meeting
4 quality standards, if in fact I can't get
5 there? We have benchmarks that keep on
6 changing on us. More people make it. It
7 becomes harder and harder if you don't grade
8 improvements more, then these plans will just
9 give up and people will fall out of the
10 system.
11 Casement adjustment for medication
12 adherence, there is none in MA, so that's a
13 big problem for us. One of the areas I want
14 to suggest, if you need a proxy, to figure out
15 what is an SES, socioeconomic status, why
16 aren't we looking at health professional
17 shortage areas? They're out there, they're
18 graded, everybody knows what they are. If you
19 need to change the standards because there's
20 too many that are out there, if that's the
21 issue, and we've heard that a little bit from
22 CMS, then change them.

1 But use it, because that's an
2 indicator of whether the people have access to
3 care, or they don't have access to care. And
4 if they don't have access to care, what's
5 going to end up happening is, if they have to
6 travel long distances, or they go to a clinic
7 where it's crowded, the scores on patient
8 satisfaction go down tremendously. Or they
9 can't get an appointment, they go down
10 tremendously. Then you don't have compliance,
11 they don't get the care they need. And you
12 wonder why they don't come out and do as well
13 as they should do.
14 And again, it is, in many of these
15 areas, the providers, or the plans, are doing
16 the best they can trying to serve the
17 populations they're serving, but the demand
18 exceeds the supply of physicians. And you
19 compare that against plans and providers that
20 are in areas where there are surplus of
21 services, I don't see how you're going to come
22 out and get a real, true picture of whether a

1 plan, or a provider, is doing a good job.
2 Finally, on the stratification,
3 again, we think this is important. I know
4 there's been discussions about the dual
5 eligibles. I think it's important to put it
6 in there. I recognize the issue about
7 Medicaid's going to vary from state to state.
8 In terms of MA, you could look at low-income
9 subsidy, which would be another way to get at
10 it if you have a problem with the dual
11 eligibles. So we think the dual eligible
12 issue was something that is looked at in MA
13 quite a bit because they have the dual
14 eligible snap, so it is accepted in the MA,
15 maybe not as good for providers. Thank you.
16 MALE PARTICIPANT: Thank you very
17 much, very helpful.
18 CO-CHAIR NERENZ: If I could just
19 do a very quick response right on that point?
20 MS. PACE: Go ahead.
21 CO-CHAIR NERENZ: And again, all
22 I'm doing is checking an assumption. If we

1 provide in our report a list of
2 sociodemographic factors that we speak
3 positively about, I'm presuming that we are
4 not going to write words that suggests these
5 variables must be included in adjustment
6 models in all circumstances.
7 So I hope, and we'll check
8 ourselves, but we're not going to say that
9 insurance status should be included in an
10 adjustment model for measures applied to MA
11 plans.
12 MR. SIGNER: No, I just wanted to
13 point that out because I knew you were talking
14 more in the hospitals now.
15 CO-CHAIR NERENZ: Okay. But, no,
16 I think it's a valid point, but I just want to
17 make sure that -
18
19 MR. SIGNER: Yes.
20 CO-CHAIR NERENZ: -- we keep that
21 in mind in the right way.
22 MR. SIGNER: Sure, yes.

1 MS. JESTER: Hi. Michelle Jester
2 with the National Association of Community
3 Health Centers, but these comments I'm saying
4 as an individual. Thank you all just for
5 tackling such a complex issue and for letting
6 us listen in and make some comments. Most of
7 these comments relate to the discussion that
8 happened in the Breakout Group Number 1 on
9 which sociodemographic factors to include and
10 risk adjustment.
11 I would recommend that the
12 Committee really broaden the scope and try to
13 flesh out that neighborhood factor to really
14 include more patient-related variables, to
15 include things such like, food and security,
16 housing and security, transportation safety,
17 home environments, domestic violence,
18 emotional/sexual abuse. Because obviously,
19 there's a lot of research out there that shows
20 that these lead to poorer health outcomes.
21 And not just the direct relation, but the
22 stress that they cause, just leading to poor

1 health outcomes as well.
2 There was also discussion in that
3 breakout group on concerns about asking these
4 types of questions, in terms of how
5 comfortable it would be for patients to answer
6 them. And, obviously, we need to be very
7 sensitive to that and ask the questions in a
8 way that it would be comfortable for the
9 patients to answer. But there is research
10 that shows that patients are actually really
11 glad that healthcare organizations are taking
12 an interest in these areas and are taking
13 these into account. So I just wanted to put
14 that out there as well.
15 And then, finally, to echo what a
16 lot of people have said already, I think
17 Rachel mentioned this yesterday, but a
18 recommendation from NQF has a lot of broad
19 impact and implications, and so even if there
20 isn't data collected on these issues now, with
21 the recommendation from NQF, they will be
22 collected. There are actually already a lot

1 of tools, both validated and not, but a lot of
2 them are validated that are collecting
3 information on a lot of the sociodemographic
4 factors and I think that will only increase
5 over time. So, thank you.
6 MR. DEMEHIN: Good afternoon.
7 Akin Demehin from the American Hospital
8 Association. I just again want to thank this
9 Panel for an incredible discussion over the
10 past couple of days, and for all of the
11 thoughtful recommendations that are coming
12 forth from the group so far.
13 I just wanted to reflect on just a
14 couple of aspects of this that you all have
15 tangled with over the past couple of days.
16 The first is the issue of reporting unadjusted
17 rates and adjusted rates.
18 And I think we share a similar
19 concern about how those data will be
20 interpreted by those using them. Often times
21 these data are turned into public report
22 cards, some of them generated by CMS, some of

1 them not. Making sure that people are drawing
2 the correct inferences out of the data that
3 they're given is definitely a challenge. That
4 being said, we absolutely agree that having
5 access to both kinds of data is important for
6 understanding disparities. So definitely an
7 issue that I would encourage you to continue
8 grappling with as you develop this report.
9 And the other thing that I would
10 say is, I think there have been a couple of
11 discussions around, you know, has the
12 discussion at the group been too focused on
13 one kind of provider, has it been too focused
14 on hospitals? And certainly, we are very,
15 very concerned about socioeconomic adjustment
16 for various measures. The recommendations of
17 this committee will have a lot of legs and a
18 lot of life. So certainly, making sure to
19 build in some flexibility, so that as a
20 healthcare system evolves, the approach is not
21 so deterministic that better ways of adjusting
22 aren't ruled out because the guidance isn't

1 flexible enough.

2 And, you know, we think that the

3 issue of SES will continue to be an issue, but

4 the science around it and the way that you

5 adjust for it may change in the future and the

6 report should accommodate that. Thank you.

7 MS. PACE: Operator, anyone else

8 on the line that wants to make a comment?

9 OPERATOR: No, ma'am, there are no

10 public questions or comments.

11 MS. PACE: Okay. Go ahead.

12 MS. PRASAD: Hi, my name is Ricca

13 Prasad, and I am a student at the George

14 Washington University. Thank you for allowing

15 this discussion to be listened to by the

16 public. There's a lot of wisdom in this room

17 and I feel that I've learned a lot.

18 As my colleague, Michelle, said, I

19 would just like to put a plug in for some

20 other sociodemographic variables. I really

21 like all the discussion that's happened around

22 homelessness, I think it's great. But I think

1 it's also a very extreme case of patient
2 complexity. And some of the barriers that
3 overlap to create that situation also affect
4 a wider proportion of the patients that you're
5 trying to adjust the risk for.
6 And some of those overlapping
7 barriers that I see are things like food
8 insecurity, housing insecurity, and safety.
9 And so although a patient may not be homeless,
10 you know, they may be facing the decision of
11 whether they purchase food versus their
12 medication. Or they may have a house that's
13 been in their family for generations, but at
14 the same time they may not be able to afford
15 clothing.
16 So I just wanted to say that I
17 think those are also critical barriers to
18 address. And then also, personally, I
19 specifically study incarcerated populations
20 and I haven't heard a mention of them at all,
21 but re-entry is a big issue right now in this
22 country. We do incarcerate at the highest per

1 capita rate in the world and as the government
2 continues to focus more and more on re-entry,
3 I think healthcare is a critical link to help
4 former inmates re-enter society, and so I
5 would just like to point that out in this
6 conversation. Thank you.
7 MEMBER GOLDFIELD: I think I,
8 maybe several others, mentioned incarceration
9 yesterday, and I think we just, I think,
10 omitted it. But I know New York State, they
11 are incorporating incarceration and they're
12 linking several databases, one of which has
13 incarceration as part of the issue of risk
14 adjustment. So I appreciate your highlighting
15 that.
16 MEMBER SAWHNEY: It's particularly
17 important in the Medicaid environment because
18 we, by definition, are getting under, for the
19 states that are expanding, everyone as they
20 walk out of prison and jail because by
21 definition, they don't have a job and they
22 don't have an income.

1 And we know that the vast majority
2 have some sort of alcohol or substance abuse
3 problem. But it may not be documented in
4 their health history. So whereas you might
5 say you pick it up on clinical risk
6 adjustment, you might not be.
7 MEMBER NUCCIO: A quick comment
8 about the slide that's up here. The words not
9 relevant were bothering me. And I was
10 wondering, if one of the rationales for
11 including representation of a sociodemographic
12 information on there is to assuage
13 a provider the perspective of fairness, then
14 I'm not sure how one could, you know,
15 adequately deal with that in an analytic way,
16 other than that you've, you know, interviewed
17 providers, as part of your process.
18 I'm, you know, I could certainly
19 leave it and we can discuss it, but that was
20 a concern that if we simply not including
21 socioeconomic or sociodemographics, based on
22 clinical reasons, as Larry has pointed out,

1 that if we are also going to use the criteria
2 of perceived fairness of the metric, then it
3 would be more difficult to do that.
4 MEMBER GROVER: I think when we
5 had the discussion in the group, the idea was
6 that if it wasn't clinically relevant you
7 wouldn't, as in the case of central line
8 infections, you could go through a conceptual
9 construct and say, you know, it just doesn't
10 have a role here. But we wouldn't want to
11 hamper the ability to collect information and
12 at least know if there are disparities there.
13 If it turns out that, you know, blacks
14 actually have a higher central line infection
15 rate, you would want to know that, right?
16 So it may not be used in an
17 adjustment, but you still want to collect
18 information for the disparities.
19 MEMBER CASALINO: But I mean --
20 yes, it would be nice to know that, but I
21 mean, the guidance to the committees from NQF,
22 for example, I mean, I think would be this

1 word, analysis could imply you need to bring
2 data.
3 And I, personally, wouldn't want
4 to say okay, if you want to bring up a measure
5 about central line infections, you have to do
6 an analysis to see if certain groups of
7 patients have higher rates of central line
8 infections than others. I mean, I think I
9 would rely on the Committee's common sense in
10 evaluating the argument made by the developer
11 measure that no data is needed, right?
12 And in some cases that may seem
13 pretty clear, and in other cases it would be,
14 you know, it may not be so clear. And then
15 the Committee and the developer are going to
16 have to deal with it. I mean, I think that's
17 the best I can think of.
18 CO-CHAIR NERENZ: And I was just
19 going to make a similar point. I thought that
20 when we had this slide up earlier, when we
21 were doing, immediately after the groups, that
22 we kind of decided as a group the word

1 analysis, here, was probably going to change
2 to something like rationale, meaning that it
3 was not designed to imply formal statistical
4 analysis.
5 And I think that, to me, would
6 provide some reassurance, Jean, to your
7 question, that not relevant, with that change
8 in wording, could basically imply that the
9 conceptual model, the rationale, had evidence
10 in it that SES factors were not relevant, or
11 should not be relevant. And others gave some
12 couple of examples of that.
13 Again, as Larry pointed out, that
14 this is the kind of thing, I think, as we
15 envision this whole process in the future of
16 being under the judgment of an NQF panel who
17 sits reviewing these materials and endorsing
18 the measures, I realize it still leaves some
19 fuzziness in there about what should come
20 forward and what should not come forward.
21 But at least, I thought, by
22 rethinking that word, we have not implied that

1 a developer must show formally, empirically
2 that some set of SES variables do not matter.
3 I don't think we had set that bar in place.
4 MEMBER NUCCIO: I was more
5 focusing on sort of another rationale for why
6 we were doing this. And that is that by
7 including sociodemographics in there, we are
8 saying to providers, we recognize the
9 differences among the patients you serve
10 beyond their clinical characteristics.
11 And so if a criteria for ensuring
12 that it's in there is the criteria of
13 fairness, then not including it might imply
14 unfairness, okay. And trying to, you know,
15 demonstrate a negative is a little, you know,
16 challenging.
17 CO-CHAIR NERENZ: Yes, and it's,
18 if I can just go in a little bit, we start to
19 now imagine future scenarios that are hard to
20 imagine, when we split hairs and whatnot.
21 You know, Steve, yesterday, made
22 the point I think on this issue, that in many

1 cases you may conceivably wish to include an
2 SES variable, even if it is not significantly
3 associated in the empirical sense, because
4 doing so will improve the perception of
5 fairness in the community, it will cut off
6 objections and what not.
7 And I don't think that line of
8 thought conflicts with what I perceive to be
9 on the screen. And that is that if in the
10 course of presenting the conceptional model
11 and the logic for a particular measure,
12 including the contents of risk adjustment, a
13 developer says there's just no conceptual
14 basis for including SES.
15 And in fact, no providers out
16 there are going to think it's unfair if we do
17 not. Now, of course, well they'd have to
18 argue that. But, you know, then at least, if
19 I imagine myself a member of that review
20 committee, I'll probably say, oh okay.
21 But I could also see a little
22 different branch where they'd say, you know,

1 we don't think, scientifically, it should
2 matter, we don't think, empirically, we see it
3 matters. But we do understand out there in
4 the provider community, and therefore we, you
5 know, have put it in anyway, or something like
6 that. To my ear, we haven't said anything
7 that somehow makes that process of putting
8 information forward and evaluating it bad.
9 MEMBER BERNHEIM: If I could, just
10 a few points, and these are language points,
11 but I think in this case the language would
12 work. I would not use the word fairness,
13 anywhere.
14 Because, you know, different
15 people have different definitions of fairness,
16 right. And some people think fairness is, I
17 got the best score, you give me the best pay,
18 right. So that would be number one.
19 Number two is, I would just
20 emphasize again, I really would make very
21 clear that the default position that the
22 Committee, and therefore the developer, should

1 take is that SES is relevant, unless logic
2 and/or data convince the Committee otherwise,
3 right. And I would add a sentence or two that
4 would say, stating that something is a process
5 measure, with no other argument, is not
6 adequate to show SES is not relevant.
7 And that was all I was going to
8 say. But in relation to Steve's point, I'm
9 glad it came up. I actually, I think, and I
10 think Susannah's going to probably say this
11 too, I think I would disagree that if an SES
12 variable does not add anything to the model,
13 put it in, because it might make some
14 providers happy, I think is a mistake because
15 people are going to notice that.
16 And then there's going to be the
17 whole clamor that this is completely
18 unscientific. You know, variables are being
19 put into the model that by any scientific
20 criteria it ought not to be in the model and
21 it's just pandering and it makes the model
22 inaccurate and so on and so forth. So that

1 one has troubled me, but although I'd be
2 interested to hear what other people had to
3 say. I wouldn't do it just to make providers
4 not complain, in other words.
5 MEMBER LIPSTEIN: I don't know why
6 you don't want to pander to me.
7 (Laughter.)
8 MEMBER LIPSTEIN: I think that
9 you're correct, if we're just talking about a
10 few providers, we're just talking about a few
11 providers.
12 But we talked about this in our
13 breakout group a little bit, about whether
14 less is more, or more is more. And if there
15 is broad industry concern with an unadjusted
16 measure and then the idea of adjusting, in
17 order to gain broad acceptance, not one or two
18 complainers, but broad acceptance, I think is
19 a big deal and one that NQF has to consider.
20 If 800,000 physicians are going to
21 reject a measure because it's not adjusted,
22 that's not one or two complainers, okay? If

1 5,000 hospitals are going to discredit a
2 measure because it's not adjusted, that's not
3 one or two complainers.
4 And so I do think, one of the
5 things we talked about in our panel a little
6 bit, was whether or not in addition to TEPs,
7 Technical Expert Panels, there could be
8 another kind of a panel which has to do with
9 end user application, an end user
10 applicability panel, that basically provides
11 it --
12 (Off microphone discussion)
13 MEMBER LIPSTEIN: Yes. So that
14 the likely -- that's exactly right, to do
15 stakeholder engagement with the likely
16 complainers, about a measure, is a great way
17 to onboard them at the beginning of the
18 process instead of waiting until it comes out
19 of CMS.
20 MEMBER BERNHEIM: Not
21 surprisingly, I agree with you, Larry. I
22 think it's a very slippery slope to create

1 criteria that says, purely for acceptability,
2 we're going to bring something into the model.
3 I think there are times where
4 we're making decisions, where it's uncertain
5 what the right thing to do is. And then
6 there's lots of reasons to pay attention to
7 the stakeholder standpoint.
8 But, ultimately, they're meant to
9 be, sort of, scientifically valid measures.
10 And, you know, if all the hospitals in the
11 country came and said, we think you should
12 risk adjust for complications, I don't care
13 how many of you there are, if it's
14 scientifically wrong to do. So I think, you
15 know, there is a place for user acceptability
16 playing into it, but it's not as the sole
17 motivation.
18 I'm also a little bit
19 uncomfortable with something that you were
20 just suggesting, which was, sort of, saying
21 that the guidance is, when in doubt, we
22 recommend risk adjusting.

1 I think there are going to be,
2 again, cases where it's quite clear, and
3 there's going to be cases where it's very
4 fuzzy and there's risks to both sides.
5 And so I think it's much better if
6 this Committee comes forward saying, we want
7 a cogent description of what you considered
8 and the pathways and why this makes sense, or
9 doesn't.
10 Unless the scientific panel
11 address that, I think, especially in a context
12 where we may not always have the right
13 variable, if you said or say, when in doubt,
14 risk adjust, that's also going to cause some
15 problems.
16 So I would rather that the
17 language be a little bit more neutral, but
18 setting a high bar for thorough
19 considerations, so that the scientific
20 committee has a lot to evaluate about what the
21 decision was and whether it was the right one,
22 in that case, so that measure.

1 MEMBER GOLDFIELD: In a positive
2 way, though. Susannah and I we're saying that
3 it's been such a pleasure to sit next to each
4 other, because it's, you know, we're
5 colleagues and we're learning from each other.
6 But within in that spirit, I have
7 to disagree, which is to say, again, at the
8 risk of being repetitive, I think we have to
9 distinguish between variables.
10 Let's just take the two extreme
11 examples, like complications, you know, that
12 if some hospital says, we're going to risk
13 adjust for complications, that everybody
14 agrees with complications, then you laugh them
15 off the face of the earth.
16 There's a separate issue, which is
17 not part of the conversation, as to whether or
18 not you should include complications, where
19 you're not sure they're complications, into
20 the risk adjustment model, so let's put that
21 aside.
22 The issue, however, to take an

1 example, is homelessness. And I'm going to --
2 we don't collect it. However, there are
3 states that are just saying, we believe, we
4 have a consensus that it makes a difference
5 and we are going to collect the information
6 and we're going to go further.
7 We are going to use the Number 2
8 in charge of Medicaid for one state, we're
9 going to goose up a payment rate for people
10 who are homeless, because of the fact that we
11 believe it's true.
12 Now we don't know how much we
13 should be changing it, but that's essentially
14 a belief that with respect to homelessness,
15 that we should be, essentially, adding in that
16 factor, even though we don't know to what
17 extent it is.
18 So I think it really depends on
19 what the variable is. There are a whole bunch
20 of variables that were listed, some of which
21 have stronger face validity than others.
22 And I think that's, you know,

1 we've made so much progress, so I'm happy to
2 even have, you know, come up with, you know,
3 what Susannah was saying.
4 But I think there's just some
5 variables, because just at the end of the day,
6 what Steve has said that, you know, for some
7 parts of the country there's not as much time
8 for low income populations, in terms of health
9 services being cut back, you know, we should
10 be in a positive way, aggressive.
11 MEMBER SUGG: I think we should
12 though keep in mind, when we talk about
13 whether to put a socioeconomic factor in,
14 based just on, scientifically, whether it
15 makes a difference.
16 I think there's a difference
17 between something that is significant in an
18 epidemiologic sense, and something that's
19 significant in what the pay for performance
20 folks will do.
21 So you may have a 0.2 difference,
22 which is not significant, but that 0.2 may

1 represent tens of thousands of dollars to an
2 organization.
3 So I think we have to be a little
4 careful about how we use, or how we define
5 what is a significant shift in socioeconomic
6 factors, because it's very different,
7 depending on how you're going to use the
8 information.
9 MEMBER LIPSTEIN: I think that
10 that's the point that's got me concerned about
11 this, is that the more discretion the measure
12 developer has, given that measure developers
13 are in a very difficult position, because
14 they're trying to work with limited data sets
15 that are available at the national level. And
16 the implications of their adjustment decisions
17 are profound, are significant and material.
18 Now, in a monetary and a human
19 impact sense, there just has to be a broader
20 process and a more inclusive process of what's
21 relevant and what's not, when it comes to
22 adjustment.

1 I just don't think you can leave
2 the topic of relevance up to a statistical
3 analysis. That's what worries me a little
4 bit.
5 And so, especially since this has
6 really got to move into the public domain in
7 ways that are unprecedented for measure
8 development in the past.
9 MEMBER CASALINO: I think, in
10 terms of Steve's argument, that even if a SES
11 variable doesn't really add any information to
12 the model, if providers thinks it's important
13 maybe it should be there anyway.
14 We don't have to just -- I think
15 there is a specific case about which we can
16 discuss this, it's actually happened and we
17 don't have to discuss it just in the abstract.
18 Rachel, correct me, if I'm wrong
19 in what I'm about to say. But, Rachel Werner
20 wrote a paper some years ago that launched her
21 amazing career since then, which showed that
22 prior to the New York State Public Reporting

1 Program for Cardiac Surgery, there were
2 black/white disparities in bypass surgeries
3 with blacks having less, for better or for
4 worse.
5 And that when New York State
6 instituted that program, it had pretty
7 sophisticated, especially for the time, risk
8 adjustment formula that deliberately didn't
9 include race, because the designer said it
10 doesn't have any effect on the outcome, that
11 after we adjust for these other things,
12 whether you're black, or not, doesn't affect
13 your mortality rate for cardiac surgery.
14 And what Rachel found was, as soon
15 as that program was instituted the gap between
16 blacks and whites in rates of cardiac surgery
17 in New York State increased.
18 And over the same time period in
19 some states that she looked at where there was
20 no program, there was also a gap, but it
21 didn't change.
22 So that and some other evidence

1 suggested that surgeons didn't believe the
2 risk adjustment formula and they thought that
3 they were going to get worse results with
4 their black patients, regardless of what the
5 risk adjustment formula said. Is that a fair
6 characterization, Rachel?
7 MEMBER WERNER: Yes.
8 MEMBER CASALINO: So the question
9 then, you know, not abstract but really real,
10 does that mean that the New York State program
11 developers should use race, or should have
12 used race, or not, right?
13 Because in fact, had bad
14 consequences for African American patients
15 that it wasn't used. On the other hand, it
16 didn't appear, my understanding of the story
17 is there was no scientific validity to use it.
18 Do you have anything to add to that, Rachel?
19 MEMBER WERNER: I don't know
20 anything about whether, much more than what
21 you just said about whether or not, why they
22 didn't include race in the model, I think it

1 was because it didn't do much. But it
2 subsequently had consequences for patients in
3 New York.
4 MS. PACE: For patients, in terms
5 of getting the surgery, versus any change on
6 the mortality rates, is that what you're
7 saying?
8 MEMBER WERNER: Well, so far fewer
9 black patients and Hispanic patients got
10 surgery compared to beforehand.
11 MS. PACE: Got surgery.
12 MEMBER WERNER: I don't know, it
13 could have been good for those patients not to
14 get surgery, I don't know. But, it reduced
15 their access, is all I can say.
16 MEMBER JIMENEZ: I had a question.
17 I wonder if we could skip ahead, it may have
18 been like the, I don't know what slide number
19 it was, but it was, I think, for the Group 2's
20 recommendation.
21 MS. PACE: Those are about the
22 measure development and statistical --

1 MEMBER JIMENEZ: I think the
2 measured development --
3 MS. PACE: Okay.
4 MEMBER JIMENEZ: -- part. I mean,
5 my question was, I don't know if I misread it,
6 or I misunderstood, but I was wondering if it
7 was actually a recommendation that the measure
8 developers should run their measure through
9 sort of the P for P methodology, to see if
10 there was an impact, whether or not there was
11 a risk adjustment that was applied. So that
12 was one thing I had a question about.
13 MS. PACE: No, I think it was to,
14 you know, do a conceptual review of the
15 reasons for including our relationship of
16 these factors and then to look at the impact
17 with and without it.
18 I don't think, we didn't get,
19 specifically, that they should use the P for
20 P methodology, because, I mean, that's a very
21 specific -- so we didn't get to that level of
22 dictating what ways they would look at it with

1 and without, but I'll let Sean and Susannah
2 and Mark, Jean, weigh-in.
3
4 MEMBER JIMENEZ: Yes, I guess the
5 affect of performance score with and without,
6 I wanted more clarification on what was meant.
7 MEMBER BERNHEIM: I mean, I think
8 often we don't know, I mean, as people have
9 said, often these measures get used in ways,
10 so I don't think, realistically, that you
11 could do that, because you often don't have
12 it.
13 And sometimes they, you know, use
14 information to, you know, that, like, HBVP
15 lumps four measures together, or however many
16 measures. So I don't think, realistically,
17 you can use that. It was really to look at
18 the performance scores.
19 And I do think, probably, it's
20 valuable to say, sort of the distribution of
21 performance scores across stratified
22 providers, because I think that's an important

1 thing to look at.
2 MEMBER JIMENEZ: Right. Because I
3 think my question was, whether or not that
4 would compromise, like, the scientific
5 validity of your measure development.
6 So for example, like in the
7 measure you were talking about with re-
8 admissions, you didn't see an effect of when
9 you applied the Medicaid adjustment, for
10 example.
11 But, if you actually ran it
12 through the HGP methodology, you probably
13 would see a big difference, potentially. And
14 so would that lead to saying we should risk
15 adjust, but it sounds like that's kind of a
16 moot point.
17 But my other question was really
18 around will there be an opportunity, at some
19 point, to talk about what types of variables
20 should not be used for an SES proxy under
21 certain circumstances?
22 Like, for example, you probably

1 want to put out there that maybe county income
2 shouldn't be used for, like, an individual
3 level, or even for a hospital level
4 adjustment, for example.
5 CO-CHAIR FISCELLA: I just wanted
6 to comment again on the issue of holding us to
7 the criteria of model improvement. And I do
8 have concerns about that, because we're not
9 going to be subjecting every single clinical
10 variable that currently is in model, to the
11 same level of scrutiny.
12 And we all know that when you have
13 a model that has a whole bunch of variables in
14 it, that adding any additional variable,
15 unless it's extraordinarily powerful, is not
16 going to significantly improve model fit.
17 And we see this in prediction
18 models all the time, with people wanting to
19 add new risk factors. And they're really not,
20 if you really, you know, hold fast to
21 scientific standards, they typically do not
22 really improve model discrimination, or even,

1 in many cases, calibration.
2 Yet, I do think the more difficult
3 questions are whether the implications on pay
4 for a performance, and I don't know that we're
5 going to be asking measure developers to
6 conduct simulation experiments to look at
7 well, what's the impact going to be on pay for
8 performance and who's going to lose?
9 And I think it may not be fair to
10 ask the measure developer to look at provider
11 acceptability, but I think as a group, I think
12 we do want providers to embrace our measures.
13 I think we need to move towards
14 outcome performances. And I think the better
15 these measures are perceived, the more willing
16 people are going to be to move towards
17 clinically relevant outcome measures.
18 So I think there's lots of reasons
19 to do that. But I don't want us to say, what
20 I don't want us to see happen is, have measure
21 developers say well, it didn't really
22 meaningfully improve my model fit, so I'm not

1 going to do it.

2 And, you know, here's the data to

3 show that the R-square, you know, only went up

4 0.001, and there was very little net

5 reclassification, or so on, so I'm not going

6 to do it.

7 We don't do that with the other

8 existing clinical variables in the model, so

9 why, if we are treating the sociodemographic

10 variables and saying they're comparable, why

11 would we hold them to a higher standard?

12 MS. PACE: I think to a certain,

13 sometimes that's used for clinical variables,

14 but I guess then my question would be, so are

15 you basically saying then, it should always be

16 in?

17 CO-CHAIR FISCELLA: No, I guess

18 I'm supporting the argument that there really

19 should be a strong onus to say do it in the

20 absence of compelling reasons not to do it.

21 Obviously, if it leads to model

22 deterioration you don't want to do that. But

1 I think hanging our hats simply on improved
2 model performance, I think is a real --
3 MS. PACE: Well, yes, I don't
4 think that was the only one, but I totally
5 hear --
6 CO-CHAIR FISCELLA: But I can --
7 MS. PACE: -- what you're saying.
8 Right.
9 CO-CHAIR FISCELLA: -- see measure
10 developers going down that path and saying,
11 you know, because it's a lot more work and
12 it's the easy way out.
13 MEMBER GARRETT: So I just wanted
14 to point out something that Steve pointed out
15 in our small group, though that was
16 insightful. So he just mentioned that one of
17 the natural divisions that has kind of formed
18 in our groups is, the measure developers kind
19 of have a point of view that's developing,
20 because we're telling them to be more
21 prescriptive, and that's maybe not, from their
22 point of view, a good thing.

1 And so there's kind of this
2 natural division that's developed. And given
3 that, I think it's really impressive how we've
4 actually been able to come to some pretty
5 strong recommendations.
6 So I think that's really, commends
7 the group to be able to come together to do
8 that. And it's one of the wonderful things
9 about the Committee to have the different
10 diverse points of view.
11 So I think I'm really agreeing
12 with what I heard Norbert and Steve say, and
13 I think, Kevin, I think this is what you were
14 saying, as well, which is that the conceptual
15 model here is really important of, if
16 conceptually, it makes sense that there's a
17 relationship between these sociodemographic
18 variables and the outcomes we're looking at,
19 then we really should have a bias towards
20 including them.
21 And it shouldn't be just an
22 empirical test, because empirically, we're

1 going to miss things, we don't have good
2 measures on a lot of these things yet, and the
3 science is evolving.
4 And so I think we should have that
5 bias toward really looking at that conceptual
6 model and having that be part of the criteria
7 that the developers have to go through.
8 MEMBER BERNHEIM: Just including
9 the caveat that, you know, there are going to
10 be cases where it may be a lot easier from -
11 Oh, sorry. I've said it before,
12 but it's my counterbalance, and the thing I'm
13 really worried about is the cases where we
14 have as much reason to think that there's real
15 quality issues, there's real, you know, poor
16 patients going to poor providers issues, and
17 that that's a place where, even if it improved
18 model performance you wouldn't include it
19 right.
20 MEMBER GARRETT: And that's the
21 conceptual model.
22 MEMBER BERNHEIM: Yes, right.

1 MS. PACE: Exactly, I just want to
2 keep it on the table.
3 MEMBER GARRETT: Yes.
4 MEMBER LIPSTEIN: You know, I'm
5 hoping we'll stop saying, poor patients will
6 end up with poor providers and say, poor
7 patients have poor outcomes, which is what I
8 think we're trying to avoid.
9 But I do have a question for the
10 measure developers, because it came up, you
11 remember the conversation we had that said
12 okay, we're going to adjust for clinical
13 variables first and then see what happens, and
14 then add sociodemographic variables onto that.
15 And so if you do that, it would be
16 interesting if you do the reverse, if you
17 adjust for sociodemographic variables first
18 and then clinical variables second, you know,
19 part of me says, do we uncover a burden of
20 disease if we adjust for clinical variables
21 first, and if we do it the reverse, do we
22 expose a burden of poverty?

1 If the underlying root cause of a
2 disease burden is poverty in the community, by
3 adjusting for clinical variables first do we
4 disguise that? That's my question. Gene, do
5 you understand what I'm trying to get at?
6 MEMBER NUCCIO: That's what I said
7 I didn't do, that I should have done, just
8 because I'm curious about that sort of thing.
9 I think, you know, historically, our
10 perspective has always been patient clinical
11 first. So maybe that too, that methodology
12 also will evolve. I don't know what, Sean,
13 what do you do with your models?
14 MEMBER O'BRIEN: I don't know.
15 MEMBER NUCCIO: I mean, you use
16 statistical models, right?
17 MEMBER O'BRIEN: Yes, I mean, so
18 for models I've been involved in developing,
19 we've included sociodemographic variables that
20 we had access to.
21 But we didn't look specifically
22 about impact of adjusting, you know, when you

1 do a multi-variable analysis you're kind of
2 simultaneously adjusting for all the variables
3 in the model and then seeing what the residual
4 effect is, and that's kind of the way you look
5 at it.
6 MEMBER LIPSTEIN: When you do look
7 at it, do you think of it in terms of
8 conceptually one as a burden of disease and
9 one as a burden of poverty?
10 MEMBER O'BRIEN: No, I think I
11 think of it as you can remain agnostic about
12 the causal mechanisms, to some extent, if you
13 focus on always comparing outcome to the like
14 patients.
15 So if a patient with the same
16 characteristics got treated at two different
17 hospitals, which one's going to have a better
18 outcome.
19 You really don't need to figure
20 out, necessarily, if those differences are
21 driven by biology, or something else, you have
22 enough data, you just want to go the hospital

1 that's going to have the best outcomes for
2 that type of patient.
3 MEMBER GOLDFIELD: If I could just
4 comment. I mean, at the end of the day, I
5 mean, DRGs are the archetype of everything
6 that's come after that and, obviously, for
7 different ways.
8 As I said yesterday, you always
9 have to ask the question, what are you using
10 this information for? So the reason you would
11 never start with poverty is that this is not
12 an anti-poverty program, this is a means of
13 redistributing resources, or providing
14 information about outcomes to help the
15 institutions, providers and information to the
16 patients.
17 So that's why we start with a
18 clinical description. That said, everybody
19 knows that I've been very, Larry was very
20 generous, passionate about trying to
21 incorporate socioeconomic variables.
22 But always keep in mind, what are

1 we using this information for? And that's why
2 you always start with clinical, patient
3 characteristics that are pertaining to their
4 clinical status.
5 Then comes the question is, for
6 example, as compared to 1982, or when it first
7 started in 1969, do you include health status?
8 Okay, so we've come a long way, because health
9 status has only been incorporated in a routine
10 manner in about 25 percent of Medicare
11 enrollees in the last few years, so health
12 status is something that's pretty warm now.
13 But at the end of the day it's
14 always patient characteristics with trying to
15 describe human beings too for the purpose of,
16 for managing purposes, or accountability
17 purposes describing.
18 MEMBER SAWHNEY: We need to
19 explore what a good model is, just a little
20 bit more, and I'll let the technical people
21 throw their shoes at me if I get it wrong.
22 Goodness of fit is important and

1 sometimes adding a variable -- and first of
2 all, you'll never have a deterioration of fit
3 when you add a variable, but sometimes adding
4 a new variable does not, in fact, add much to
5 goodness of fit, but what it can do is reduce
6 bias.
7 And reduced bias is its own goal
8 in model fitting, separate and apart from
9 goodness of fit. So if you have -- and bias
10 has to do with the distribution of errors on
11 variables that you're not including in your
12 model, you look for bias.
13 So one of the variables that to
14 date hasn't been included is socioeconomic
15 status. And we're finding that the results,
16 the distribution of the residual terms are
17 unevenly distributed by a socioeconomic
18 status.
19 And by putting it in, it may not
20 be a massive increase in goodness of fit, but
21 it could be a decrease, well, it will be, by
22 definition, be a decrease of bias. And that

1 in itself is a goal.
2 MEMBER O'BRIEN: I totally agree
3 with that perspective. And I think that the
4 analyses Susannah showed, where addressing
5 that issue of bias, that there was a bias from
6 not adjusting, or there's the zip code level
7 variables in that analysis, the magnitude of
8 bias relative to the magnitude of the other
9 effects that were being measured in the model
10 between provider effects was really small.
11 So I think you get, in that case,
12 making a case that the bias was relatively
13 negligible. But I think that how much you can
14 increase, enhance the accuracy for predicting
15 outcomes at the individual patient level is
16 much less relevant than the extent you can
17 feel comfortable that you've addressed the
18 bias that you were trying to adjust away.
19 MEMBER SAWHNEY: I wasn't the best
20 at these classes, but I wasn't asleep.
21 DR. BURSTIN: Just one quick
22 thought, I think some of it is that we also

1 just have to acknowledge that a lot of our
2 risk adjustment has been the old story of the,
3 you know, the drunk looking for his keys under
4 the lamp light where does he look? Where the
5 light is shining.
6 And so we've spent a lot of time
7 adjusting for the data we have. So I think
8 this whole concept will likely shift in the
9 years to come, as Norbert talked about health
10 status measures, for example.
11 I think there's going to be a
12 whole different set of indicators that will
13 become the likely suspects, as you move away
14 from a pure claim based model, which I sort of
15 hope to see.
16 And I know we, my staff and I,
17 have had this debate about what does dual
18 eligibility really mean, and is it really just
19 poverty?
20 And I keep saying well, to me,
21 taking care of patients, there's something
22 different about a patient who's dually

1 eligible, that's sort of a social complexity
2 that's unmeasured currently. That it would be
3 very interesting to kind of get beyond the
4 usual suspects and really get better models.
5 But then again, I don't think
6 you'd have to sequence it, Steve, I think they
7 would be the important models and we would
8 bring them in as appropriate, given their
9 impact on the outcomes.
10 CO-CHAIR FISCELLA: I just want to
11 say, I'm really in awe of what the group has
12 been able to accomplish. I was concerned with
13 a two-day time frame to really address this
14 very complex and challenging topic that we've
15 been able to accomplish, as much as we have.
16 I realize the task is not done,
17 but I think it's been enormously productive
18 and it's really attributable to how hard each
19 of you have worked and hung in there to the
20 end.
21 MS. PACE: Yes, absolutely. We
22 want to thank you all for your contributions

1 and sticking with us. We have accomplished a
2 lot. And David wanted to express the same
3 thing, but he had to get back for something
4 going on at MedPAC.
5 So Suzanne's going to fill us in
6 on next steps. Just to, I think you already
7 have this on your calendar, but we will be in
8 touch with you as soon as possible. So,
9 Suzanne.
10 MS. THEBERGE: Yes. So the
11 Committee will meet again by conference call
12 February 10th and February 18th. I don't have
13 the times, I think they're 2:00 p.m. to 4:00
14 p.m. and 12:00 p.m. to 2:00 p.m., but I'm not
15 positive.
16 So we'll have that up on
17 SharePoint and on the public website, we'll
18 have an agenda, as well. And I'll be in touch
19 with you all next week with the information
20 for that. And we'll be sending around the
21 draft reports for input.
22 MS. PACE: So, you know, we

1 obviously have to do some thinking with all of
2 the great input you've given us of how to
3 organize this. But probably the first thing
4 we'll try to concentrate on is a draft of the
5 recommendations and some rationale around
6 those and get that out for comment and edits.
7 And then work, you know, move from
8 there to the more additional content that
9 would go into report around it, but we want to
10 make sure we get the recommendations nailed
11 first. And we'll be in touch with you about
12 that.
13 MEMBER GARRETT: So, you know, it
14 sounds like we came to consensus on some
15 version of SES and sociodemographic should be
16 included, or should be considered in the
17 process.
18 So let's just say that that's what
19 we end up with the final recommendation, it
20 goes through the NQF process, how quickly
21 could that actually change the way things are
22 done? So just playing that out, are we

1 talking two months, a year, you know, what
2 does that look like?
3 Twenty years, oh gosh, I'm going
4 to give up.
5 MS. PACE: I don't know that I can
6 say off-hand, I mean, because some of it has
7 to do with where things are in a development
8 cycle from the measure developer's standpoint,
9 what data are readily accessible.
10 So, you know, ideally, people
11 could do it fairly quickly, but, you know,
12 they may be only able to do it with certain
13 variables that may not be what people are
14 really interested in.
15 I mean, so I think, as much as we
16 want this to move quickly, you know, we have
17 some real limitations. So it's hard for me to
18 give it a time line.
19 Generally, what we expect when we
20 make some updates to our guidance or criteria,
21 first of all, it has to bet fully approved,
22 but generally we expect, you know, it takes at

1 least six months for developers to be able to
2 incorporate new requirements and that all
3 depends on whether they've got something in
4 process or not, whether they can do any
5 readjustment. Helen, you want to --
6 DR. BURSTIN: That sounds about
7 right. I do think though that because some of
8 these recommendations are not so incredibly
9 specific to the way we evaluate measures, I
10 suspect this report will have, somebody said
11 longer legs and something or another.
12 But I think the implications for
13 CMS, for example, the implications for plans,
14 I think there will be a lot of discussions
15 about this report in the next six months, some
16 of which are not completely dependent upon
17 what we do inside NQF.
18 But I think this was such a far
19 reaching discussion and such and important
20 area, I think though the implications we'll
21 begin to see rather quickly.
22 I also think some of the advocacy

1 community will begin pushing some of these
2 recommendations in a way that will likely move
3 it at a significantly faster speed than I
4 think the measure development community can.
5 But we'll work with the
6 measurement development community, as these
7 recommendations come forward and see what
8 logically makes the most sense.
9 MEMBER GARRETT: And when is that
10 final report approved, what's the time line
11 again?
12 MS. THEBERGE: June, it'll be
13 completed by June 30th.
14 MS. PACE: Only if you send us
15 your picture.
16 Well, we should say, we constantly
17 are calling for nominations for our other
18 projects, and so, you know, all of you, I
19 mean, one of the things we've talked about is
20 getting people on our review panels that have
21 this perspective of disparities and
22 sociodemographic factors.

1 So we would encourage all of you
2 to consider thinking about serving on one of
3 our other committees, because I think it would
4 be useful.
5 Everyone have safe travels and
6 everybody on the phone, thank you. And
7 Marshall and Mary Beth, I know it was
8 challenging for you to hang in there with us
9 and we'll look forward to communicating with
10 you more over the email and next call.
11 MEMBER CALLAHAN: Well, thank you
12 for --
13 MEMBER CHIN: Thank you, everyone.
14 MEMBER CALLAHAN: -- making the
15 arrangements for the phone, thanks. Bye.
16 (Whereupon, the above-entitled
17 matter was concluded at 3:29 p.m.)
18
19
20
21
22

A

$1,300 104:1
A-G-E-N-D-A 3:3
a.m 1:10 4:2 106:18 106:19 143:14
AARP 1:14
ability 26:7 113:5 132:20 134:6 194:11 241:11
able 14:17 18:3 29:5 38:9 55:12 60:1 103:21 104:19 129:4 181:16 215:19 238:14 267:4,7 277:12,15 280:12 281:1
above-entitled 106:17 143:13 283:16
absence 59:15 126:17 127:6 170:13 265:20
absolute 149:3 155:16,19,20 172:12 209:20 211:4,6,7
absolutely 7:17,18 13:2 53:1 75:2 81:6 119:6 202:2 205:8 236:4 277:21
abstract 124:14 256:17 258:9
abuse 233:18 240:2
accept 43:15,17 93:14 196:9
acceptability 250:1 250:15 264:11
acceptable 14:21 15:1 117:20 151:22
acceptance 93:12 248:17,18
accepted 231:14
accepting 75:20
access 92:8 149:1 176:16 204:12 230:2,3,4 236:5 259:15 270:20
accessible 280:9
ACCIUS 1:14 45:12 205:8
accommodate 237:6
accomplish 28:19 60:12 277:12,15
accomplished 193:11 278:1
accomplishing 31:20
account 29:6 74:8 77:3 163:16 180:21 234:13
accountability 21:3 21:7 30:6 40:1,2 40:12 57:11,18 60:12 72:5 94:16 94:19 95:13 97:9 97:13 98:1,6 99:5 99:8,10,12 113:9 113:20 117:11 153:17 169:6,13 273:16
accountable 125:1
accounted 77:6,9
accounting 31:15 135:20 163:19
accuracy 275:14
accurate 69:17
achieve 18:3 32:4 43:14,20 103:5
acknowledge 276:1
acronym 96:3
ACSW 1:19
action 72:11
activation 175:4,7 179:22 180:8 185:12 186:4 189:5
activity 193:20
actual 93:15 131:9 132:2 181:2 183:1 221:1
ADAMS 1:15 133:8 168:17
add 5:7,9 6:18 7:10 26:13 50:15 65:2 69:19 73:4 88:18 95:4 105:14 106:6 124:8 131:4 133:8 147:13 157:7 175:1 181:8 183:13 216:3 247:3,12 256:11 258:18 263:19 269:14 274:3,4
adding 96:21 129:2 160:8 253:15 263:14 274:1,3
addition 119:14 249:6
additional 108:5 112:11 115:16 131:17 169:13 263:14 279:8
address 12:4,7,11 12:14 20:18 34:1 34:8 63:14 88:22 125:14 131:2 134:6 138:14 140:7 141:15 168:13 188:19 190:3 198:8 206:8 206:15 218:5,6 220:12 224:22 238:18 251:11 277:13
addressed 7:9 64:22 89:3 168:10 197:10 200:12 201:10,22 202:10 225:17,19 275:17
addresses 91:17 207:11
addressing 6:7 89:7 202:21 225:8,20 226:13 275:4
adds 22:21 62:8 205:5
adequate 78:6 79:5 247:6
adequately 240:15
adherence 92:8 229:12
adjust 4:22 20:6 24:16 43:10 55:1 73:14,20 74:3 80:6 94:15 119:17 121:14 134:20 147:8 151:20 153:15 188:15 200:1 214:11,14 218:1 237:5 238:5 250:12 251:14 252:13 257:11 262:15 269:12,17 269:20 275:18
adjusted 17:20 30:5 34:16 72:15 72:18 76:19 93:15 109:14 111:12 130:3,3 131:1 147:1 148:14 154:5,17 164:18 164:19 166:16,17 167:16 203:2,20 221:6 224:19 235:17 248:21 249:2
adjusters 216:22
adjusting 57:1,2 89:5,9 93:11 144:13 173:9 236:21 248:16 250:22 270:3,22 271:2 275:6 276:7
adjustment 1:3 7:11 17:12,17 19:14 20:7,11 24:16 29:9,12,16 30:11,15,17,20 31:4,18 32:10,18 33:21 34:21 38:14 39:3 40:18 44:19 45:11 46:20 52:8 55:1 56:17 59:12 64:21 79:9 82:15 86:15 87:6 103:4 104:12,17,18 105:2,4,6,15,17 105:20 109:9 110:18 112:4 120:7,13 122:7 123:1 133:20 134:15 135:12 144:20 145:2 154:8 159:16 163:18 168:12 170:6 172:22 189:18 190:8 191:4 192:21 197:22 204:7 206:20,21 215:5 217:17 218:11,15 218:20 219:4 221:4,13,22 222:2 222:14,22 223:4 225:10 228:5,7 229:11 232:5,10 233:10 236:15 239:14 240:6 241:17 245:12 252:20 255:16,22 257:8 258:2,5 260:11 262:9 263:4 276:2
adjustments 4:17 27:18 135:18
administration 22:11
admissions 262:8
adopt 16:3 42:21
advance 40:14
advantage 16:6 93:11 227:12
advantages 29:11 209:6 212:21
adversely 59:17
advice 44:4 212:12 212:13
advocacy 281:22
advocates 148:22 204:21
advocating 58:8

affect 25:2 59:17 74:19 101:13 145:5 228:10 238:3 257:12 261:5
afford 238:14
affordable 193:4
African 258:14
afternoon 8:13 205:19 235:6
agenda 3:5 4:9,10 101:18 107:1 278:18
aggregate 132:12
aggressive 254:10
agnostic 271:11
ago 12:1 51:21 71:1 153:22 256:20
agree 9:15 18:13 22:14,20 27:21 31:13 48:4 53:3 65:14 87:16 100:15 118:5 122:4 133:9 134:1 148:6 178:16 209:19 210:4 211:11 214:3 236:4 249:21 275:2
agreeing 267:11
agreement 46:14 118:7 120:4 121:18 178:13
agrees 47:6 252:14
ahead 4:15 39:19 101:20 118:22 122:16 143:17 196:11 216:9 223:8 231:20 237:11 259:17
AHRQ 2:7
aim 169:8 182:14
aims 169:8
Akin 235:7
Alabama 192:4
Albany 102:7 223:17
alcohol 240:2
all-out 149:20
allow 67:4 93:3 98:11
allowing 237:14
alternative 52:17 90:19 166:13,16 218:4
altogether 214:15
ALYCE 1:15
Alyna 1:21 19:10 155:22 176:5
Alyna's 193:7
amazing 256:21
American 1:16 2:1 2:3 235:7 258:14
AMIN 2:13
amount 24:18 46:3 129:1 169:18 216:6
ample 81:3
Amtrak 205:19
analyses 17:14 96:17 158:4,4 214:12 275:4
analysis 18:4,15 67:4 70:8 93:3,5 144:17,22 149:6,7 149:9,19,21 150:1 153:5 158:22 161:11 242:1,6 243:1,4 256:3 271:1 275:7
analytic 149:14 158:19 240:15
analyze 151:15
analyzed 35:16
and/or 44:17 92:7 140:2 208:10 247:2
ands 38:5
anew 212:17
ANN 2:14
Anschutz 2:6
answer 14:22 15:1 16:14 43:11 52:7 150:5 234:5,9
answering 220:10
answers 55:22 79:7 97:20 197:13
anti-poverty 272:12
antibiotics 22:11
anticipate 42:19 43:22
anybody 81:7 102:13 146:3 155:9 181:8
anymore 50:15 180:1
anyway 87:1 169:10 246:5 256:13
apart 52:4 274:8
apologize 141:12
appealing 110:10
appeals 64:6
appear 94:11 258:16
apples 89:22
applicability 249:10
applicable 35:13 182:16
application 36:14 36:21 40:3 161:8 172:5 249:9
applications 21:3,7 40:13 113:9 129:4 130:15
applied 214:7 228:4 232:10 260:11 262:9
apply 22:8,12 70:12 80:3 92:19 227:13 227:15,16
applying 97:13
appointment 230:9
appreciate 193:20 216:20 239:14
approach 12:20 17:17,18 18:9,17 19:6,6 32:15,17 33:22 35:11,19 52:14 53:2 55:4,6 62:7 70:4 112:6 115:3 120:7 121:12,13 122:14 123:18 131:22 132:15 157:12 160:10 169:8,10 236:20
approaches 5:13 6:8 8:5 19:4 115:12 119:10 137:2 139:8 143:8 168:21 189:6
approaching 35:3
appropriate 15:14 15:17 26:20 27:15 44:19 50:13 52:8 83:15 84:9 159:16 226:13 277:8
appropriately 27:16 207:16
approval 33:19 99:13 212:6
approved 35:8 109:5 146:5 280:21 282:10
arbiter 26:1
arbitrarily 140:17
archetype 272:5
area 36:18 103:9 168:9 173:14 176:8,9 192:4 225:14 227:9 281:20
area-based 91:14
areas 93:21 206:1 229:13,17 230:15 230:20 234:12
argue 11:11 15:10 69:2 72:14 73:1 125:9 245:18
arguing 12:12 101:7,10 125:8
argument 80:1,7 135:10 149:16 150:1,1 151:19 152:11,15 242:10 247:5 256:10 265:18
arguments 209:6
arms 171:14
arrangements 138:2 283:15
artificially 127:19 131:15
Asian 2:9
aside 61:10 145:7 171:3 218:10 252:21
asked 24:10 107:9 156:13 195:2,8
asking 32:14 220:10 234:3 264:5
asleep 275:20
aspects 174:14 235:14
assembling 8:17
assess 71:10
assessment 71:11
assigned 41:16 131:15 140:18
assignment 131:5
assigns 23:22
assistive 132:22
associated 245:3
Association 2:3 225:21 233:2 235:8
assuage 240:12
assume 167:14 221:5
assuming 159:11
assumption 41:5 231:22
attainment 154:14
attention 250:6
attest 202:16
attitude 186:4 216:21 217:7
attitudes 185:14 187:9
attitudinal 188:4 225:15

attributable 277:18
attribute 105:18
Atul 2:3 25:15 26:16 60:18 149:19
audience 18:10
authority 16:5 104:5
available 105:9 147:1 158:18 164:5 180:14 184:5 187:17 255:15
avoid 42:11 200:7 226:10 269:8
avoiding 42:16
aware 68:17
awe 277:11
awhile 118:21

B

back 4:4,9 10:7 19:8 26:16 28:16 29:4 30:8,12 45:21 46:3,8,21 47:18 58:4 64:3,5 70:2 73:10,22 74:21 78:18 84:17 87:1 88:10 111:22 113:15 117:7 121:22 136:11 142:10,14,16 145:3 152:8 164:2 164:7 165:12 172:6 176:1 188:21 195:13,21 198:15,20 201:2 202:7 203:1 205:19 218:10 221:9 254:9 278:3
backgrounds 16:20 162:19
backs 192:16
backwards 144:7
bad 33:13 89:21 246:8 258:13
balances 64:7
Baltimore 126:17
bar 244:3 251:18
BARGER 1:16 177:12
Barnes-Jewish 126:12
barriers 101:13 238:2,7,17
base 59:1 127:5 147:3 224:9
based 4:17 11:12 17:20 23:7 87:6 92:1,2 109:9 123:21 133:6 154:10 163:14 209:20 215:18 240:21 254:14 276:14
baseline 41:18 159:3
basically 19:3 21:8 44:11 45:7 48:13 67:17 70:1 103:4 113:16 192:10 199:5 219:11 243:8 249:10 265:15
basis 22:17 221:1 245:14
Bathing 132:19
began 122:5
beginning 197:9,19 199:19 249:17
behavior 59:8 60:9 60:10 73:6 77:19 186:3 216:21 217:7 226:13
behavioral 188:3 188:10 225:15 226:5
behaviors 184:20 185:15 187:9
beings 273:15
belief 253:14
believe 12:22 38:7 39:1 59:5,12,14 60:6 79:18 144:6 253:3,11 258:1
believed 152:18
belongs 28:6
benchmark 105:8 218:12
benchmarking 98:14
benchmarks 57:17 229:5
beneficiary 40:5
benefit 91:7 93:6
BERNHEIM 1:17 28:15 30:18 36:5 65:16 77:20 80:15 96:15 157:14 164:22 168:1 172:3 213:22 216:15 246:9 249:20 261:7 268:8,22
best 4:18 8:5 18:8 22:17 29:13 48:18 49:16 51:15 122:1 194:8 196:3 201:18 224:4 230:16 242:17 246:17,17 272:1 275:19
bet 280:21
Beth 1:19 9:20 70:21 83:10 84:17 86:2 87:20 120:18 138:2 140:12,21 283:7
Beth's 26:15 82:10
better 19:6 23:20 31:21 32:22 36:9 51:5 101:8 114:16 140:21 166:2 168:14 176:4 188:2 191:20 236:21 251:5 257:3 264:14 271:17 277:4
beyond 22:19 34:21 74:12 208:4,4 213:19,20 214:5 244:10 277:3
BHAREL 1:18 66:13 68:4 172:17 175:5 178:5 180:4 181:4 182:13 183:19 185:3
bias 16:1 125:22 186:10 267:19 268:5 274:6,7,9 274:12,22 275:5,5 275:8,12,18
biases 58:9,15
big 24:7 66:4 124:22,22 125:4 125:11 126:9,10 204:21 205:17 220:1 227:2 228:9 228:15 229:13 238:21 248:19 262:13
bigger 62:18 75:13 75:13 121:9 180:9 226:2
Bill 226:20
binding 66:10
biologic 90:14
biological 43:8
biology 271:21
birth 90:17
bit 14:7 17:7 20:16 39:9 56:15 75:21 82:6 85:7 88:4 109:22 128:10 134:2 159:20 174:18 188:13 192:12 196:11 218:14 220:15 221:2 229:21 231:13 244:18 248:13 249:6 250:18 251:17 256:4 273:20
BJC 2:5
black 119:15 257:12 258:4 259:9
black/white 257:2
blacks 241:13 257:3,16
blah 108:10,10,10
blend 155:16 209:20 210:4 211:6
blended 166:14,14 210:19
blending 211:10
bless 146:6
bloc 140:17
blood 78:21 117:9 215:4
BMI 188:16
board 14:14 64:6 225:22
boards 14:12
body 78:13
Boston 1:18,21 126:18
bother 229:3,3
bothering 240:9
bottom 105:11 106:4 117:4 165:4 167:5 196:18 213:15
boundaries 190:18
boundary 10:14,15 186:19
bounds 156:6
brain 193:19
brainstorming 173:7 181:10
branch 245:22
break 88:9 101:19 106:16 107:6
breaking 107:10
breakout 3:13 6:1 8:7 19:17 88:12 124:3 136:8 137:2 142:3,9,12 166:12 201:5 233:8 234:3 248:13
breakouts 5:21 136:6,7
breaks 121:4
brief 39:13 73:8

124:1 143:22
briefing 178:19,21
briefly 88:17 106:22
bring 6:14 7:13 81:13,14 96:1 124:2 136:11 142:14 193:9 209:2 242:1,4 250:2 277:8
bringing 16:21 30:8 160:4 162:5
brings 212:17
broad 30:16 179:8 181:21 224:9 234:18 248:15,17 248:18
broaden 63:5 233:12
broadened 173:3
broader 31:14 39:7 187:5 193:14 255:19
broadest 31:17
brought 35:6 59:2 90:7 108:19 117:19 123:12 127:4 130:9 138:8 146:16 155:21 158:7 174:11 189:22
bucket 30:11
build 156:19 216:2 236:19
building 26:14 27:19 84:18
built 35:4
bullet 95:8,18 121:12 147:16 148:4 149:7,20 150:4,21 155:14 165:4 168:19
bunch 253:19 263:13
bundles 195:1
burden 91:7 93:9 184:6 269:19,22
270:2 271:8,9
buried 99:18
BURSTIN 2:14 51:4 52:22 63:15 87:10 96:6 98:8 156:15 275:21 281:6
business 156:8 190:3 208:17
buts 38:6
button 194:21
Bye 283:15
bypass 257:2

C

calculate 30:22 31:7
calculating 31:9
calendar 278:7
calibration 264:1
California 62:22 63:1
call 116:14,15 141:11 142:3 170:5 176:12 185:14 219:16 222:1,21 225:18 278:11 283:10
CALLAHAN 1:19 9:19,22 70:20 71:5,8 82:10 83:10,19,22 84:16 87:19 113:21 120:19 140:20 141:13,16 178:17 178:21 283:11,14
called 87:5 109:8
calling 43:8 282:17
calls 196:12
Campus 2:6
capability 105:14
capacities 174:19
capacity 173:16,17
capita 239:1
capitation 80:12
caps 228:8
capture 165:16
167:7 173:17 176:8 183:16 184:1,7
captured 22:22 165:13
captures 77:22
card 118:21
cardiac 206:12 257:1,13,16
cardiothoracic 146:17
cards 235:22
care 24:22 25:4 56:18 58:22 67:2 74:6 91:9 94:3 125:1 133:21 152:3 189:20 190:2 203:18 230:3,3,4,11 250:12 276:21
career 256:21
careful 126:22 255:4
caregiver 62:2
caring 155:3 181:15
CASALINO 1:20 6:22 7:3,15 11:20 46:13 49:20 54:5 68:16 71:15 73:7 84:18 108:6,15 110:21 113:22 124:12 139:10 147:13 151:11 155:10 157:7 205:15 210:20 211:20 241:19 256:9 258:8
case 52:8 91:3 93:1 93:1 102:19 124:16,18 125:6 132:6 145:2,6 147:22 153:12 158:8 206:9,16 238:1 241:7 246:11 251:22 256:15 275:11,12
Casement 229:11
cases 23:3 78:9,17 78:20 80:1 91:21 94:8,9 110:10 113:19 114:18 124:21 125:11,13 139:13 154:12 164:4 206:22 242:12,13 245:1 251:2,3 264:1 268:10,13
categorical 131:5
categories 84:11 127:20
category 58:8 59:4 86:6,12 131:4,19 174:2 177:2,3 186:12 219:9,10 220:9
causal 157:20 191:14 271:12
cause 134:4 233:22 251:14 270:1
causing 10:13
caveat 124:7 268:9
caveats 107:20 115:7 117:21
CDPS 105:21
Census 22:18,19 90:21 91:15,21 177:14,15
center 2:2,7,8,11 79:14
Centers 233:3
central 72:17 114:9 115:20 116:5 118:6,11 119:4 151:17 241:7,14 242:5,7
certain 38:2 40:11 40:12 131:8,16 149:11 170:3 174:8 176:16 203:8 216:22 242:6 262:21 265:12 280:12
certainly 5:6 9:2,10
46:20,22 47:3 51:2 53:5,13 62:3 64:18 79:12 80:7 141:14 145:6 188:9 236:14,18 240:18
cessation 226:1
cetera 6:9 11:15 22:3 56:9 98:18 133:18 195:14
chair 121:4
Chairs 1:10
challenge 13:13 19:9 41:5 42:3 181:9 236:3
challenges 56:11 91:8,19
challenging 244:16 277:14 283:8
chance 88:18 124:5
change 5:22 59:7 60:9 67:22 68:1,9 75:20 135:17 181:17 226:2,12 229:19,22 237:5 243:1,7 257:21 259:5 279:21
changeable 181:13 186:8
changed 86:3
changes 57:14
changing 60:10 112:1 226:5 229:6 253:13
chaotic 209:3
characteristic 38:5 43:17 180:1,3
characteristics 109:15 179:6 184:21 188:16 219:13,17 244:10 271:16 273:3,14
characterization 177:16 258:6
charge 8:8 10:10 156:6 186:16,21 187:3 213:19,21

221:3 253:8
check 53:6 106:12 140:12 232:7
check-in 71:14
checked 62:8 129:22
checking 231:22
checks 64:7
cherry-picking 199:8
Chicago 1:22 126:12,19
CHIEN 1:21 112:13 131:20 179:2 180:12 192:9
child 13:7 118:4 152:9
Children's 1:18,21
CHIN 1:22 19:7 33:5 51:18 54:12 82:12 83:13 84:3 120:16 141:1 168:6 197:3 198:10 200:17 283:13
choice 218:12
choose 81:13 131:21
choosing 137:10
chose 178:7
Chris 156:17
circle 73:10
circulation 196:13
circumstance 78:5
circumstances 15:17 90:15 97:17 159:6 232:6 262:21
city 126:17 192:6
CLABSI 145:3
claim 276:14
clamor 247:17
clarification 66:22 147:14 150:21 155:14 164:7 182:5 193:12 195:14 261:6
clarification/reco... 214:2
clarifications 3:6 139:11 171:2
clarified 71:12
clarify 67:13 68:5 86:2 87:15 115:20 137:6 221:20 222:3
clarifying 39:13,21 40:15 62:15 66:14 143:22 151:10 157:1,3 195:20
clarity 46:15 83:13 110:12
class 185:13 215:12 225:14
classes 275:20
classic 199:21
classifying 216:18
clause 109:16
clear 10:2 11:2 19:12 22:8 47:9 48:7 93:17,18 104:20 151:16 152:14 164:9,16 202:9 213:7 242:13,14 246:21 251:2
clearly 23:6 118:12 149:12,12 175:17 191:5 198:2 227:16
clinic 100:6 230:6
clinical 16:11 24:22 32:9,17 38:4,10 65:10 92:18 93:1 93:6 94:4 96:18 133:3 159:18 160:6,9 163:17 166:15 169:19 170:10,12 174:16 214:14 240:5,22 244:10 263:9 265:8,13 269:12 269:18,20 270:3 270:10 272:18 273:2,4
clinically 164:19 167:16 241:6 264:17
clinically-adjusted 224:18
clinician 38:21 154:20
Clinton-esque 108:12
clockwise 175:10
closely 186:14,20 223:6
closer 124:4 175:12 219:4
clothing 238:15
CMS 13:6 23:22 25:8 41:2 50:3 65:18 97:3,4,7 105:21 216:1 229:22 235:22 249:19 281:13
CNM 1:16
Co-Chair 1:13,14 4:8,14 6:19 8:9 9:15,21 11:4 21:11 25:12 30:14 39:5,18 40:8 63:9 66:6 80:20 81:11 81:19 82:1 83:1,6 83:17 86:1 87:14 88:15 96:14 99:15 101:15 106:20 108:18 113:19 117:18 118:8,22 119:22 120:5 121:3 122:4,18 124:7 125:16 135:5 140:11 141:8 143:16 149:18 150:3 151:9 153:6 156:2 156:22 167:3 172:15 175:8,11 175:15,16 176:20 185:9 187:22 189:21 193:6 194:10,14 196:4 196:16 198:7 200:9 209:13 210:17 216:10 220:13 221:17 222:9 231:18,21 232:15,20 242:18 244:17 263:5 265:17 266:6,9 277:10
co-leaders 200:22
code 275:6
codes 22:19
cogent 251:7
COHEN 2:1 149:5 149:22 165:2
coherent 52:6,19
colleague 237:18
colleagues 252:5
collect 13:6,18 14:4 22:16 100:6 241:11,17 253:2,5
collected 13:9 100:7 170:1 188:5 234:20,22
collecting 91:8 170:17 235:2
collectively 185:20
College 1:16,21 2:1
Colleges 2:3
Colorado 2:5 58:10
combination 221:1 222:11
come 16:20 17:21 22:4 31:21 37:4 42:10 52:12 53:7 55:21 58:4,10,15 67:21 70:2 73:10 82:6 84:11 88:10 88:22 97:2 101:22 102:10 107:21 110:12,13 111:15 111:22 113:15 114:4 116:6 117:1 121:22 137:7 142:13,16 143:4 145:17 165:12 172:6 177:16 180:6 185:5 191:8 194:5 195:13 197:14 198:5 199:2 200:5 201:1 201:9,10,20 206:5 207:19 212:1,4 218:10 230:12,21 243:19,20 254:2 267:4,7 272:6 273:8 276:9 282:7
comes 9:5 12:20 18:8 42:7 50:22 55:19 64:1,3,4,6 66:5 105:3 106:9 125:17 178:12 185:11 201:6 208:8,13 214:12 249:18 251:6 255:21 273:5
comfortable 120:1 201:22 210:8 234:5,8 275:17
coming 4:4 20:4 51:20 65:3 114:21 152:8 153:3 180:20 235:11
commends 267:6
comment 3:11 21:12 26:14,15 33:6 34:20 35:22 42:13 63:10,16 64:3 65:1 66:1 99:16 100:15,22 101:18,20,22 102:2 106:5 143:19 170:21 181:6 183:9 185:11 191:10 193:7 208:11 223:9 237:8 240:7 263:6 272:4 279:6
comments 26:15 33:8 63:11 64:19 86:10 104:11 106:14 124:6

126:1 147:2 151:10 169:16 174:4 182:20 196:17 209:14 217:11 223:11 226:18 233:3,6,7 237:10
committed 13:2
committee 17:15 18:10 28:19 36:11 37:10,18 47:6 48:12 51:1 52:20 53:17 54:17 64:2 64:4,5 208:14 223:20 233:12 236:17 242:15 245:20 246:22 247:2 251:6,20 267:9 278:11
committee's 70:14 242:9
committees 8:1 19:21 27:10 36:7 37:16 47:10 53:14 61:8 70:18 71:19 93:18 241:21 283:3
common 55:15,21 242:9
commonly 152:18
communicating 283:9
communication 222:8
community 60:8 103:17 158:10 182:12,17 224:8 233:2 245:5 246:4 270:2 282:1,4,6
companies 76:6
comparable 55:5 123:6 265:10
compare 113:3 230:19
compared 123:4 162:17 259:10 273:6
comparing 55:4 123:6,8 271:13
comparison 31:19 32:19 128:8 174:14
comparisons 92:1 123:20
compartmentaliz... 52:12
compelling 117:3 265:20
compensate 56:10
compensation 57:1
competency 43:2
competing 19:5
compile 102:4 223:15
complacency 163:3
complain 248:4
complainers 248:18,22 249:3 249:16
complementary 198:11
complete 202:17
completed 282:13
completely 53:3 64:9 82:4 98:7 154:4 165:21 209:3 213:10,11 247:17 281:16
complex 130:4 233:5 277:14
complexity 33:16 34:19 128:16 180:20 205:5 238:2 277:1
compliance 230:10
complicated 19:1 33:19 161:21 189:1,10 214:4,18 215:2 217:8 218:9
complicating 189:18
complications 131:9,10 250:12 252:11,13,14,18 252:19
composite 219:21 220:2,5
comprehensive 172:9
compromise 262:4
computed 41:13
conceivably 32:7 156:4 245:1
concentrate 279:4
concept 27:2,12 30:12 70:10 79:15 162:8 214:6 215:15 276:8
conceptional 245:10
concepts 35:5 162:3 180:18 181:2
conceptual 16:11 86:16 96:19 116:20 118:18 119:20 120:9 150:9,10,11,12 151:18 157:20 160:15 179:10 180:13 241:8 243:9 245:13 260:14 267:14 268:5,21
conceptually 86:13 159:9 164:1 218:7 267:16 271:8
concern 38:17 73:22 89:15 126:7 187:11 227:10 235:19 240:20 248:15
concerned 52:10 203:17 220:14 228:11 236:15 255:10 277:12
concerns 11:14 62:19 81:4 127:14 198:9,17 200:12 202:6 203:2 204:21 209:17 217:22 218:2,5 234:3 263:8
concise 19:19
concluded 283:17
conclusion 18:12 18:13 158:14
conclusions 20:5 41:22 42:1
conditional 137:17
conduct 264:6
conference 1:9 136:21 137:22 139:1 141:11 142:3 196:12 278:11
confident 35:12
conflict 195:22
conflicts 245:8
confusing 46:1 214:22 217:18
congratulate 192:12
connect 27:20
cons 5:16 39:8 124:1 168:22 173:14
conscious 85:15
consensus 3:19 18:17 43:4,12 64:5 85:12 95:1 144:15 168:2,8 173:20 180:6 201:10,15 211:14 253:4 279:14
consequences 11:15 18:5 45:6 76:14 95:14 200:14 258:14 259:2
consider 9:12 11:18 14:15 15:12 16:8 23:8,11 25:17 26:7 28:7 30:3 37:8 45:18 46:18 48:12 53:19 59:3 59:19 60:3,5,16 60:18 61:3 68:19 68:20 69:10 70:5 81:15 84:8,22 85:13 94:18 101:12 107:12 108:7,8,16 110:22 111:6 114:5,17 116:4,10 136:18 151:5 152:12 160:15,16 164:14 176:19 189:8 248:19 283:2
consideration 21:15 25:7 45:3 45:20 92:9,18 96:19 124:6 158:9 158:16 200:13
considerations 11:13,14 21:20 42:9,20 44:21 48:17 86:16 118:18 137:10 159:18 160:3 187:21 251:19
considered 14:8,9 15:7 25:19 26:3 28:13 37:5 47:12 59:20 62:6 64:12 71:17,21 72:8 82:7,14,21,22 83:3,4,9,14,16 86:20 103:11 107:11 110:1 112:2,9,12 114:2 114:3,13 115:14 116:3 120:6,12,17 139:13 158:6 184:22 251:7 279:16
considering 44:6 62:11 80:8 85:16 101:2,5 160:4
considers 51:10
consistent 14:4 17:16 37:3 220:20
consistently 13:19
consolidate 223:22
constantly 171:21

282:16
construct 26:21 241:9
constructs 182:22
consumer 129:7 148:22 204:20 205:10
consumers 94:5
content 158:1 205:20 208:2 279:8
contents 245:12
context 19:18 21:5 21:21 31:14 42:1 49:12 56:1,2,5 64:12 79:21 80:14 92:3,14 111:19 113:7 125:14 144:3,12 161:5 251:11
contexts 61:12 89:1
contextual 6:12 25:14 138:5 139:5 199:15
continuation 137:4
continue 42:3 68:8 236:7 237:3
continued 81:2
continues 239:2
continuing 112:18
continuous 127:18 127:18
contracted 41:2 130:19
contrasting 125:11
contribution 213:1
contributions 277:22
control 50:11 74:8 154:19 189:3 190:15
convened 42:15 43:1
conversation 45:13 46:7 163:21 174:21 178:4 182:8 184:4 239:6 252:17 269:11
conversations 28:17 164:2 204:20
convince 247:2
Cook 126:20
core 5:7
Cornell 1:20
correct 11:8 68:11 83:18 84:2,15 157:15 165:3 166:20 205:9 236:2 248:9 256:18
correctly 11:19 139:15
correlate 152:13
correlated 100:4 184:20
cost 53:15 94:3 104:1 109:18 130:8,18
costs 103:5
counseling 68:22 72:18
count 22:1 120:13
counterbalance 268:12
country 24:20 25:1 63:3,8 91:2 126:13 127:3,10 238:22 250:11 254:7
county 2:1 126:20 263:1
couple 7:19 26:15 52:1 54:14 55:10 73:9 95:3 125:11 138:11 153:22 170:22 200:19 223:21 235:10,14 235:15 236:10 243:12
course 10:6,7 198:12 200:18 245:10,17
covariate 44:21
covered 25:13 63:1 185:7 198:2,21 206:6 209:11
Covisint 104:10
create 54:2 110:9 132:10,10 142:21 219:21 238:3 249:22
creates 140:14
criteria 17:10 65:20 66:19,20 67:16 100:16 227:13 228:1 241:1 244:11,12 247:20 250:1 263:7 268:6 280:20
criterion 71:16 140:7
critical 238:17 239:3
crowded 230:7
crystal 10:2 11:1
cultural 43:2
curious 40:22 210:18 270:8
current 20:22 50:8 54:15 66:19,20 68:1 70:4 105:12 120:16 129:12 156:18 174:18 185:7 209:11 222:12
currently 67:17 91:10 107:11 185:6 187:17 263:10 277:2
curve 165:18
cut 107:5 216:12 245:5 254:9
cycle 280:8

D

D.C 1:9
Dallas 1:19
dashboarding 129:4
data 13:18 18:15 32:4 33:12 36:18 91:8 93:3 96:9,10 96:10,12 104:16 105:3 107:17 108:10 127:11,21 131:6,8,12,17 136:19,19 144:18 146:17 148:13 149:1,4,6,9,14,20 150:15 151:15 152:11,15 159:3 159:20 161:9 173:14,17 174:18 174:19 177:14 182:4 184:5,5 187:17 203:2,5 204:22 219:7 220:10 234:20 235:19,21 236:2,5 242:2,11 247:2 255:14 265:2 271:22 276:7 280:9
database 13:9,19
databases 239:12
date 274:14
daunting 193:8,8
Dave 175:9
David 1:10,13 8:10 146:15 194:8 197:3 201:19 278:2
David's 179:6
day 3:6 49:1 61:14 80:19 171:9 190:6 191:5,6,7 202:14 223:18 254:5 272:4 273:13
days 52:1 54:14 55:10 200:19 235:10,15
deal 50:2 121:9 129:4 148:1 184:4 186:17,22 216:1 240:15 242:16 248:19
dealing 69:6 127:17 128:2
dealt 69:12,14 215:20
debate 175:6 186:7 276:17
debates 186:19
decide 7:4 15:3 20:17 35:6 37:11 68:6 84:22 85:2 188:21
decided 14:20 37:9 112:15 134:11 169:9 242:22
decides 32:16
deciding 45:10
decision 51:9 205:13 238:10 251:21
decisions 23:15 52:6 93:4 205:12 217:13 250:4 255:16
decrease 188:18 214:14 274:21,22
deeply 148:16
default 12:16,17 147:19 153:14 246:21
define 127:15 255:4
defined 26:21 161:16
defines 192:7
defining 105:1
definitely 40:16,17 50:16 61:6 68:15 140:10,21 182:2 187:4,18 195:12 236:3,6
definition 6:5 63:5 105:5 127:15 136:16 173:2 177:19 239:18,21 274:22
definitions 105:13 172:21 178:8,20 182:5 246:15

definitive 28:12
deliberated 26:19
deliberately 257:8
deliberation 27:15
deliver 24:22
delivered 25:5
delivery 224:11,12 224:14 225:6,13
delta 58:20
delve 122:5 124:4
demand 230:17
Demehin 235:6,7
demographic 21:22 154:7 162:18 163:5 180:1,8
demonstrate 62:4 144:18 149:9,15 244:15
denonimator 151:3
Denver 58:19
depend 52:9 134:22 212:6
dependent 73:5 133:6 281:16
depending 5:22 20:6,18 56:1 110:20 255:7
depends 37:22 110:11 112:21 199:3 253:18 281:3
describe 44:16 223:7 273:15
describes 151:2
describing 115:9 273:17
description 157:20 251:7 272:18
deserts 176:15 225:8
deserves 169:8
design 42:9
designed 161:17 243:3
designer 257:9
desire 103:3
despite 37:11
detail 109:16 155:17 195:4 214:4
detailed 63:20
details 70:15 111:1
deterioration 265:22 274:2
determinant 87:22
determinants 87:6 109:10 173:4 177:21 179:11 180:14,18
determinative 127:7
determine 57:19
deterministic 236:21
develop 12:21 28:2 41:3 65:17 66:15 125:20 135:3 236:8
developed 44:16 117:17 138:20 267:2
developer 11:11 14:17 15:2,11,20 15:21,22 16:15,17 17:13,20 18:8,11 18:19 19:12,22 20:12 23:18 27:4 27:4 35:7 37:4 39:1 41:3 49:21 50:1,21 54:8 55:12 59:20 62:4 64:9 70:18 81:12 84:8 103:13 107:12 108:3 114:20 132:3 137:18 145:9 161:7 164:14 168:15 171:9 207:12 208:7,13 212:2 215:1 242:10,15 244:1 245:13 246:22 255:12 264:10
developer's 15:8 64:16 280:8
developers 7:21 13:10,18 16:4 19:2,20 20:17 21:14 25:21 28:2 30:1 36:7 37:17 39:22 40:13 44:5 44:16 45:8 46:10 47:11 54:20 57:15 57:22 58:6 59:6 63:18,21 65:2,3 67:17 71:19 84:12 84:21 85:21 93:17 97:2 115:13 124:20 137:16 140:2,7 147:21 157:19 187:15 197:16 206:7,8 212:1,4 255:12 258:11 260:8 264:5,21 266:10 266:18 268:7 269:10 281:1
developing 40:1 47:12 65:6 130:21 204:5 266:19 270:18
development 25:7 48:14 49:6 50:20 52:4 57:16 93:5 256:8 259:22 260:2 262:5 280:7 282:4,6
devices 132:22
devil 111:1
devised 212:19,19
devoted 206:10
diabetes 22:2 190:15
diabetic 190:13
diagram 20:10
dialogue 57:14
dictating 260:22
differ 94:6
difference 24:7 25:5 41:20 46:1 48:3,6 57:3 74:22 75:14 77:15 82:13 82:16 90:14 93:16 153:10,12 226:1 253:4 254:15,16 254:21 262:13
differences 6:12,13 23:7 31:15 77:3 78:10 90:22 94:18 127:10 128:2 133:14 138:6,9 160:13,17 192:6 214:13 215:7,18 244:9 271:20
different 10:9 12:3 12:13 13:14 14:8 19:4,15 20:4,11 20:16 27:17 29:7 29:8 30:2 31:1,2 38:20 39:11 41:10 42:4,22 43:12,13 46:12 48:18,19 55:8,22 56:18,20 58:20,21 62:16 63:8 65:22 74:15 74:16 76:2,15 77:4 79:22 80:8 86:13,18 88:1 89:1,4 91:1,2,4 92:4 94:1,2 97:18 97:20 100:12 101:5,13 110:18 110:20 112:6 114:15 124:15 125:3,15 126:13 126:18,20 127:1,2 128:7,10,13 129:5 129:10 130:4 132:10 133:3 139:19 146:19 162:8 168:21 169:7 170:22 171:2 174:19 177:7 183:15 186:13 198:1 200:8 203:10,22 205:12 207:15 212:15 216:19 217:17 218:8,22 221:3 222:15 245:22 246:14,15 255:6 267:9 271:16 272:7 276:12,22
differentiate 110:3 158:3 203:7,11 204:1
differentiation 98:11
differently 9:2 10:9 30:5 41:6 75:4,8 80:3
difficult 90:10 188:6 189:12 193:10 205:17 226:6 241:3 255:13 264:2
difficulties 56:8
difficulty 189:16
dimension 104:16 104:17
dimensions 206:14
dinner 4:5
Dionne 2:4 39:14
direct 92:9 233:21
directed 28:8
directing 67:17
direction 36:4 189:11
directive 35:12 36:2
directly 100:15 147:9 185:10
disability 132:18
disadvantage 155:6
disadvantaged 89:12 95:11 101:11 184:17
disadvantages 29:12 209:7 212:21
disagree 60:14 80:18 178:16 196:9 209:18 247:11 252:7

disagreement 195:22
disallow 150:13
disappear 57:4
discharge 68:22 72:18
disconnect 79:17
disconnecting 142:6
discouraging 95:15
discovery 135:8
discredit 249:1
discretion 15:22 16:5 46:4 58:7 81:16 255:11
discrimination 263:22
discuss 3:13 36:19 155:17 184:19 218:13 221:6 240:19 256:16,17
discussed 15:18 25:14 36:15 81:22 85:5,6 99:17,21 151:13 160:2 174:7 197:8 200:20 201:5,13 202:13 207:18 228:15
discussing 124:13 124:18 176:7 207:6 211:13
discussion 3:18 4:6 5:12,15 6:1,15 7:7 8:21 9:8,16 18:15 23:1,17 39:7 44:12 45:8 47:15 47:17 48:21 50:16 51:1,14 56:5 66:14 68:13 84:15 88:7,11 91:13 93:22 94:20 97:1 102:11 107:3,6 111:20 113:14 123:22 124:1 125:15 137:5 138:12 141:21 142:15 144:2,4 146:3 147:12 157:10 158:11 162:11 163:10 169:19 170:8 175:22 176:15 177:19 178:14 179:18 180:6 182:10 183:22 184:9 193:14 194:3 200:10 206:19 233:7 234:2 235:9 236:12 237:15,21 241:5 249:12 281:19
discussions 13:16 19:5 35:18 36:3 103:19 111:16 142:13,18 187:14 192:20 195:16 223:19 231:4 236:11 281:14
disease 78:16 92:7 269:20 270:2 271:8
disguise 270:4
disparate 27:1
disparities 36:18 43:2 45:5 51:21 59:13 62:19 63:6 67:1,2,5,11,20 73:12,13,15 79:22 89:5,7,8 94:13 95:7 102:14,17 134:5 135:16 162:2,7 169:3,6 169:14 200:1 236:6 241:12,18 257:2 282:21
disparity 34:2 75:7 75:10 77:16 191:12,16
disposal 219:12
dissension 86:4
distances 230:6
distinction 56:13 57:10
distinguish 252:9
distributed 58:3 274:17
distribution 261:20 274:10,16
distributional 133:13
ditto 179:3
diverse 8:17 267:10
division 1:15 267:2
divisions 266:17
doc 204:1
doctor 203:14
documented 169:22 240:3
doing 13:4 28:4 36:11 37:14 38:20 70:13 84:1 108:4 116:8 128:1 130:17,19 155:18 160:21 162:9,16 162:17 195:20 200:7 206:7 209:4 226:22 230:15 231:1,22 242:21 244:6 245:4
dollar 211:8
dollars 57:21 58:3 99:4 255:1
domain 156:4 256:6
domestic 150:14 233:17
door 7:4 9:5 36:8 143:9 152:3,15
dots 27:20
doubt 250:21 251:13
DR 51:4 52:22 63:15 87:10 96:6 98:8 156:15 275:21 281:6
draft 87:2 194:17 195:12 196:1,13 201:2,21 278:21 279:4
drafting 6:2
drag-out 186:18
drawing 236:1
dream 21:17
DRGs 131:7,9 272:5
drill 145:13
drive 76:3,20 93:4 96:17 226:6
driven 214:19 271:21
driver 103:3
drivers 103:2
DrPH 2:9
drunk 276:3
DSH 126:16
dual 133:16,17 168:22 170:4 183:15 231:4,10 231:11,13 276:17
dually 276:22
due 78:11 91:11 92:3 93:8 140:12 142:1
Duke 2:6
dynamic 171:10

E

ear 246:6
earlier 48:22 159:5 168:20 206:18 216:18 242:20
earliest 28:16
early 9:18 33:9 164:3
earth 252:15
easier 268:10
easily 14:15
easy 180:15 183:21 183:22 226:12 266:12
echo 193:7 234:15
edits 279:6
educated 100:11
education 100:1,7 100:20 101:3 106:1 134:19 136:1 176:3 181:20 227:14
educational 225:3
effect 158:20 164:8 164:10 257:10 262:8 271:4
effectiveness 189:14
effects 23:11 154:5 173:15 275:9,10
efficiency 24:2,4
effort 85:15 158:14
either 8:3 35:11 36:1 39:16 47:22 70:9 103:12 140:15 141:2 150:1 166:14 170:1 178:16 200:8,14 222:22
either/or 112:18
electronic 188:1
element 13:18 105:5 192:10
elements 188:3,4 196:21
elephant 97:11
eligibility 24:17 91:11 145:16 276:18
eligible 133:17 183:16 231:11,14 277:1
eligibles 170:5 231:5,11
eloquently 216:11
else's 10:3
email 87:2 283:10
embrace 264:12
embraced 59:6 60:8
emerged 5:9
emotional/sexual 233:18
emphasis 121:8
emphasize 57:9 228:21 246:20
empirical 11:14

86:16 93:3,11 96:16 116:20 118:18 120:9 245:3 267:22
empirically 244:1 246:2 267:22
Employees 2:4
employer 76:10
Encompassed 3:9
encompasses 183:2
encompassing 176:17
encourage 8:14 14:1 38:7 181:8 226:9 236:7 283:1
encouraged 211:22 212:4
encouragement 108:5
ended 166:6
endorse 84:6
endorsed 97:15 105:16
endorsement 21:7 51:6 53:7 98:6,10 103:13 156:19 161:6 212:8
endorses 113:7
endorsing 208:17 243:17
ends 104:19 105:8 200:8
energy 109:6
engagement 249:15
English 90:7 100:9
enhance 275:14
enormously 277:17
enrollees 273:11
enrollment 133:17
ensure 44:18 78:6 79:5 109:11
ensuring 244:11
enter 9:7
entirely 49:3
environment 58:16 239:17
environmental 225:7
environments 233:17
envision 27:3 243:15
envisioning 56:16
epidemiologic 254:18
equal 43:20 79:5
equality 183:5
equation 24:1 69:8
equity 34:1,8 52:14 53:3 103:4 226:8
errors 274:10
especially 28:9 48:22 58:22 77:17 184:12 251:11 256:5 257:7
essence 107:15 108:1 109:2 195:7 195:8
essentially 91:3 107:14,19 121:15 149:15 159:17 225:3 226:6 253:13,15
establish 87:5 109:9
established 159:8
estimation 49:17
et 6:9 11:15 22:3 56:8 98:18 133:18 195:14
ethnicity 67:6 99:19 128:22 174:6
evaluate 8:2 16:2,3 93:19 137:18 159:15 163:5 208:16 251:20 281:9
evaluates 208:14
evaluating 242:10 246:8
evaluation 17:8 51:2 71:4
everybody 8:18 124:5 153:3 193:21 229:18 252:13 272:18 283:6
everybody's 144:2 191:18,19
evidence 18:2,16 26:9 36:17 70:8 103:15 243:9 257:22
evolve 98:15 172:12 270:12
evolves 236:20
evolving 172:13 268:3
exacerbate 203:13
exactly 29:14 47:21 53:21 121:10 142:22 156:13 163:22 168:4 205:11 222:16,17 249:14 269:1
exam 58:16,17,19 58:19,21
examine 70:6
examined 150:11
example 13:7 16:21 24:15 34:3 48:1 51:8 52:3 53:16 54:12 61:14 72:22 78:22 90:18,21 114:10,17 118:4 124:22 125:2 128:18 130:6 131:7,14 132:12 132:16,19 133:15 133:17 145:3 150:14 152:7,9 154:21 160:18 162:12 167:13 170:3,4,16 171:4 171:19 183:7 190:7 197:15 199:2,19,22 201:4 210:15 211:16 220:22 225:3 241:22 253:1 262:6,10,22 263:4 273:6 276:10 281:13
examples 55:7 67:6 77:1 92:11,12 94:10 131:22 146:15 192:2 213:11 243:12 252:11
exceeded 156:6
exceeds 230:18
exchange 183:12
exclude 174:3
excluding 70:9
exclusive 124:9
exercise 149:17
exhaustive 64:17
exist 73:17 127:2 177:17 186:1 204:22
existence 221:5
existing 6:5 136:19 173:14,16 265:8
exists 91:11 216:5
expanding 190:18 239:19
expect 74:5 280:19 280:22
expectation 12:10 15:13 171:13 172:12
expectations 7:22 29:7 70:17 85:20 86:6 93:18
expected 36:16 37:4 44:8 104:20 106:10 137:16 140:2 190:19
expected-to-obse... 104:21
expecting 74:1,16
expeditious 13:20
experience 94:3
experiments 264:6
expert 1:3,8 16:18 65:20 66:1 249:7
expertise 58:6
experts 27:11 158:1
explain 23:11 56:16 172:19
explanatory 195:4
explicit 54:19 200:11 201:14,14
explicitly 29:11 65:20 201:10
explore 273:19
exploring 134:10
expose 269:22
express 81:4 278:2
expressed 122:6
extensive 175:22
extent 79:7 161:12 253:17 271:12 275:16
external 147:8
extra 93:9 106:6
extraordinarily 263:15
extreme 238:1 252:10
extremely 205:14
extremes 133:16,18
eyebrows 167:10

F

face 56:11 93:12 118:12 252:15 253:21
faced 56:8
facile 136:2
facing 238:10
FACNM 1:16
fact 15:8 21:22 23:3 27:5 29:6 51:13 53:9 97:8,12 124:10 130:14 131:8 132:22 150:16,17 152:20 189:12 190:19 224:21 229:4 245:15 253:10 258:13 274:4
factor 31:16 139:7 151:20 189:8

190:9 233:13 253:16 254:13
factors 1:3 5:1 6:4 10:11,20 11:18 18:4 21:20,22 22:1,7,14 25:14 26:2,8 42:17 45:4 45:11 65:9 85:17 89:6,10 90:4,11 90:12,20 92:7,10 92:19,19,21 93:1 93:7,20 94:16 95:7,20 101:3,5 106:1 107:12 112:5 115:12 119:6 130:4 133:4 135:13 136:2,9,17 143:12 144:14 145:4,5 147:8,20 148:19 153:9 154:7 163:16 166:15 178:13 179:11 184:3 188:10,14,19 205:13 216:21 218:2 232:2 233:9 235:4 243:10 255:6 260:16 263:19 282:22
fair 128:8 156:16 165:21 169:18 216:5 258:5 264:9
fairly 20:9 163:5 196:14 213:2 280:11
fairness 43:19 240:13 241:2 244:13 245:5 246:12,15,16
fall 28:1 45:15 229:2,9
familiar 15:20
family 184:13,15 238:13
far 4:17 27:22 168:2 174:20 198:12 235:12 259:8 281:18
fascinating 45:14
fashion 173:7 200:13
fast 116:7 263:20
faster 175:13,14 282:3
favor 28:11
FCCP 2:3
feasible 54:14 69:20,22 107:15 108:8,15,16,17
February 278:12 278:12
federal 13:4 57:20 63:2
feedback 110:16
feel 9:3 24:9 37:13 38:16 42:18 64:8 64:15 69:21 73:10 75:17 76:16 78:20 93:15 128:8 146:3 201:22 204:4,6 205:20 209:21 217:10,13 237:17 275:17
feeling 148:9 161:4 163:11
feels 95:8 129:13
fell 194:16
felt 161:1,21 168:22 173:21 185:6
fewer 259:8
field 106:9 209:2 213:1 225:12
fields 89:3 188:5
figure 166:17 229:14 271:19
figures 225:4
fill 171:6 198:14 278:5
FIM 170:2,17
final 26:1 158:13 211:8 279:19 282:10
finally 231:2 234:15
financial 103:4 110:15 111:9,9
financially 199:7
find 19:18 23:6
finding 115:6 274:15
fine 22:12 217:20 227:5
finish 44:14 143:17
firm 210:14
first 4:11 26:6 28:22 33:8 42:15 46:21 48:9 69:3 70:11 81:6 100:3 121:19,20 131:7 140:19,22 149:7,7 149:20 160:6 164:7 165:7 169:12 171:11 175:9 183:20 194:18 197:5 217:6 224:2 235:16 269:13,17 269:21 270:3,11 273:6 274:1 279:3 279:11 280:21
Fiscal 24:3
Fiscella 1:10,12 4:8 4:14 6:19 8:9 9:15 9:21 11:4 21:11 25:12 30:14 39:5 39:18 40:8 63:9 66:6 80:20 81:11 81:19 82:1 83:1,6 83:17 86:1 87:14 88:15 96:14 99:15 101:15 106:20 108:18 113:19 117:18 118:8,22 119:22 120:5 121:3 122:4,18 124:7 125:16 135:5 140:11 141:8 143:16 151:9 153:6 156:22 172:15 175:8,15 187:22 189:21 193:6 198:7 200:9 209:13 210:17 263:5 265:17 266:6,9 277:10
fit 49:12 98:9 118:13 156:18 263:16 264:22 273:22 274:2,5,9 274:20
fits 119:21
fitting 274:8
five 123:15 191:7,7 212:15
fix 165:1
flavor 44:2,15
flesh 177:3 233:13
fleshed 182:3 183:11
flexibility 236:19
flexible 135:19 237:1
floor 1:9 117:20
flow 57:20 199:10 220:21
flux 156:18
fly 202:15
focus 107:4 125:18 136:8 162:3 218:10 227:5,8 239:2 271:13
focused 39:9 88:10 169:11 187:3 228:18 236:12,13
focusing 169:5 244:5
folks 16:19 80:21 88:17 141:18,22 175:13 193:9 228:18 254:20
follow 21:12 64:18 78:1 86:22 115:2
followed 81:2 171:1
following 84:10 98:15 103:16,20 159:17
follows 185:10
food 176:15 225:8 233:15 238:7,11
Ford 1:13
forget 47:7 49:9 96:3 179:16 208:22 212:11
forgetting 47:18
forgot 148:8
form 200:12
formal 34:5,6 194:4 243:3
formally 244:1
formed 266:17
former 239:4
formula 33:21 55:1 257:8 258:2,5
forth 146:6 170:18 176:1 235:12 247:22
Forum 1:1,9
forward 4:5 7:13 67:14 130:9 158:7 162:6 178:2 198:13 204:9 243:20,20 246:8 251:6 282:7 283:9
found 103:21 157:16 174:2 257:14
four 120:8 126:10 208:5 261:15
fourth 25:16 82:16 83:20 84:5,6 107:13 118:14 131:4,19 212:10
frame 49:13 74:3 89:16 167:14 277:13
framed 11:7
framing 104:2
frankly 171:8
free 9:3 33:14 34:11 146:4
frequently 150:18
front 14:11 144:4 154:18 173:10 197:6

frustrating 124:14
FSA 2:9
full 73:10 122:7 141:14 144:3 149:20 215:22
fuller 144:2
fully 215:6 280:21
fun 136:4 171:8
function 219:18
functional 15:16 61:15 132:17
functionality 174:13
fund 99:1
fundamental 199:21
funded 97:3 126:19 126:21
funding 103:22
funds 57:20
further 23:13 73:17 79:12 111:16 195:14 253:6
futility 149:17
future 6:6 96:10,12 136:19 173:17 174:20 187:20 188:8 237:5 243:15 244:19
fuzziness 243:19
fuzzy 251:4

G

gain 173:20 248:17
gained 71:13
Galea 100:18
game 156:16
gap 257:15,20
garner 11:3
GARRETT 2:1 86:11 109:3 110:4 116:13,18 119:19 127:13 184:18 209:15 266:13 268:20 269:3 279:13 282:9
geared 97:7,8
gender 67:7
Gene 2:5 270:4
general 17:18 35:1 41:8 55:18 70:10 85:8 126:11 140:1 156:8 185:10 209:16 212:12,13 227:21
general-ness 199:11
generally 17:19 72:4 280:19,22
generated 235:22
generations 238:13
generous 272:20
genetic 90:15
geocoded 91:14
geocoding 91:16
George 237:13
get-go 135:4
getting 63:13 66:3 73:22 155:5 161:20 183:12 189:9,16 190:2 213:19,20 214:3 228:19 239:18 259:5 282:20
give 16:4 25:20 28:5 29:21 33:13 34:11 36:9 42:3 47:10 72:12 84:8 88:17 106:10 108:21 117:3 124:5 131:21 182:19 210:1 212:11 217:4 229:9 246:17 280:4,18
given 18:15 33:14 45:4 71:18,22 92:9 94:10 140:16 163:2,5 164:11 188:20 193:8 212:16 220:11 236:3 255:12 267:2 277:8 279:2
gives 24:5 36:11 51:14 121:7 225:9
giving 157:18 187:15
glad 179:4 234:11 247:9
global 33:22
go 4:14 7:20 8:5 23:9,12 24:15 28:16 29:4 35:6 35:20 39:19 47:18 60:1,4 72:21 75:19 84:17 88:11 88:13 95:19 99:1 101:20 117:6 118:22 120:19 122:16 124:8 136:16 140:16 142:7 143:17 146:6 149:18 159:10,12 164:7 169:16 170:20 172:15 173:13 175:10 176:7,14 193:5,14 195:21 202:7,22 208:3,4 208:6 214:15 215:16 216:9 223:8 230:6,8,9 231:20 237:11 241:8 244:18 253:6 268:7 271:22 279:9
goal 29:5 53:5 169:12,14 274:7 275:1
Goals 3:5,8
goes 6:1 64:2,4,5 78:17 279:20
going 4:6,10,20 5:4 5:20 7:22 12:16 12:17 14:14 19:17 20:9 22:18 23:19 24:2 25:2,9,11 26:1,5 27:8,10,14 29:13 30:12 32:3 39:6,19 40:5,14 41:4,15,16 42:2 46:21 51:5 52:12 52:19 53:10,12,19 53:21 54:22 59:4 61:18 63:3,10,14 66:6,8 75:6 76:12 76:19 77:16 80:22 81:1 83:1,19 85:22 87:1,4 97:2 97:22 99:1 100:5 101:7 106:20 107:1,2,5,21 109:4 111:1,2,4 111:14 113:7 114:19,22 115:11 116:1 119:13 120:19 122:11 124:3,14,15 125:7 125:18,19 127:12 127:16 133:21 134:1 135:3 136:5 136:7,8,20 137:12 137:20 138:1,22 139:6,16 141:15 143:4,16 144:5,7 145:3 147:6 148:1 153:2,13 159:12 162:12 167:3 176:22 186:5 187:12 188:1,2,6 199:4,13 203:11 207:13 208:16,16 208:22 212:7 213:16,17 215:19 216:10,17 217:4 223:18 226:11 229:1,2 230:5,21 231:7 232:4,8 241:1 242:15,19 243:1 245:16 247:7,10,15,16 248:20 249:1 250:2 251:1,3,14 252:12 253:1,5,6 253:7,9 255:7 258:3 263:9,16 264:5,7,8,16 265:1,5 266:10 268:1,9,16 269:12 271:17 272:1 276:11 278:4,5 280:3
GOLDFIELD 2:2 12:18 37:19 80:17 118:3,9 131:3 169:15 175:2 213:3 239:7 252:1 272:3
good 4:3,8 7:18,18 13:19 22:19 60:17 64:16 85:12 98:13 108:9 118:8 140:9 157:10 159:4,13 178:15 180:19 182:21 192:13,17 205:11,11,16 208:18 213:2 227:17 231:1,15 235:6 259:13 266:22 268:1 273:19
goodness 273:22 274:5,9,20
goose 253:9
gosh 183:21 280:3
gotten 84:20 96:22 114:20 193:12
government 57:20 239:1
grab 142:16
gradation 113:5
grade 74:12 229:7
graded 165:17 229:18
gradient 112:19
grant 103:22 104:5
grants 75:14
grapple 137:12 193:9
grappling 236:8
great 11:5 33:6 51:13 55:7 78:22 96:14 98:12 123:11 141:16 146:12 180:13

182:13 184:4 193:21 194:13 195:15 203:21 226:22 237:22 249:16 279:2
ground 198:13 216:4
group 4:11 6:7,10 7:3 8:4,5,17 9:1,4 10:18 21:13 25:13 25:17 32:16 42:15 43:12 48:21 49:8 49:12 50:6 51:10 51:21 87:11 92:17 102:16 116:6 124:6 125:17,20 134:12 136:8,12 136:15,20 137:2,7 137:14,19,20,21 138:3,22 139:5,7 139:8,14,20,22 140:4,8,14,16 141:15 142:15 143:6,21 144:5,9 144:15 148:22 151:12 157:12,15 158:12 159:7 161:4,4,13,19 162:4,13 163:11 163:22 164:1 165:7,7 166:7,9 166:10,12,21,22 168:10 170:9 172:17 174:22 178:15 179:4 180:9 181:7 185:20 188:14 192:12 194:7 195:13 197:5 201:5,12,18,19 205:17 207:5,19 208:1,3 210:6 211:12 217:20 220:21 233:8 234:3 235:12 236:12 241:5 242:22 248:13 259:19 264:11 266:15 267:7 277:11
group's 160:5
groups 3:13,16 6:2 8:7 19:17 25:22 31:19 32:19 43:12 47:8 55:5 88:12 107:7 123:6,19 124:3 141:20 142:9 219:1 242:6 242:21 266:18
GROVER 2:3 21:16 25:18 73:4 82:20 119:12 121:5 134:8 144:7 148:7 210:10 241:4
guarantee 42:19
guess 9:9 19:20 27:22 34:17 46:2 52:10 61:4 86:7 111:15 158:8 185:18 186:9 187:11 188:22 193:16 194:2 195:19 197:4 199:13 224:6 261:4 265:14,17
guidance 8:1 21:14 29:10 37:1 47:9 48:13 49:14,21 50:1,3,13 54:20 68:3 71:18,21 84:9,12,13 85:3,8 85:9 90:1 93:19 103:12 115:10,17 116:11 138:17,20 143:10 145:21 146:11 153:17 157:19 185:19 186:16 188:20 197:16 210:13 211:17 215:16 216:3 217:5 236:22 241:21 250:21 280:20
guide 19:19 70:18 130:21
guiding 28:2
guys 15:18 52:18 120:1

H

hairs 244:20
half 180:11,11 214:22,22
halfway 214:11
HAMMERSMITH 2:14
hamper 241:11
hamstring 135:2
hand 39:10 80:22 81:9 82:10 258:15
handle 53:3 92:20 116:12 129:8 142:20 185:21
handoff 51:8
hands 81:10,16,18 82:2,7,9 83:3,5 120:11,14 121:2 152:5 181:12 192:15
hang 283:8
hanging 193:21 266:1
happen 32:9 68:6 211:22 229:2 264:20
happened 51:20 233:8 237:21 256:16
happening 51:22 53:18 68:10 78:21 230:5
happens 51:22 129:20 131:6 269:13
happy 247:14 254:1
Harborview 2:11
hard 37:18 42:11 53:16 57:12 60:9 80:4 115:6 116:6 157:16 162:8 183:22 184:1 201:17 244:19 277:18 280:17
harder 229:7,7
hardest 79:2 147:11
harm 89:11 95:10 200:3,7
hash 201:17
hashing 122:12
hate 108:12 217:11
hats 266:1
Haughton 104:8,8
Haven 1:17 58:11
HBVP 261:14
HCC 105:21
He'll 8:12
headed 33:11
heading 178:12
health 1:13 2:8,9 59:13 61:19 74:19 87:7 92:13,15 100:17,21 101:14 109:10,14,17 127:8 130:9 150:7 169:20,22 170:7,9 170:13,14 173:5 173:16 174:10,15 177:22 180:19 181:16 188:2 190:20 191:15,21 223:20 224:8,12 224:13 229:16 233:3,20 234:1 240:4 254:8 273:7 273:8,11 276:9
health-related 184:19
healthcare 2:5 74:17 78:12 91:1 98:21,22 99:1 179:12 180:22 181:13 224:11,12 224:14,22 225:6 225:12 234:11 236:20 239:3
Healthfirst 226:21
hear 8:18 14:15 68:17 113:21 248:2 266:5
heard 5:5 52:14 54:13 64:11,18 68:2 86:2 88:17 88:20 89:8,13 102:13 103:2,18 103:19 112:20 144:2 156:16 201:13 224:7,13 229:21 238:20 267:12
held 118:2
Helen 2:14 50:14 55:16 63:9,14 139:4 156:5 281:5
help 10:7 11:2 67:9 133:2 190:14 205:11 209:1 239:3 272:14
helpful 10:21 66:15 152:22 222:8 231:17
helps 128:9
Hennepin 2:1
Henry 1:13
heritage 12:20
heterogeneity 92:3
HGP 262:12
Hi 102:6 104:8 233:1 237:12
high 192:7 220:1 228:6 251:18
high-income 191:19
high-profile 53:20
higher 92:21 119:15 131:18 172:1 241:14 242:7 265:11
higher-strength 112:14
highest 238:22
highlight 170:11 171:17 190:1

192:2
highlighted 12:19 13:8,21
highlighting 239:14
highly 61:21 100:4 100:11 184:20
HIPAA 91:18
hire 76:12
Hispanic 259:9
historical 146:16
historically 270:9
history 240:4
hit 111:1
hold 10:17 142:7 263:20 265:11
holding 263:6
hole 202:9
holes 198:6,14 202:20
holistic 52:16,21
home 17:1 21:19 61:19 184:16 233:17
homeless 238:9 253:10
homelessness 13:7 22:21 38:4 90:8 92:12 99:20 118:10 189:22 190:7 237:22 253:1,14
homogeneity 191:18
hone 90:5
honest 100:8
hope 4:4 142:13 143:17 232:7 276:15
hopefully 22:18 172:1
hoping 143:3 183:1 269:5
Hopkins 126:11
hospice 16:21 17:3
hospital 1:19,22 16:22 69:1 113:3 124:22 125:4,12 126:17,19,21 148:12 206:12 214:19 219:9,15 219:18 235:7 252:12 263:3 271:22
Hospital/Center 1:17
hospitals 24:15,18 24:20,21,21 25:2 30:3,4 33:13 34:10 61:15,17 65:21 126:9,10 127:2 128:2,3,4,5 128:6 199:6 227:6 232:14 236:14 249:1 250:10 271:17
hour 217:10,10
house 238:12
housing 90:20 190:3 233:16 238:8
hovering 23:19
hows 68:13
huge 25:5 65:16 98:2 212:22
human 255:18 273:15
hundred 24:17
hundreds 129:2
hung 277:19
hypertension 22:2
hypothetical 24:14

I

idea 14:10 29:5 43:4 85:14 110:8 130:2 144:11 146:22 153:10 194:8 207:9 209:20 210:11,22 212:7,8 241:5 248:16
ideally 145:15 280:10
ideas 72:4 136:13 212:1,5
identification 67:4
identified 67:3,12 109:15 168:9 187:5
identify 43:5 67:20 94:13 123:19 162:2,7 189:2 202:8,11
identifying 169:1,2
ifs 38:5
Illinois 2:9
imagine 19:11 20:3 34:3 126:14 244:19,20 245:19
imagining 196:5
immediately 242:21
impact 43:7 104:3 109:17 144:18 160:6 190:11 191:1 226:2 227:2 228:9 234:19 255:19 260:10,16 264:7 270:22 277:9
impacting 56:7
impacts 226:4
impair 92:8
impetus 51:15
implement 24:13 135:4 146:1 213:7
implementation 25:10 32:2 49:14 50:14 51:11 52:5 52:9 55:20 89:15 90:1 97:22 138:17 143:10 146:11 163:15 210:13 211:17
implemented 23:14 49:18 53:8,10 97:3 131:7 153:14 213:15,16,17
implementers 84:13 85:4 168:16 197:17
implementing 132:2
implication 54:11 102:20 126:4
implications 27:9 46:12 54:7 94:1 110:17 125:3 188:13 234:19 255:16 264:3 281:12,13,20
implicitly 56:18 219:20
implied 243:22
implies 57:5
imply 61:7,8 149:20 242:1 243:3,8 244:13
importance 150:9 169:22 173:8 216:20
important 28:9 40:15 48:20 51:17 56:3 61:3 76:17 77:21 78:4,8 89:22 93:12 95:18 112:22 125:13 149:10 163:1,4 167:8 174:1 186:1 190:12 204:7,11 205:14 218:6 219:8 227:1,8 231:3,5 236:5 239:17 256:12 261:22 267:15 273:22 277:7 281:19
importantly 174:5
impossible 187:16
impressed 193:11
impressive 267:3
improve 29:21 59:9 60:11 74:13 132:20 166:18 188:11,18 245:4 263:16,22 264:22
improved 266:1 268:17
improvement 21:4 57:16 98:5,5,13 113:2,10,13 117:8 117:13,15 146:8 146:13 149:3 154:14 155:1,19 163:1 170:6 197:22 211:3,5 217:15 221:2 222:12 225:5,10 228:21 263:7
improvements 94:14 228:14,14 229:8
improving 133:4 155:4 228:19
in-the-weeds 191:10
inaccurate 247:22
inapplicable 26:11
incarcerate 238:22
incarcerated 238:19
incarceration 239:8,11,13
incentive 207:1,17 212:18
incentives 46:8 109:13 110:15 111:9,10 188:18 188:19
incentivized 78:14 218:3
include 15:13 44:11 44:12,22 45:8,10 45:11,19 46:19 47:1,1,2 60:16 62:8 67:18 81:22 86:17 93:8 94:12 112:5 114:8 116:3 119:9,20 130:18 144:17 161:7 171:5 173:3 175:3 180:15 185:8 210:3 233:9,14,15 245:1 252:18 257:9 258:22

268:18 273:7
included 47:14 65:11 86:15,19 90:6,20 92:13 109:21 110:1 112:9,12 114:1,7 116:10 118:10,11 118:13,17 119:3 120:8 130:11 145:11 148:5,6 172:22 192:19 232:5,9 270:19 274:14 279:16
including 29:18 30:16 62:13 70:9 85:16 89:12 91:15 111:14 114:17 185:4 186:11 188:9 240:11,20 244:7,13 245:12 245:14 260:15 267:20 268:8 274:11
inclusion 42:17 92:22
inclusive 255:20
income 22:15,22 90:6 99:19 100:4 101:2 129:1 134:19 135:22,22 145:14,15 176:2 176:11 177:5,6 181:20 183:4,5,20 184:12 191:16,19 227:14 239:22 254:8 263:1
incorporate 164:20 170:7 272:21 281:2
incorporated 170:19 174:15 273:9
incorporating 224:4 239:11
incorporation 93:19
incorrect 184:2
increase 75:6,9 77:16 235:4 274:20 275:14
increased 79:18 257:17
incredible 235:9
incredibly 281:8
incumbent 62:4
indexes 177:14
indicate 93:6
indicates 116:11,16
indication 227:18
indications 161:9
indicative 90:10 189:19
indicator 41:9,19 230:2
indicators 97:6 276:12
individual 22:16 33:17,18 35:7,8 76:1,7 77:19 125:1,5,12 134:15 134:19 144:16 145:15 154:20 181:15 182:6 184:11,14 186:6 198:3 206:12 211:9 233:4 263:2 275:15
individual's 76:11
individual-level 177:5
individually 33:1
individuals 25:22
industry 248:15
inevitable 196:19
infection 241:14
infections 72:17 78:21 114:10 115:21 116:5 118:6,12 119:4 151:18 215:4 241:8 242:5,8
inferences 89:10 95:10 236:2
influence 59:7
90:13 157:21
information 15:14 17:14 22:18 29:3 29:17,22 30:9 36:12 37:11,16 54:1 62:9 71:13 96:7 98:14 100:6 103:9 104:9 106:9 134:18 160:8 161:8,15 162:15 162:22 163:4,13 164:5 205:11 235:3 240:12 241:11,18 246:8 253:5 255:8 256:11 261:14 272:10,14,15 273:1 278:19
informative 113:12
informed 157:22 166:10,11
informs 119:7
infrastructure 147:4
initial 178:6,8,18
initially 171:7
initiative 96:2
inmates 239:4
input 59:21,22 65:4 205:3 278:21 279:2
insecurity 238:8,8
inside 281:17
insightful 45:14 266:16
insist 45:7
inspiration 166:2
inspire 163:1
instance 97:4,7
instances 28:14 77:3,8
instantly 158:18
Institute 1:20
instituted 257:6,15
institutional-level 158:4
institutions 75:13
131:17 272:15
instructions 19:12 111:2 124:20 168:15
instructive 135:15 135:17
instrument 197:16
instruments 198:18 199:4
insurance 76:6 183:9,14 227:15 232:9
insurers 203:19
integrate 51:6 54:1
integration 53:4
intended 21:2 27:7 29:20 33:2 44:20 45:5 51:11 113:8 117:12 161:7 162:1,6
intent 109:1 163:7
interchanging 177:21
interest 173:12 234:12
interested 28:19 81:8 248:2 280:14
interesting 68:17 87:11 162:11 181:5 190:20 269:16 277:3
interject 17:6 39:6
internal 113:2
International 2:4
interpretability 205:4
interpretation 44:17,20
interpreted 178:10 235:20
interventions 189:13
interviewed 240:16
intrinsic 105:19
invalid 89:10 95:9
investigate 15:9 16:10
investigated 14:19
investigation 70:13
involve 149:12,13
involved 16:1 17:9 29:1 270:18
involves 78:16
irrelevant 159:9
isolated 52:3
issue 19:18 20:8 22:15 32:2 33:16 41:17 63:13 64:22 79:15 81:14 85:16 88:21,21 89:2,18 90:2 94:14 102:9 103:11 122:5 132:1 136:18 140:14 153:16 156:9 161:2 168:7 169:10,20 170:21 171:15 175:12 185:12 206:4 210:13 221:10 222:5,11,12 228:16 229:21 231:6,12 233:5 235:16 236:7 237:3,3 238:21 239:13 244:22 252:16,22 263:6 275:5
issues 6:4,12 14:2 23:5 34:1,8 43:19 44:5,12 51:20 53:3 79:17 89:20 102:8 125:18 158:12 174:9 193:10 197:8,14 197:18,21 199:21 200:19 201:6,9,13 217:21 223:4 224:8,17 225:1 227:8 234:20 268:15,16
it'll 282:12
items 181:7

J

jail 239:20
JANUARY 1:6
Jean 1:14 58:4 60:1 60:1 64:11 65:13 204:17 205:6 243:6 261:2
Jester 233:1,1
JIMENEZ 2:4 39:16,20 40:10 259:16 260:1,4 261:4 262:2
job 157:9 190:14 193:2,2 202:1,3 231:1 239:21
John 102:6 104:8 148:20 223:16 226:16
Johns 126:11
Johnson 139:5
join 8:12 141:19
jotting 44:13
judgment 243:16
jumping-off 132:3
June 282:12,13
justice 43:20
justification 26:10 64:12 93:8 220:5
justified 120:7 121:13,14
justify 70:8

K

Kaiser 1:15
Karen 2:15 6:22 31:9 48:1,2 49:21 57:8,9 66:10 71:6 79:7 139:5,10 156:5
Karen's 26:14 45:1
keep 8:6 30:7 51:20 52:11 98:1 106:5 128:15 152:7 172:14 186:5 229:5 232:20 254:12 269:2 272:22 276:20
keeper 105:16
keeping 154:18 223:18
Kevin 1:10,12 4:7 5:1,4 6:18 9:19 11:20 28:22 62:15 68:12 123:16 124:12 139:5 197:19 200:18 267:13
Kevin's 79:14
key 5:5 96:12 200:19
keypad 102:3 223:14
keys 276:3
kicking 109:4
kids 74:11
killed 199:7
kind 4:21 5:1,2,14 6:2,7 7:8,11,12 8:4 10:8,14 11:3 12:6,7,11 22:11 31:16 32:9 42:14 47:11 48:18,19 50:9 55:9 58:7 70:3 75:19 86:21 88:4 109:21 116:6 121:16 123:17 124:18 126:16 129:14,21 130:6 131:2 132:18 136:5,15 137:15 143:5 145:20 170:19 176:12 179:18 181:17 192:15,19 193:19 203:6 209:4,16 210:11,16 214:21 218:9,18 236:13 242:22 243:14 249:8 262:15 266:17,18 267:1 271:1,4 277:3
kinds 58:21 61:22 137:16 158:16 236:5
knew 43:6 232:13
know 7:18 9:18 10:5,10,14,20 16:11 18:14 20:4 25:19,20 32:17,21 32:22 36:15 40:2 40:11,13 50:15 53:9,18,20 54:19 55:5,7 56:3 57:5 58:2 62:5,11 63:21 65:8,13 68:12,19 72:7 75:10,13 79:9 86:11 87:20 96:4 97:15,21 105:7 113:4 119:16,18 121:5 128:17 129:15,15,20 137:9 138:10 145:14 148:17 149:2 152:18 153:13 154:1,6,11 155:3,9,11 172:4 174:17 176:5 177:17 181:5 183:10 184:4 185:21 188:15 189:4,17 190:18 193:10,17,18,22 194:6 195:11 202:14 203:11 204:14 205:6,10 206:3 207:2 210:14 212:5,17 218:22 219:6,8,15 219:19 220:9 222:9 223:5 226:10 231:3 236:11 237:2 238:10 239:10 240:1,14,16,18 241:9,12,13,15,20 242:14 244:14,15 244:21 245:18,22 246:5,14 247:18 248:5 250:10,15 252:4,11 253:12 253:16,22 254:2,2 254:6,9 258:9,19 259:12,14,18 260:5,14 261:8,13 261:14 263:12,20 264:4 265:2,3 266:11 268:9,15 269:4,18 270:9,12 270:14,22 276:3 276:16 278:22 279:7,13 280:1,5 280:10,11,16,22 282:18 283:7
knowing 39:22 97:2
known 54:2,3
knows 88:3 229:18 272:19

L

labeled 173:22
lack 46:15 64:20 89:20 152:15 176:3,15
lacking 107:17
laid 159:22
lamp 276:4
land 30:12
landed 163:22
language 31:13 33:20 45:16,22 46:16 68:1 82:21 83:8 85:14 86:12 87:17,21 88:3 90:7 100:11 108:22 112:19 113:1,18 129:1 147:17 150:6 222:5 223:6 227:14 246:10,11 251:17
larger 18:10 136:12 142:15 178:15
Larry 11:7,8,19 115:2 117:22 126:9 155:9 159:4 197:19 240:22 243:13 249:21 272:19
Larry's 33:8 115:9
last-minute 8:11
laugh 252:14
Laughter 58:13 108:14 116:17 126:6 141:5 165:19 202:4 216:14 248:7
launched 256:20
LAWRENCE 1:20
laying 35:14
LCSW 1:19
lead 5:1 36:3 42:21 89:10 233:20 262:14
leaders 201:20
leading 157:9 233:22
leads 265:21
leaning 40:16 154:6 194:21
learned 237:17
learning 252:5
leave 15:9 55:17 63:17 137:11 138:21 141:3 143:18 207:22 216:1,16 240:19 256:1
leaves 68:22 146:21 243:18
led 42:14 217:22
left 212:2
legislation 87:2,5 87:12 109:1,4,8
legs 236:17 281:11
length 174:7 183:14
LEP 99:19
let's 9:7 13:18 72:13 81:5 101:20 120:10 126:14 139:2 141:3 154:21 167:14 172:15 252:10,20 279:18

letting 72:12 233:5
level 13:4,5 22:21 33:15 34:19 89:2 90:22 91:12 103:13 125:20 128:14 131:18 133:21 134:6,19 145:15 148:11,12 148:12 158:22 159:1 161:10 164:8,11,11 168:14 176:6 177:15 182:11,12 182:12,17,17 183:3 186:6 201:7 218:11 219:20 225:11 228:20 255:15 260:21 263:3,3,11 275:6 275:15
levels 29:8 43:13 90:22 132:11 183:2
library 129:21
life 236:18
light 175:12 276:4 276:5
limitation 141:10
limitations 91:9 134:5 142:2 280:17
limited 100:9 255:14
Lindsey 2:16 139:4
line 50:9 72:17 105:11 106:4,12 114:9 115:20 116:5 117:4 118:6 118:11 119:4 142:7 151:18 213:15 237:8 241:7,14 242:5,7 245:7 280:18 282:10
lines 45:15 48:8 70:3 101:21 168:18 172:11 185:6 223:10
link 239:3
linking 239:12
LIPSTEIN 2:5 15:19 18:18 57:8 58:14 62:14 84:10 95:6 96:8,20 116:8,15 126:3,7 165:15,20 166:8 248:5,8 249:13 255:9 269:4 271:6
list 99:19 175:16 176:22,22 177:4,9 179:6,15 181:8,18 182:21 183:17 202:7 217:3 232:1
listed 173:7,12 174:6 253:20
listen 141:20 233:6
listened 237:15
listening 46:7 72:12
listing 182:19
literacy 92:15
literally 214:9
literature 11:14 36:17 158:1 181:5 184:12
little 8:21 9:16 14:7 17:6 18:7 25:20 26:4 28:1,12 53:6 75:20 85:7 88:1,4 124:4 128:10 133:11 134:2 142:19 145:20 147:17 157:16 159:19 161:3,18 174:18 188:12 192:12 218:14 220:14,15 221:18 229:21 244:15,18 245:21 248:13 249:5 250:18 251:17 255:3 256:3 265:4 273:19
live 26:12 116:21 142:3 176:9,9 177:17 202:9
lively 207:6
local 58:16 59:1 104:4 127:5,6 128:14
logic 98:9 245:11 247:1
logical 52:13 149:16 151:19
logically 42:5 51:8 282:8
logistical 140:13
long 183:22 230:6 273:8
longer 281:11
longstanding 102:9
look 13:17 14:2 28:5 30:1 34:12 52:2 61:1 65:9,22 73:12,12 76:6 77:18 98:22 99:2 104:21 147:3 148:15 156:5 160:6 164:10 179:7 195:17 196:11 203:4,5 216:7 231:8 260:16,22 261:17 262:1 264:6,10 270:21 271:4,6 274:12 276:4 280:2 283:9
looked 52:4 172:20 194:15 228:14 231:12 257:19
looking 4:5 13:2 33:11 66:22 67:12 73:16 74:14 75:8 85:16 135:1 172:10 176:10 198:13 203:19 209:16 224:7 227:11,11 229:16 267:18 268:5 276:3
looks 31:10 99:15 172:5
loosely 182:18
lose 29:2 129:9 166:2 264:8
losing 51:16
loss 30:9
lost 98:7 193:2
lot 29:17 41:1,12 46:14 48:21 50:11 50:16 51:14 63:12 66:2,3 75:11 77:22 79:17 98:21 102:11 103:3,18 109:6 111:5 115:4 159:14 172:4 175:7 189:4,5 191:15 193:19,22 201:5 203:5 205:5 206:19 207:5 214:14 220:20 224:6 227:8 228:17 233:19 234:16,18,22 235:1,3 236:17,18 237:16,17 251:20 266:11 268:2,10 276:1,6 278:2 281:14
lots 155:22 250:6 264:18
Louis 126:20
Louisiana 62:20
love 97:11
low 89:13 90:17 92:15 154:22 191:18 192:8 254:8
low-income 91:5 228:7,18 231:8
lower 74:1,5,8 131:9
lower-SES 150:17
lowest 219:22
lucky 190:16
lump 217:18
lumps 261:15
lunch 107:1 142:5,8 142:10,11,17
Lung 225:21

M

MA 228:5 229:12 231:8,12,14 232:10
ma'am 237:9
MAAA 2:9
magnitude 275:7,8
maintained 172:14
maintaining 81:8
major 24:19 96:2 195:3
majority 178:6 240:1
making 4:16 41:22 41:22 57:9 62:9 64:21 220:17 236:1,18 250:4 275:12 283:14
MALE 226:15 231:16
mammogram 72:22
mammography 72:20 154:22
man 4:21 39:11
managed 190:2 203:18
management 61:16 61:17,20 65:19
managing 273:16
manner 13:20 14:4 273:10
manual 65:19
many-hundred 65:18
MAP 51:3,7,22 103:19
marginal 93:6
mark 2:1 150:8 151:14 174:11 261:2
Marshall 1:22 19:7 33:5 47:19 48:10 51:19 52:22 54:4 54:6 58:12 82:12

120:15 138:1 140:12 168:6,18 197:4 198:7 200:9 202:5 205:22 206:18 283:7
Marshall's 21:12 84:3
Mary 1:16,19 9:20 26:15 70:21 82:10 83:10 84:16 86:2 87:19 120:18 138:1 140:12,20 283:7
mask 59:13 89:7 102:16
masking 94:15 102:14 135:16
mass 126:11 134:4
Massachusetts 62:21
massive 274:20
material 255:17
materials 44:9 196:13 243:17
matter 106:18 111:4 112:16 119:6,8 143:14 221:5 244:2 246:2 283:17
matters 105:4 176:8,9 246:3
MD 1:12,17,18,20 1:21,22 2:2,3,10 2:11
MDS 170:1
mean 9:10 11:16,17 11:21 15:15,16 18:12 30:22 31:5 34:14 36:14 40:4 46:19,21,22 63:19 65:9,17 68:19 69:10 72:9 74:4,5 77:7 79:6 82:14 86:14 97:19 102:21 107:18,19 108:11,12,16 111:4,10 116:5,18 118:6 119:10 120:6,12 129:7 137:13 150:9 165:10 167:16,21 169:7 175:18 183:20 187:2 189:9 192:4,5 199:18 201:2 205:5,9,16,18 210:21 211:20 213:10 222:22 223:5 227:13 241:19,21,22 242:8,16 258:10 260:4,20 261:7,8 270:15,17 272:4,5 276:18 280:6,15 282:19
meaning 70:5 129:9 243:2
meaningful 146:20 184:7 220:4
meaningfully 264:22
means 11:10 46:18 57:21 68:20 74:6 81:13 83:14 92:4 98:7 109:16 114:5 122:19 123:5,8 188:15 272:12
meant 71:15 73:2 155:18 167:21 204:3 250:8 261:6
measure 6:14 7:11 7:13,21 11:10,12 12:5 16:18,22 17:7,22 18:19,22 19:2,3,11 24:5,13 25:8,9,21 26:20 27:4,16,19 29:15 30:1,5,22 31:7,9 33:18 35:9 36:19 37:3,4 39:21 40:2 40:3,13 41:3,13 44:18 47:13,20 48:4,5,7,14 49:6 49:16 50:1,10,20 50:21 51:10 52:4 53:9 54:9 56:20 57:14,15,21 58:6 59:5,20 61:15 64:1 65:6,18 66:15 67:3 69:13 71:4,21 72:2,3 80:2,8 85:2,19 93:17 98:12 103:12 104:14 105:5,16,18 106:7 107:11,18 108:2,3 129:9 130:7,8,10 132:17 133:6 140:2,5 144:20 145:1,10,12,18,22 146:5,12 147:1,9 147:21 150:22 152:10,12 153:15 153:21 158:17 159:1 160:19,20 160:22 161:15,22 162:1,1,6 163:12 163:13 171:21 172:14 175:19 181:3 184:13,14 187:14 192:22 206:9,11,15 207:12,13,21 208:9,18,22,22 212:6,11,11 215:1 215:10 219:12 220:2,5 221:6 242:4,11 245:11 247:5 248:16,21 249:2,16 251:22 255:11,12 256:7 259:22 260:7,8 262:5,7 264:5,10 264:20 266:9,18 269:10 280:8 282:4
measure-by-mea... 85:8
measured 27:13 78:13 176:5 182:11 186:6 208:20 260:2 275:9
measurement 34:4 93:5 96:7 114:9 154:14 169:12 282:6
measurements 110:15
measures 12:5 14:12 15:15,16 17:19 19:5 21:1,6 22:9 28:10 29:20 38:15 40:11 42:10 44:15 53:7,15,16 53:21 57:4 61:11 61:12,12 62:16 64:20 65:3,17 72:4 73:1,19,21 77:17 90:19 91:6 91:14 92:10 93:14 94:4,9 95:14 99:6 101:6 105:1 106:8 109:11 110:5 111:8 112:4 113:7 117:5,10 128:12 128:13 129:16,21 130:2,13,22 135:1 135:3 138:10,13 139:13,17 144:16 148:10 152:19 158:6 159:8,12,13 160:9 162:4 169:2 172:6 183:2,3,4 204:6 207:10 209:7 215:4,12 216:22 217:6 219:21 225:15 232:10 236:16 243:18 250:9 261:9,15,16 264:12,15,17 268:2 276:10 281:9
measuring 104:14 207:14
mechanical 106:5
mechanisms 58:22 89:4 271:12
mediated 160:17
Medicaid 2:10 24:17 91:10 105:21 126:15 145:16 227:19 239:17 253:8 262:9
Medicaid's 231:7
medical 1:21 2:1,3 2:6,6,11 104:9 154:5
Medicare 40:5 227:11,12,19 273:10
medication 61:16 61:17 193:3 229:11 238:12
medications 61:20
MedPAC 8:11,12 31:6 123:18 278:4
MEDPAR 127:11
meds 61:16
meet 136:20 143:8 278:11
meeting 1:4 64:19 197:9 205:16 229:3
member 6:22 7:3 7:15 9:19,22 11:20 12:18 14:6 15:19 16:7 18:18 19:7 21:16 25:18 26:13 27:21 28:15 30:18 33:5 36:5 37:19 39:16,20 40:10 42:7 45:12 46:13 49:20 51:18 54:5,12 56:2 57:8 58:14 60:13 62:14 65:16 66:13 68:4 68:16 69:19 70:20 71:5,8,15 73:4,7,8 77:7,12,20 80:15 80:17 81:21 82:10 82:12,18,20 83:10 83:13,19,22 84:3

84:4,10,16,18 86:5,11 87:19 95:6 96:8,15,20 96:21 98:19 99:9 99:17 100:14,22 108:6,15 109:3 110:2,4,8,21 111:7 112:8,13 113:21,22 115:1 115:19 116:8,13 116:15,18,22 118:3,9,16,20 119:2,12,19 120:16,19 121:5 121:11 124:12 126:3,7 127:13 131:3,20 132:5 133:8 134:8 135:7 139:10 140:20 141:1,13,16 144:7 147:13 148:7 149:5,22 150:6,20 151:7,11 155:10 157:7,14 164:6,22 165:2,15,20 166:8 168:1,6,17 169:15 172:3,17 175:2,5 175:21 177:8,12 177:18 178:5,17 178:21 179:2 180:4,12 181:4 182:9,13,20 183:13,19 184:10 184:18 185:3 191:9 192:9 197:3 198:10 200:17 202:22 205:8,15 209:15 210:10,20 211:20 213:3,22 216:15 217:9 219:2 222:4,7,21 223:3 239:7,16 240:7 241:4,19 244:4 245:19 246:9 248:5,8 249:13,20 252:1 254:11 255:9 256:9 258:7,8,19 259:8,12,16 260:1 260:4 261:4,7 262:2 266:13 268:8,20,22 269:3 269:4 270:6,14,15 270:17 271:6,10 272:3 273:18 275:2,19 279:13 282:9 283:11,13 283:14

members 8:1 37:18 65:21 94:10 107:8 107:21 157:15 162:13 166:10 174:22 184:15

memo 178:19,22

mental 186:11

mention 20:22 32:12 148:8 185:22 207:5 238:20

mentioned 17:11 29:18 34:14 54:18 60:18 66:18 91:20 92:14 93:10 122:21 126:9 153:22 168:18 190:10 234:17 239:8 266:16

merit 167:2

message 98:3,4

messaging 46:9

met 1:8

method 32:4 222:14

methodologic 27:17

methodological 42:9 62:5

methodologically 220:12

methodology 260:9 260:20 262:12 270:11

methods 39:7 56:9 109:12 124:2 125:15 129:22 131:21 221:13

metric 94:7 241:2

metrics 93:20 164:12

MHA 2:5

MHS 1:17

Michelle 233:1 237:18

microphone 249:12

middle 198:16 216:4 219:22

mike 40:9

mind 8:6 10:3 20:6 73:13 124:16 128:15 154:18 223:18,22 232:21 254:12 272:22

Minnesota 87:7 109:5 127:22

minority 183:6

minutes 95:3 99:22 122:10,10 153:22 193:9

mis-speaking 164:21

misclassified 98:18

miscount 121:19

misdirecting 59:15 59:16

misinformation 98:17

misread 260:5

misrepresenting 146:4

missed 88:19 95:5 217:9

missing 96:17 102:15 195:4 199:17 201:16

mission 98:1

Mississippi 58:20

Missouri 62:21

mistake 247:14

misunderstood 203:15 260:6

misused 198:19

mix 91:3 93:1,1 163:5

mixes 128:7

model 29:2 47:3 60:21 94:13 105:21 122:20 130:5 132:13,14 133:7,7 144:20 150:10,11,12 151:6,18 153:4 164:20,20 172:10 188:11 232:10 243:9 245:10 247:12,19,20,21 250:2 252:20 256:12 258:22 263:7,10,13,16,22 264:22 265:8,21 266:2 267:15 268:6,18,21 271:3 273:19 274:8,12 275:9 276:14

modeling 5:16 132:9 150:9 214:18

models 12:21 67:19 132:11 133:3,12 134:7 179:10 180:13 185:7,8 188:10 214:22 215:2 232:6 263:18 270:13,16 270:18 277:4,7

modifiable 179:12

moment 39:6 102:4 223:15

monetary 255:18

money 99:4

Monica 1:18 66:12

month 190:14

months 13:22 280:1 281:1,15

moot 262:16

morning 4:3,8 8:12 9:18 71:3 88:21 89:8,14,19 90:7 94:21 147:18

mortality 100:19 257:13 259:6

motivation 64:21 250:17

move 42:5 59:4 64:17 66:12 67:14 88:6,14 122:2 131:20 141:6 143:5,12 176:21 178:2 189:12 193:13 256:6 264:13,16 276:13 279:7 280:16 282:2

moved 162:21

moving 87:4 171:21 189:10

MPH 1:12,16,18,22 2:9,10

MPP 1:15 2:4,8

MSPB 23:17,19,22 24:5,16

mull 138:21

multi-variable 271:1

multiple 18:21 19:2 66:17

multitude 136:1

murky 45:22

must/should 82:7

mutually 124:9

N

N.W 1:9

nailed 279:10

name 237:12

named 77:21

Nancy 2:1,10 86:9 87:15 108:18 116:9,16 209:14

Nancy's 135:10

narrow 152:15

narrowest 173:2

narrowly 161:16

national 1:1,8 61:1 92:2 98:22 128:11 132:13 233:2

255:15
native 100:11
natural 196:18 266:17 267:2
nature 226:5
near 163:9
necessarily 27:6 40:19,20 43:15 45:18 46:20 52:5 52:13 53:8 69:16 72:3 75:18 77:13 90:15 97:7,8 99:11 119:17 124:9 134:10 135:2 160:14,22 187:2 212:6,13 271:20
necessary 140:22
need 5:9 9:11,12 12:4 17:19,22 20:5,13 21:9 26:19 30:1 31:13 35:4,15,20 44:11 49:13 55:1,13 63:4 70:5,5,7 71:18 72:17 73:1 73:20 74:2 77:6,9 83:15 87:8 89:2 93:17,18 98:14 99:3 111:17 112:18 113:11 115:14 118:13 122:2 125:8 126:22 133:1 136:15 148:21 150:10 151:19 152:5 158:5 161:14 164:4 177:10 178:4 182:2,3 184:4 185:19,20 186:15 187:18 196:1 199:13 229:14,19 230:11 234:6 242:1 264:13 271:19 273:18
needed 187:5 242:11
needing 93:21
needs 28:13 35:7 53:1 71:21 72:14 72:19 79:3,18 87:16,18 89:18 96:18 105:14,17 115:10 150:11 152:14 168:9 170:19 172:22 182:4
negative 199:10 228:5,7 244:15
negligible 275:13
neighborhood 104:6 134:21 175:17,20 176:6 184:11 191:13 233:13
Neighborhood-le... 177:6
neighborhoods 179:8
Nerenz 1:10,13 149:18 150:3 156:2 167:3 175:11,16 176:20 185:9 194:10,14 196:4,16 216:10 220:13 221:17 222:9 231:18,21 232:15,20 242:18 244:17
net 127:7 128:5 200:3 265:4
network 76:9
neutral 251:17
never 78:3 153:13 218:1 272:11 274:2
new 58:11 156:20 170:16 183:10 192:5 239:10 256:22 257:5,17 258:10 259:3 263:19 274:4 281:2
NHDR 99:2
NHQR 99:2
nice 4:4 6:20 45:1 128:18 156:12 241:20
night 15:18 21:17 21:18 87:2
NIH 96:3
NINEZ 2:8
nobody's 36:14
nominations 282:17
non-binding 81:6
non-risk 30:4 154:17
non-working 184:15
noon 87:3
Norbert 2:2 174:11 179:20 267:12 276:9
Norbert's 86:22
normally 222:1
notch 203:20
note 158:2 227:4
notes 67:16 142:21 183:17
notice 247:15
nots 68:14
NQF 2:13 7:8 14:1 15:2 17:7 21:1,6 23:13 26:6,9,18 33:22 34:7,18 35:2 36:7,13,20 38:7 39:3 43:1 44:9 47:10 48:12 48:15 50:9,17 52:11 63:20 66:5 66:22 68:3 71:4 72:2 73:19 84:8 85:7 89:22 97:14 97:21 98:4 99:13 103:19 113:7 114:22 116:10 128:13 129:12,15 139:15,16,22 144:17 146:4,9 152:1 153:16 154:11 155:11 156:7 159:22 161:8 172:5,6 178:3 185:19 201:1,20 206:7 208:11,14,16,22 210:12 211:22 212:5,8 213:1 224:3 234:18,21 241:21 243:16 248:19 279:20 281:17
NQF's 50:17 116:14 138:19 151:1
NQF-endorsed 97:12
nuance 18:7
nuanced 20:9 57:10 115:3
NUCCIO 2:5 14:6 16:7 60:13 112:8 132:5 150:20 151:7 164:6 182:9 240:7 244:4 270:6 270:15
number 14:7 24:19 40:16 61:5,6 67:9 69:11,11 71:18 81:17,22 82:2,3 89:1,18 90:4 95:19 99:18 100:20 102:11 106:2 112:2 115:9 118:16 120:11,22 120:22,22 127:14 129:8 233:8 246:18,19 253:7 259:18
numerator 151:2
Nurse-Midwives 1:16
nursing 17:1

O

O'BRIEN 2:6 42:7 81:21 86:5 217:9 219:2 222:4,7,21 223:3 270:14,17 271:10 275:2
o'clock 107:6
OASIS 170:1
objection 60:15 176:21
objections 245:6
obligation 84:7
observation 156:3 185:10
observed 106:10
obvious 40:4 43:9 218:17
obviously 41:12 65:11 95:1 98:20 187:7 233:18 234:6 265:21 272:6 279:1
occupation 134:20 181:21
occur 12:2
occurs 195:6
off-hand 280:6
offer 50:13
officer 104:9
official 108:22
oftentimes 18:21
oh 40:10 83:22 92:17 96:1 116:15 137:19 143:2 152:5,9 153:3 165:9 192:14 203:13,19 245:20 268:11 280:3
okay 4:12,14 6:21 30:18 57:2,6 69:3 74:10,11,11 80:15 81:6 82:15 83:6 83:12 85:22 87:13 101:16,19 106:15 120:18,21 130:17 135:5 137:1 140:9 141:8 143:1 144:8 151:7 156:14 161:3 175:8

176:20 179:1 186:4 222:6 226:19 232:15 237:11 242:4 244:14 245:20 248:22 260:3 269:12 273:8
old 276:2
omitted 239:10
onboard 249:17
once 41:13 49:15 57:15 72:1 84:5
one's 101:8,8 271:17
ones 45:1 55:9,15 136:17 173:20 190:10 199:21 216:4
onus 11:10 108:3 265:19
open 7:4 35:10 36:1 36:2 84:19 101:21 137:11 146:21 196:6 223:10
opened 9:6 152:4
opening 36:8 52:15
operating 192:15
operationalize 56:4 191:12
Operator 101:20 102:1 106:11,13 223:9,12 226:17 237:7,9
opinion 15:1
opportunities 146:10
opportunity 5:6 65:7 81:3 170:6 262:18
opposed 15:9 28:7 37:21 60:16 113:3 114:2 133:1 179:13 191:17 208:19 211:1
optimistic 194:11
option 12:10 14:5 23:10 25:16 29:9 46:2,2 81:12,17 81:20,21 82:2,3 82:16 83:20 84:5 84:6,7 107:10,13 112:3,11 113:5 118:14,14
optional 77:13
options 8:22 9:11 39:11 45:17 84:1 120:10 135:9
order 10:1 39:14,19 117:9 209:2 248:17
organization 5:17 56:14 61:2 123:7 123:14 125:1 182:6 211:9 218:21 255:2
organization's 123:15
organizational 5:18 91:3 123:17 218:18 221:10 222:13
organizational-b... 75:12
organizations 10:9 31:18 91:1,5 123:3,3,5,7,9,19 126:8 133:19 190:2 203:18 204:12 234:11
organize 279:3
organizing 32:4
original 187:3
ought 22:6 23:8,9 23:13 25:6 26:2 47:12,13 50:3 54:8 60:18 72:8 139:17 140:7 145:17 147:7 153:14 166:22 206:8 212:13 216:12 247:20
outcome 6:13,14 16:13 17:19,21 43:14 59:10 93:14 94:7 103:6 104:15 110:3,5 112:3 133:4 138:7,13 145:6 159:21 160:19 171:21 184:22 257:10 264:14,17 271:13 271:18
outcomes 1:17,18 17:18 23:6 35:14 43:7,18 56:7 59:13,17 60:11 68:5 78:7 79:6,11 90:13 94:3 96:7 127:8 144:16 149:11 157:21 170:4 173:16 191:17,20 226:11 233:20 234:1 267:18 269:7 272:1,14 275:15 277:9
outline 200:6
outlined 197:20
outside 66:4 74:7 78:15 117:16 221:2 222:1
overall 52:13 64:13 162:16 179:16 210:9 220:4
overarching 89:18
overlap 117:22 224:3 238:3
overlapping 238:6
overlaps 166:20
overriding 75:5
OWENS 2:7 26:13 96:21 98:19 99:9 121:11 177:18 191:9
owner 106:7

P

P 260:9,9,19,20
p-for-p 48:3
P-R-O-C-E-E-D-... 4:1
p.m 143:15 278:13 278:14,14,14 283:17
PACE 2:15 4:3,12 4:16 6:21 7:2,14 7:17 9:9 17:5 18:20 20:21 31:12 35:10 41:1 49:11 50:5 65:1 67:15 68:11 70:1 71:2,7 76:22 77:11 80:10 82:13 83:7,12,21 85:10 86:9 88:6 99:6,14 101:17 106:11,15 110:7 111:13 112:10 113:6 115:8 116:1 120:3,15,18,21 121:16 122:16 123:11 136:4 140:9 141:3,6,9 141:14 142:9 151:5,8 157:11 165:6 166:3 178:19 179:1 187:1 188:22 193:16 194:13 195:10 196:15 202:2,5 204:16 211:15 218:13 221:15,19 222:6 222:16,17,19 223:2,8 226:19 231:20 237:7,11 259:4,11,21 260:3 260:13 265:12 266:3,7 269:1 277:21 278:22 280:5 282:14
packet 178:8,18 180:16
page 47:21 65:18 95:6,19,21 178:9 178:17 196:18
pages 129:3
Pam 2:7 179:2
pander 248:6
pandering 247:21
panel 1:3,8 16:19 17:3 43:1 60:4 65:20 66:1 67:22 168:15 235:9 243:16 249:5,8,10 251:10
panels 15:20 197:17 249:7 282:20
pap 72:20
paper 197:22 256:20
paraphrase 108:21 108:22 220:16
parents 184:16
parse 214:19
part 13:12 14:2,3 21:13 32:7 38:12 38:13,17 39:3 45:16,20 48:22 52:3 65:15,16 66:4 67:16 85:21 98:8 105:4 136:4 145:18,19 151:6 154:7 165:22 180:4 190:8 191:4 191:8 197:11 239:13 240:17 252:17 260:4 268:6 269:19
partial 166:15
PARTICIPANT 226:15 231:16
particular 15:3 16:13 17:21 19:22 28:9,14 35:19 65:9 72:3 79:15 90:6 100:18 103:6 105:7 107:18 122:14 158:2 160:3 171:5 220:11 245:11
particularly 23:14 90:2 103:12 138:7 138:15 160:16 192:3 239:16

Partners 130:9
parts 63:8 126:13 127:2 254:7
pass 33:14 34:11 38:10 194:18
passion 193:22
passionate 272:20
passive 69:1 71:11 71:12 72:9 73:3
passively 72:12
paste 216:12
path 7:20 42:6 64:7 266:10
pathway 28:22 78:15 157:21 159:11,12 160:15 191:15
pathways 56:6 90:9 187:8 251:8
patient 18:2 40:21 59:10,17 69:1 72:11,21 91:17 95:11,16 103:17 104:1 109:15 114:15 128:7 132:17,21 152:21 158:21 161:10 164:10 175:3,7 179:22 180:2,8,20 182:11,16 189:5 203:8 204:20 214:20 218:11 219:10,17 230:7 238:1,9 270:10 271:15 272:2 273:2,14 275:15 276:22
patient's 73:5 132:20
patient-derived 170:15,17
patient-level 158:3 158:9
patient-related 145:4 233:14
Patient-Reported 96:6
patients 24:12 29:18,21,22 38:22 43:13 65:5 72:18 89:12 94:5 119:15 126:15 133:1 135:21 189:7 190:13 228:7 234:5,9,10 238:4 242:7 244:9 258:4 258:14 259:2,4,9 259:9,13 268:16 269:5,7 271:14 272:16 276:21
pause 80:21 102:4 223:14
pay 211:2 214:5 217:14 221:7 222:11 246:17 250:6 254:19 264:3,7
pay-for 41:10 48:3 94:19 139:17 163:19
pay-for-perform... 49:19 57:11 69:15 77:2 80:13 111:11 154:9 155:15 208:10 209:8 210:21 211:1 212:14
payer 214:5
payers 25:9 213:6 213:18
paying 58:1 75:8 103:10 155:1 209:20
payment 23:14 29:8 40:18 41:7 75:1,4 80:9,11 88:21 89:2 91:12 109:12,13 131:10 146:7,14,20 147:7 220:22 225:12 253:9
payments 75:11 80:3
peer 123:19
penalize 34:9 76:20
penalized 24:11,12
penalizing 89:20
penalties 41:17 89:16
Pennsylvania 2:12
people 5:3 7:9 9:2 16:22 17:1 28:21 30:20 33:18 34:11 34:14 36:10,15 41:22 42:3 49:5 56:20 57:7 59:1 59:11,14 62:17,17 62:20,20,21,22 66:11 67:11 68:2 74:2 76:4,20 91:17 95:4 97:11 98:16 99:12 100:8 108:19 113:17 114:14 117:14 122:21 135:3 143:5 148:15 152:4 155:5,6 161:21 172:3 177:16 179:10,16 181:2 193:18 196:16 198:17,18 199:19 200:22 202:8 203:5 208:2 214:10 222:1 226:9 227:17,18 229:6,9 230:2 234:16 236:1 246:15,16 247:15 248:2 253:9 261:8 263:18 264:16 273:20 280:10,13 282:20
people's 74:19 202:19
per-member 130:8
per-month 130:8
perceive 245:8
perceived 241:2 264:15
percent 24:1,22 25:4 63:2 91:5 183:6 213:9,13 228:22 229:1 273:10
percentage 126:15 159:13 228:6
perception 245:4
perfection 171:22
perform 30:3
performance 6:14 41:9,11,20 44:15 48:4 49:16 73:19 74:22 80:2 94:20 98:5,12 109:12 110:14 112:4 117:5,11 138:13 139:18 144:20 146:17 158:21,22 161:1 162:1,4 163:20 164:8 169:2,12 171:20 188:11 203:9,10 204:6 206:13 214:7 219:19,22 254:19 261:5,18 261:21 264:4,8 266:2 268:18
performances 264:14
performs 219:9
perinatal 23:6
period 38:5,13 118:11 257:18
periodically 209:1
peripheral 5:15
Permanente 1:15
permitted 108:21
permutations 129:5
person 14:13 17:3 71:10,14 100:12 133:2 141:19 181:15 194:11
personal 44:2 156:11
personally 42:10 238:18 242:3
persons 71:1
perspective 14:13 14:22 15:8 16:16 20:19 36:6 130:18 130:20 205:10 213:19 224:9,21 240:13 270:10 275:3 282:21
perspectives 8:16 42:21 94:4
pertaining 170:4 273:3
pharmaceuticals 171:7
PhD 1:13,14,15,16 1:20 2:1,1,3,5,6,7 2:8,9,11
philosophy 45:9
phone 9:20 23:18 138:2,3 141:11 142:1,7 197:4 283:6,15
phrased 14:7
physician 74:13 76:11 77:19 125:2 125:5,12 148:12 154:22 155:2
physician's 74:7 76:1,7 193:2
physicians 74:18 75:17 76:3,20 78:13 230:18 248:20
pick 55:14 60:7 125:10 137:8 240:5
picked 99:7
picketed 56:15
picketers 56:16
picking 23:3 181:7
picks 27:4,5
picture 179:16 230:22 282:15
piece 98:3 106:6 174:14,16
pieces 103:9 164:5 183:15
pink 97:10

place 17:6 42:15 66:2 79:9 142:19 189:16 195:16 213:2 244:3 250:15 268:17
place-based 176:12
plan 109:18 142:17 208:18 228:6 231:1
planned 52:18
planning 98:21,22 156:20
plans 109:14 228:17 229:2,8 230:15,19 232:11 281:13
plate 39:4
playing 89:2 225:11 250:16 279:22
please 8:18 9:22 10:7 65:8 66:11 102:3 106:21 120:13 126:1 146:3 169:17 175:1 223:13
pleasure 252:3
plenty 180:13
plug 237:19
PMP 1:14
pockets 174:19
point 6:16 7:7,18 8:17 10:1,22 39:13 43:8 46:3 46:15,22 62:15 63:19 86:22 87:21 88:2 96:1,14 100:1 127:5 132:4 132:6,8 140:9 148:3 150:20 151:13 155:21 156:16 159:4,10 161:20 164:6 168:19 171:3,14 171:16 172:2 182:2,7 190:17 191:2 195:16 198:16 206:2,16 206:17 207:3 220:17 227:21,22 228:13 231:19 232:13,16 239:5 242:19 244:22 247:8 255:10 262:16,19 266:14 266:19,22
pointed 240:22 243:13 266:14
points 54:4 153:7 170:22 195:22 196:7 246:10,10 267:10
policy 2:8 23:14 41:14 146:7,14
policymakers 213:16
polite 207:6
politically 184:2
politicization 38:19
poll 9:13,17 39:11 63:12 81:5 102:19 107:2,9 111:18,21
PONCE 2:8 100:14 118:20 119:2 135:7 182:20
poor 33:13 56:19 57:7 62:17,20,20 62:21,22 63:1,7,7 63:8 74:2 155:5 160:21 176:10 203:14 233:22 268:15,16 269:5,6 269:6,7
poorer 233:20
popped 138:11
population 91:4 100:17,20 103:6 133:19 155:2 161:10 183:12 188:17 223:20 224:8,12,13
populations 95:16 101:11 123:10 133:18 227:12 230:17 238:19 254:8
portray 163:8
pose 11:5
posed 11:9 12:3
position 147:19 246:21 255:13
positive 228:12 252:1 254:10 278:15
positively 232:3
possibilities 208:5
possibility 12:2 19:13 60:22 68:15 160:16 201:3 208:6,12,21 212:3 212:10
possible 13:20 38:8 107:16 129:16 154:11 175:15 193:4 204:14,15 219:17 221:13 278:8
possibly 42:19
post-lunch 196:22
poster 13:7 118:4 152:8
potential 3:13 34:21 45:5 47:19 90:4 91:7 92:12 200:14 202:20 216:21
potentially 20:10 21:12 24:12 51:5 89:6,7 104:13,22 125:4 128:1,21 136:19 155:20 262:13
poverty 63:2 192:3 192:4,5,8 269:22 270:2 271:9 272:11 276:19
power 25:21
powerful 23:2 263:15
PowerPoint 142:22
practical 197:14 198:5 200:5 201:9
practically 54:11 121:6
practice 58:16 155:7
practices 30:6
practitioner 59:8 60:9,10
practitioners 56:8 56:10
Prasad 237:12,13
preamble 14:2
precise 131:13 175:18
predicting 275:14
prediction 132:10 263:17
prefer 141:1
preferences 140:16
preferred 76:8
pregnant 150:15
prescriptive 266:21
presence 126:19 127:6
present 1:11 2:19 26:9 70:7 107:13 108:3 152:10 157:13 158:5 187:19
presented 28:22 35:16 71:3,6 85:19 165:7 176:5
presenting 70:14 122:13,22 203:16 245:10
presiding 1:10
press 102:3 223:13
presumably 85:9
presumes 149:8
presuming 232:3
pretty 10:12 22:4 23:2 42:10 48:7 85:12 112:15 121:17 159:22 163:10 164:9 165:11 187:3 209:22 242:13 257:6 267:4 273:12
previous 159:7 166:12 169:17
price 130:11,11
Primarily 110:7
prime-time 177:10
principle 75:5
principles 3:8 5:8 35:15
prior 12:15 34:19 54:18 147:2 256:22
prison 239:20
proactive 152:16
probably 8:10 33:10 48:8 52:9 61:21 64:13 67:22 134:1 159:5 165:1 166:22 177:9 178:15 180:10 190:12 198:6 199:16 200:21 201:11 207:2 215:3 243:1 245:20 247:10 261:19 262:12,22 279:3
problem 13:13 52:2 127:20,22 141:13 149:6 229:13 231:10 240:3
problematic 127:12
problems 10:13 140:13 192:13 202:20 251:15
process 17:8 18:14 20:2,22 22:9 26:6 26:18 34:5 35:1 48:20 50:9 51:7 58:1 59:21,22 61:11 63:20 64:13 64:17 65:4,12,15 66:2 72:22 73:16 94:9 103:14 104:15 110:3 129:13,15,18

138:10 139:13 140:5 144:16 152:10,12,19 153:4 156:17,19 160:19 172:19 181:10 192:21 196:14 240:17 243:15 246:7 247:4 249:18 255:20,20 279:17 279:20 281:4
produce 124:10
productive 277:17
professional 229:16
proficiency 90:8 100:10
profound 255:17
program 13:10 40:6,19 41:4 97:5 97:8,9,14 99:5 104:5 132:2 207:17 209:4 257:1,6,15,20 258:10 272:12
programmatic 153:16
programs 49:18 103:21 130:16 153:17 207:2 209:9 212:18
progress 205:18 254:1
progression 54:3
project 138:12
projects 282:18
PROMIS 96:4
properly 218:3
proponents 7:12
proportion 238:4
propose 69:6,9 86:14 130:1
proposed 44:17 116:9
proposing 87:4 122:14
pros 5:16 39:8 124:1 168:22
173:13
protect 89:21
provide 17:13 26:10 44:8 85:3 153:4 157:20 232:1 243:6
provided 84:12,13 150:2 162:15
provider 57:6 60:8 76:8 109:17 129:8 154:20 164:11 182:11 189:3,6 231:1 236:13 240:13 246:4 264:10 275:10
provider-centric 95:9
provider-derived 170:14,18
provider-level 158:10,12
providers 24:11 29:6 32:19 62:10 65:5,8 89:20 93:13 94:2 95:15 98:17 100:5 109:14 149:1 160:21 164:13 184:6 200:3 204:12 215:8,20 217:16 227:7 230:15,19 231:15 240:17 244:8 245:15 247:14 248:3,10,11 256:12 261:22 264:12 268:16 269:6 272:15
provides 98:13 225:11 249:10
providing 90:1 272:13
proxy 92:6 174:7 229:14 262:20
public 3:11 28:4 41:6,10 57:10,12 58:1,1 59:16,21
59:22 66:1 69:15 74:22 77:1,18 94:19 101:17,20 106:14 109:11 111:10 129:7 139:18 143:19 153:20 163:18 165:5 166:4 203:1 208:9 209:8 211:2 223:9,11 226:3,17 235:21 237:10,16 256:6,22 278:17
Publications 100:17
publicly 41:21 75:22 126:18,21 167:19 204:9,13
published 11:13
pull 76:10
pulling 203:8
pulse 5:2 193:18
purchase 238:11
purchasers 94:5
purchasing 24:1 40:6 154:10
pure 276:14
purely 43:7 96:16 186:10 250:1
purpose 15:4 20:7 21:2 94:13 105:7 163:14,15 169:1 199:5 273:15
purposeful 10:16
purposes 19:9 20:11 32:5 104:19 110:17 113:2 147:7 148:15 149:3 154:16 273:16,17
pushing 282:1
put 15:11 27:18 32:19 35:21 56:5 57:4 69:7 72:2,13 85:7,15 99:3 108:2 122:15 135:10 140:8 145:7 174:2
202:14 203:16 204:9 212:7 216:13 218:9 220:8 228:8 231:5 234:13 237:19 246:5 247:13,19 252:20 254:13 263:1
putting 29:2,12 48:13 127:19 128:19 152:2 171:2 188:21 246:7 274:19

Q

Q&A 102:4 223:15
QIs 98:20
QUACH 2:9 100:22 175:21 177:8 183:13
qualifications 114:4
qualify 114:3
quality 1:1,9 28:10 29:21 49:17 56:21 57:4,16 62:16 74:1,6,8,13,17 76:1 78:16 80:8 87:7 93:20 94:7 97:6 98:4 109:18 113:2,10,13 117:7 117:12,15 146:8 146:13 149:2 159:20 160:17 189:19 204:5 227:1 229:4 268:15
quantitative 216:6
quartile 171:19,20
question 4:21 5:12 6:8 7:1 11:5,8 20:13,20 34:17 35:11 38:1 39:10 39:21 40:15 52:11 60:20 66:19 69:3 69:5 78:2,8 79:7 80:4,22 84:19
91:18 92:20 101:16 102:2 109:21 112:1 137:15 138:17 139:12,19,21 150:5 156:3 174:11 182:14 184:18 188:12 190:5 195:19 204:17 205:4 208:15 211:21 212:18 217:18 220:3,11,12,22 221:4 223:13 243:7 258:8 259:16 260:5,12 262:3,17 265:14 269:9 270:4 272:9 273:5
questions 17:13 24:10 33:4 63:12 66:7 73:18 79:3 81:3 97:19,19 106:13 139:11 144:1 151:10 157:1 169:16 172:4 195:20 218:8 220:9 226:18 234:4,7 237:10 264:3
quick 6:22 63:15 88:8 111:17,21 120:10 147:14 156:2 172:7 185:9 202:15 213:22 231:19 240:7 275:21
quickly 76:2 77:15 88:12 106:9 165:12 279:20 280:11,16 281:21
quintile 24:15
quintiles 123:15
quite 20:16 27:1 45:22 135:15 167:6 168:4 208:2 215:14 220:17

231:13 251:2
quo 59:5 81:8

R

R-square 265:3
race 23:2,8 67:6 90:13 99:19 128:22 174:5 183:5,6,6 257:9 258:11,12,22
Rachel 2:11 112:20 234:17 256:18,19 257:14 258:6,18
racial 183:7,8
raise 81:3,9
raised 89:19 90:5 91:17 95:12 151:14 199:20 208:15
ran 174:12 182:1 182:14 262:11
randomness 20:16
range 217:5
rankings 135:17
rate 80:11 90:21 131:10 171:6 239:1 241:15 253:9 257:13
rated 227:3
rates 72:20,20 130:19 154:22 219:11 235:17,17 242:7 257:16 259:6
rating 221:2
ratio 104:21
rationale 16:11 18:16 26:10 35:19 42:4 70:8 107:13 108:4 116:4 122:13 138:8 210:18 243:2,9 244:5 279:5
rationales 240:10
raw 102:22 148:13 149:1,4 203:1 204:10 225:4
re-enter 239:4
re-entry 238:21 239:2
re-vote 83:2
reach 18:16 79:10 79:11
reached 18:11 168:8
reaching 79:10 281:19
reaction 179:5,20
read 74:11 121:12 150:4 167:18
readily 100:7 180:14 181:12,17 280:9
readjusting 136:5
readjustment 281:5
readmission 40:7 53:15
readmissions 103:16,18 128:18 131:15 153:13
ready 146:13 177:10
real 53:18 103:2 104:3 133:18 141:10 165:17 190:5 228:15 230:22 258:9 266:2 268:14,15 280:17
realistically 261:10 261:16
realities 53:17
reality 23:18 53:6
realize 243:18 277:16
really 5:14 8:15,18 9:1,7 21:21 28:3,7 31:2,7 35:13 36:14 39:10,10 41:20 43:3 44:14 49:3 50:19 51:14 57:19 61:2 63:19 66:9 70:3 77:21 78:4,7,15 84:20 85:4 87:10,16 88:1 93:22 96:22 98:13,15 101:12 103:17 105:13,13 107:9 110:11,12 114:20 115:9 119:7 121:7,16 122:12,13,19 124:4,17 128:6,7 128:9 129:7 134:22 135:20 146:13,20 151:13 157:10 162:11 163:1,4 164:2,4 164:17 167:7 169:5,11 176:10 180:21 181:10,22 182:7 187:3 189:17,19 191:21 193:7,20 194:6 198:22 205:10 206:5,19 207:8 209:11 210:2,6 213:18 214:18 215:16 218:19 219:14,19 227:1 228:9,9 233:12,13 234:10 237:20 246:20 253:18 256:6,11 258:9 261:17 262:17 263:19,20,22 264:21 265:18 267:3,6,11,15,19 268:5,13 271:19 275:10 276:18,18 277:4,11,13,18 280:14
realm 50:18 54:16 117:17 135:8 173:9
reason 22:8 28:6 62:12 94:17 117:2 117:3 119:20 150:10,13,18 168:19 180:5 194:20 213:4 215:12 268:14 272:10
reasonable 147:22
reasonably 164:16
reasoned 209:5
reasons 64:19 77:5 116:20 120:9 240:22 250:6 260:15 264:18 265:20
reassurance 243:6
reassuring 66:16
recall 165:3
Recap 3:6
received 211:9
recipient 69:1
reclassification 265:5
recognize 28:8 56:6 56:7 127:1,10 193:1 231:6 244:8
recognizing 107:4
recommend 34:8 54:9 144:13 160:11 224:3 233:11 250:22
recommendation 13:1,3,6 14:3 32:13,20 35:2,21 137:8,9 158:7 160:5 166:21 167:1 196:2 199:9 199:11 200:6,11 209:22 210:6,9,15 218:1 234:18,21 259:20 260:7 279:19
recommendations 3:9,14,18 6:3,11 32:15 33:3 34:5,7 44:3 50:7 67:21 115:13,17 136:10 137:4 138:18 142:14 145:9 147:6 154:12 187:13 193:15 194:4,5,16 195:17 198:21,22 199:15 200:5 201:7,14,15 206:6 208:8 209:5 209:12,17 213:6,7 217:21 222:20 235:11 236:16 267:5 279:5,10 281:8 282:2,7
recommending 34:12
recommends 35:2
reconcile 46:6
reconfigure 193:3
reconvene 106:16 106:21 142:10
record 37:21 106:18 143:14
records 188:2
redistributing 272:13
reduce 274:5
reduced 259:14 274:7
reduces 103:18
reduction 169:14
reevaluating 172:9
refer 179:9
references 92:2
referring 48:10 70:22
refinements 195:14
reflect 235:13
reflected 166:7
regard 42:16 205:9
regarding 199:14
regardless 7:5 18:3 258:4
regional 127:7 192:6
regions 91:2 92:4
regulatory 82:21
reinvent 20:1
reiterate 226:21
reiterated 89:13
reject 60:3 248:21
rejoin 142:4

relate 16:12 187:8 225:21 233:7
related 6:11 24:2 60:20 61:22 130:7 133:4 185:17 186:15,20 189:5 223:4,6
relates 174:8
relating 95:9
relation 206:21 233:21 247:8
relationship 159:21 206:22 260:15 267:17
relative 102:8 103:1 192:3 217:16 275:8
relatively 19:19 275:12
relativeness 191:22
released 129:17
relevance 94:2,11 144:18 159:7 256:2
relevant 60:6 68:21 69:3,4,5,11,12,21 85:1 94:8 96:11 145:2,8 147:20,22 158:17 207:11 240:9 241:6 243:7 243:10,11 247:1,6 255:21 264:17 275:16
reliable 41:8,19 91:15
reliance 37:21
rely 242:9
remain 271:11
remember 128:12 269:11
remind 28:21 96:16
removed 130:12
repeat 217:11
repetitive 252:8
report 60:4 75:22 124:10 143:21 165:5 166:11 172:16 178:3 185:22 194:18 216:13 219:1 220:4 225:4 232:1 235:21 236:8 237:6 279:9 281:10,15 282:10
Report-out 3:16
reported 165:8 167:20 204:13
reporting 28:4 30:6 40:21 41:6,10,21 57:10 69:15 75:1 77:1,18 87:8 94:19 102:21 109:12 111:10 129:7 139:18 144:8 148:9,13 153:20 163:18 165:5 166:4 203:1 208:9 209:9 211:2 220:6,6 224:18 235:16 256:22
reports 123:16 129:3 144:3 153:18 157:6 278:21
represent 56:14 90:14 195:2 215:17 255:1
representation 66:4 240:11
representative 202:16
represented 60:21 90:16
representing 27:2
represents 219:16
reputational 89:11 95:10
request 113:16
require 43:13 149:14
required 16:9
requirement 15:7 15:11 16:2
requirements 109:13 281:2
requires 43:21 91:16 111:19 172:6 206:4
research 1:15,17 2:8 13:15 173:15 233:19 234:9
researcher 60:17
researchers 150:7
residential 183:7
residual 215:21 271:3 274:16
resinate 227:9
resolution 195:5 207:7,19
resolve 196:1
resolved 148:18 179:4
resource 79:13 199:6
resource-related 145:5
resources 43:14,21 59:16 73:6 78:6 79:5 80:6 89:21 272:13
respect 153:18 169:19 224:16 253:14
respond 37:20 55:12 73:9 87:3 190:21
responded 220:18
response 221:9 231:19
responsibility 50:21
responsible 144:9 144:10
restrictive 37:2 151:4
result 120:6,12 153:18 197:11
results 43:21 67:5 258:3 274:15
resumed 106:19 143:15
rethinking 243:22
reverse 269:16,21
review 3:5 4:10 5:4 14:12,14 15:20 17:15 19:21 27:9 34:4 35:9 47:10 53:11 61:7 70:14 70:19 87:3 88:8 88:16 100:19 106:22 157:22 168:15 197:17 245:19 260:14 282:20
reviewed 18:9 53:15 64:2
reviewing 243:17
revised 4:9
revisit 5:7 6:16
reward 217:14,15
rewards 41:16 89:16
rewrite 160:1
Ricca 237:12
rich 56:20 62:17 63:7 131:11
rid 155:5
right 4:12 5:21 17:5 18:17 24:17 27:6 29:15 31:13 37:6 49:11 50:5 51:9 53:1 57:12 62:19 66:10 67:15 68:11 68:21 71:2,8 73:7 75:18 76:22 77:7 77:11 79:6,13 80:10,16 84:21 85:10 86:4,9 96:8 98:2,19,21 99:14 110:6 112:6,10 114:6 115:5,8 121:14 143:1 151:8,22 161:20 165:1,10,11 193:16 195:11 196:15 199:12,17 200:18 201:18 204:8 205:3 206:13 209:3 215:14,14 221:7 231:19 232:21 238:21 241:15 242:11 246:16,18 247:3 249:14 250:5 251:12,21 258:12 262:2 266:8 268:19,22 270:16 281:7
right-hand 125:22
risk 1:3 5:16 17:11 17:17,19 19:13 20:5,7,11 21:20 22:1 27:18 29:8 29:12,16 30:11,15 30:17,20 31:3 32:9,17 33:21 34:15,21 35:3 37:22 38:12,13,17 38:18,21 39:3,8 44:18 54:22 56:17 56:22 57:1 59:12 67:10,18 68:8 72:14,17 79:9 87:5 92:18 95:20 103:3 104:11,17 104:18 105:2,3,6 105:15,17,20 109:9 111:11 112:4 121:13 122:7 134:15 135:11 144:19 151:6 154:4,7 157:5 159:16 170:6 172:10,22 173:8 185:7 188:10,19 189:8 189:18 190:8 191:4 192:20 206:20,21 215:5 216:22 217:17 218:15,20,22 219:4 221:4,22 222:2,22 223:4 233:10 238:5 239:13 240:5

245:12 250:12,22 251:14 252:8,12 252:20 257:7 258:2,5 260:11 262:14 263:19 276:2
risk-adjust 20:14 21:8 30:10 55:19 56:1 61:13 78:19 79:1 102:10 103:7 115:22 155:2 160:14,22 215:6
risk-adjusted 17:22 55:13 72:19 73:2 102:21 105:8 111:14 113:11 154:4,16 155:19 209:21 210:1 211:7 214:8 215:10,22
risk-adjusting 22:6 31:8 57:3
risks 29:1 251:4
Rochester 1:13
role 23:13 50:17 89:22 138:19 241:10
roll 220:1
room 1:9 29:19 43:3 46:14 56:13 58:16,17,19,19 81:7 97:11 136:22 137:22 139:1 157:9 225:4,9 237:16
rooms 58:21 141:7
root 270:1
roster 102:5 223:15
round 143:22 193:13
routine 91:9 108:2 196:14 273:9
routinely 188:5
ruled 236:22
rules 226:3
run 134:13 260:8
running 132:1
rural 192:4

S

safe 283:5
safety 127:7 128:5 200:3 233:16 238:8
satisfaction 230:8
savings 130:15
saw 37:8 118:15 160:20 167:9 175:14
SAWHNEY 2:9 56:2 69:19 84:4 99:17 110:2 150:6 184:10 239:16 273:18 275:19
say-so 64:16
saying 7:9 9:6 12:14 16:7 22:5 23:10 25:20 31:10 50:6 54:8,10,19 60:14 68:7 69:7 74:15,16,17 77:2 77:5,14 78:10 87:15 109:22 112:7 113:1 114:8 115:2 134:3,4 150:8,16 151:21 153:3 154:6 165:10 167:17 168:11 203:19 207:15 208:3 218:18 220:19 221:21 228:22 233:3 244:8 250:20 251:6 252:2 253:3 254:3 259:7 262:14 265:10,15 266:7 266:10 267:14 269:5 276:20
says 10:10 34:7 48:1 67:1 83:2 109:10 129:18 139:22 151:17 196:8 207:12 216:3 217:5 245:13 250:1 252:12 269:19
scale 128:11 217:16
scenario 55:14,14
scenarios 20:12 42:20 44:1 55:9 244:19
school 162:14 163:6
schools 162:13,18 167:14 225:6
science 237:4 268:3
scientific 51:9 53:11 62:6,12 247:19 251:10,19 258:17 262:4 263:21
scientifically 246:1 250:9,14 254:14
scope 74:12 110:6 129:14 187:10 233:12
score 24:6,8 74:9 76:1,7,11 144:21 155:16 158:21,22 166:14 203:14,19 203:21 204:8,10 209:21,21 210:1 211:4,6,7,8 214:7 228:10 246:17 261:5
scored 203:20
scores 74:3,19 76:12,17 203:9,10 204:5 205:5 230:7 261:18,21
scoring 67:4 162:14
screen 245:9
screened 150:18,19
screening 150:14 160:21
screw 213:10
scrutiny 263:11
seal 99:13
Sean 2:6 39:17 65:13 220:16 221:20 222:18 261:1 270:12
seat 106:21
second 10:22 69:5 81:11 95:8,18 103:1 121:12,21 132:6 137:1 140:8 140:18 141:2,4 147:16 148:3 150:21 155:14 165:3,4 166:16 167:4 168:19 169:17 173:22 175:3 206:17 208:12 217:6 225:14 269:18
secondly 171:16
seconds 12:1
section 5:13 67:1
security 233:15,16
see 5:8 7:8 9:2,11 9:13 35:22 40:17 49:2 51:8 65:3 73:15 77:16 80:21 83:8 87:11 95:3 99:12 110:21 130:17 133:19 136:15 139:2 151:12 159:1 165:9 173:10,19 174:10 191:20 193:21 195:21 197:5 202:9 214:13 223:5,10 230:21 238:7 242:6 245:21 246:2 260:9 262:8 262:13 263:17 264:20 266:9 269:13 276:15 281:21 282:7
seeing 9:4 160:7 203:9 215:7 225:22 271:3
seen 53:14 195:7
segregation 183:8
select 143:3
selecting 21:20 92:18
selection 44:21 51:7 133:22 134:6
self 143:2 192:11
self-bathe 132:20
self-reported 92:13
semantic 186:10
semantics 185:16
send 196:16 282:14
sending 278:20
sense 7:6 8:22 9:14 30:16 31:19 37:14 41:8 55:11 61:13 62:7 63:17 66:9 66:11 69:2 71:13 102:15 104:3,20 109:20 116:21 134:14,16 159:6 161:13 162:20,22 185:15 196:6 198:4 203:13 215:22 221:14 223:22 242:9 245:3 251:8 254:18 255:19 267:16 282:8
sensitive 234:7
sent 201:2
sentence 247:3
separate 8:4 34:4 34:22 44:4 48:14 49:3 50:19 105:12 162:3 252:16 274:8
separated 169:5
separately 31:1 220:7
sequence 277:6
sequester 53:17
series 62:5
serve 92:6 95:11 230:16 244:9
served 91:4
service 2:4 74:1
services 2:9 79:19 80:12 91:12

230:21 254:9
serving 57:7 76:3 76:21 89:11 95:15 230:17 283:2
SES 7:11 12:5 13:2 14:15 21:22 23:7 26:20,22 27:4,5 37:5 40:17 46:19 47:13 55:2 56:7 60:6 64:20 68:21 71:17 72:19 81:14 84:22 89:13 91:14 91:22 92:4,6 99:18 101:1 109:20 114:8 128:3,19 145:14 147:19 149:10 152:12,20 153:5,8 154:6 156:9 157:21 158:20 160:4,8,13 174:8 176:6 191:12 207:11,21 212:17 219:22 220:1,1 221:4 229:15 237:3 243:10 244:2 245:2,14 247:1,6,11 256:10 262:20 279:15
session 142:4
set 29:7,8 61:1 96:9 96:10 97:18 127:11 181:14 186:21 194:15,22 196:12,22 197:18 201:8 244:2,3 276:12
sets 195:1 196:7 224:5 255:14
setting 31:2 57:17 61:19 80:11 100:6 161:10 251:18
settings 35:14 94:1 199:6 225:18,19
seven 228:22
severe 133:7,7
severity 92:7
131:18 132:11 133:6
share 8:16 87:12 235:18
shared 130:15
SharePoint 278:17
Shaw 102:6,6 223:16,16
she'd 116:10
shift 255:5 276:8
shifting 100:16,20
shining 276:5
shoes 273:21
shortage 229:17
shoulds 68:14
show 12:11 13:15 21:9 81:10,18 82:9 83:5 115:14 119:4 120:14 121:2 145:1 147:21 148:1 150:16,17 158:20 244:1 247:6 265:3
showed 18:4 214:17 256:21 275:4
showing 118:1 135:11 153:20 168:21
shown 95:8 189:14
shows 100:19 233:19 234:10
shuffle 164:13
side 22:5 63:11 66:7 136:21 139:1 139:4,7 228:12
sides 180:7 226:4 251:4
signaling 46:9
Signer 226:20,20 232:12,19,22
significant 22:15 146:19 153:8 254:17,19,22 255:5,17
significantly 245:2 263:16 282:3
signing 226:10
similar 78:6 123:9 162:18 179:5 211:6 217:16 223:19 235:18 242:19
Similarly 131:14
simplifying 102:18
simplistic 78:18
simply 196:8 240:20 266:1
simulation 264:6
simultaneously 271:2
single 132:12 263:9
sit 252:3
sits 243:17
sitting 14:13 16:19
situation 54:15 200:2 238:3
situations 48:19 74:20 79:4 100:10
six 281:1,15
sixty-three 24:18
size 127:21
skip 259:17
sky 58:11
slate 105:2
slide 21:19 45:1 70:22 78:18 79:14 92:5 96:2 122:15 123:12 154:1 155:11 164:8 165:3 169:17 170:20 172:18 240:8 242:20 259:18
slides 78:3 88:13 196:8,22 197:5,6 202:15
slightly 12:13
slippery 249:22
slope 249:22
small 3:16 93:16 153:12 155:13 266:15 275:10
smaller 137:21,21
201:19
smear 72:20
smell 38:10
smokers 226:10
smoking 184:22 186:3 188:16 226:1,3
snafu 8:11
snap 231:14
so-called 171:18
social 87:6,22 109:9 173:4 177:21 179:11 180:14 277:1
socially 89:11 184:17
society 239:4
sociodemographic 1:3 4:22 6:4 10:11 11:18 15:5 16:12 22:7 26:2 31:16 42:17 43:5 45:4 45:11 61:22 85:17 89:6,9 90:4,12,20 91:6 92:19,21 94:15 106:1 111:15 112:5 115:22 119:5 123:10 133:10 135:12 136:1,9 139:6 143:11 144:14,19 145:11 147:20 148:19 151:20 153:9,19 163:16 173:4 178:1,12 185:16 186:12 188:14 217:1 218:2 224:20 232:2 233:9 235:3 237:20 240:11 265:9 267:17 269:14,17 270:19 279:15 282:22
sociodemographics 109:20 163:19 164:18,21 240:21
244:7
socioeconomic 1:3 10:8,10,19,20 11:11 19:14 23:4 27:11 28:5 38:1,2 39:2 59:12 60:2 67:7 73:14 75:9 77:4 78:11 79:16 79:22 88:1 131:16 171:5 173:2 177:22 184:21 187:4,6 204:7 215:19 224:19 225:11 228:2 229:15 236:15 240:21 254:13 255:5 272:21 274:14,17
socioeconomically 76:19
sole 250:16
solid 210:6
somebody 38:22 96:3 117:14 172:13 213:14 225:5 281:10
somewhat 33:7 132:18 184:2
soon 257:14 278:8
sooner 142:19
sophisticated 129:3 134:2 257:7
sorry 38:14 40:10 108:6 118:21 119:1,1 121:1 123:4,12 141:9 165:9 175:5 186:2 268:11
sort 19:9 20:15 21:14 30:10 33:9 34:3,15,22 35:1 39:20 52:13 53:2 54:2 74:14 75:12 78:18 80:2 97:10 97:15 98:10 110:16 127:19 147:10 159:2,15

159:20 161:13 164:12 167:10,15 169:13 172:7 176:4 177:11,20 191:9 196:4 199:20 201:17 213:14 214:3,11 215:13 217:5 223:17 224:9 240:2 244:5 250:9 250:20 260:9 261:20 270:8 276:14 277:1
sound 167:11 179:22
sounding 108:12 180:2
sounds 157:2 188:20 262:15 279:14 281:6
source 103:22 161:9
sources 104:4
spaces 226:3
speak 8:16 102:7 174:12 232:2
speakers 54:18
speaking 87:20 121:6 164:17 178:11
special 45:3
specific 7:20 17:10 17:12 35:12 41:3 42:4 88:4 104:15 115:13 116:2 120:2 136:10 137:3 140:1 144:12 145:10 168:21 174:9 179:8,13 182:5 197:13 206:9,15 206:22 209:22 211:17,18 220:21 224:16 256:15 260:21 281:9
specifically 5:11 6:3 32:14 37:20 54:6 77:18 99:3 104:12 138:12 238:19 260:19 270:21
specification 145:12 150:22
specifications 32:8 67:3 145:18 151:6
specificity 125:21 199:14 200:7
specified 206:14
specify 176:13 181:1
specifying 125:6
speed 175:11 282:3
spend 99:22 138:16 211:12
spending 40:5
spent 178:5 207:5 276:6
spirit 185:18 252:6
split 132:21 133:5 180:10 244:20
splitting 132:13
spoke 178:6 182:18
spoken 8:15
SSI 227:17,20
St 126:20
stable 186:7
staff 2:13 34:18 139:3 142:20 185:19 201:1 276:16
stage 196:5
stakeholder 249:15 250:7
stance 87:9 156:11
stand 32:13 96:4 115:16
stand-alone 33:2
standard 17:12 56:18 76:13 92:22 133:12,20 134:7 265:11
standards 31:3 57:17 73:14 75:9 79:10 227:2 229:4 229:19 263:21
standing 157:8
standpoint 27:2,17 250:7 280:8
stands 29:15
star 223:14
start 4:20 5:15 8:7 51:15 101:5 105:2 136:9 137:3 142:17 179:21 182:7 186:11 189:10 194:4,9 195:12 202:18,21 244:18 272:11,17 273:2
started 44:13 142:19 143:17 173:1 194:21 202:6 273:7
starting 19:8 182:2 187:13 192:18 193:18 198:15
starts 34:18 82:5 117:22 180:2
state 13:4,9,22 45:17 87:7,22 91:12 105:12 132:18 231:7,7 239:10 253:8 256:22 257:5,17 258:10
stated 11:21 71:1 216:11
statement 42:14,16 46:17 55:18 109:19 110:9,19 152:17 166:5
statements 28:12 42:8,12 44:4,7,10 112:14
states 86:22 92:2 99:7 171:18 213:12 239:19 253:3 257:19
static 171:10
stating 11:19,21 247:4
statistical 5:16 6:9 47:3 67:18 94:12 122:19 130:4 131:5 132:9,14 133:20 134:15 168:12 206:21 243:3 256:2 259:22 270:16
statistically 146:18 153:8
statisticians 96:15
statistics 102:22 133:11
status 1:3 10:8,11 10:19 11:11 19:14 23:4 27:11 28:5 59:4 67:7 77:4 78:11 79:16 81:8 88:2 91:10 92:13 145:16 169:20 170:1,7,9,13,14 173:2 174:10,15 177:22 183:10 187:4,6 214:15 215:19 225:11 227:15 228:3 229:15 232:9 273:4,7,9,12 274:15,18 276:10
stay 39:9,14 138:22 139:4 143:10 157:16
stay-at 184:15
steering 17:14 18:9 36:7 51:1 64:2,3
step 23:12 39:3 149:15 200:15,22 207:20
steps 3:21 66:2,17 69:10 278:6
stepwise 54:2
Steve 2:5 84:19 192:3 244:21 254:6 266:14 267:12 277:6
Steve's 46:3 147:2 247:8 256:10
stickier 201:8
sticking 278:1
stimulating 4:5
stop 207:20 269:5
story 258:16 276:2
strata 30:2,4 31:1 33:12,14,20 34:16 34:20 127:16 128:6,20 132:10
strategic 156:20
strategies 189:7
stratification 5:17 5:18,19 6:9 30:16 30:21 33:12 34:22 35:3 37:12,22 38:12,17,18,21 39:8 57:2 60:22 67:5,10 122:8 123:2,5,8,13,17 126:8 127:1,9,14 128:1 129:13 134:17 136:3 168:11 183:3 197:21 206:20 218:19 221:10 222:14 231:2
stratified 33:11 34:15 36:20 55:4 129:19 132:14 261:21
stratify 30:22 67:19 68:9
stratifying 31:18 123:18 128:22 218:21
straw 4:21 9:13,17 39:11 63:12 81:5 102:18 107:2,9 111:18,21
stream 142:2
Street 1:9
strength 110:19
strengthening 36:22
stress 233:22
strictly 32:2 113:10 130:20 156:8

strikes 175:19 177:1 194:15 195:7 228:3
strong 35:18 38:8 87:9 109:19 113:1 118:15 122:6 140:15 163:11 224:17 265:19 267:5
stronger 25:16 82:18,19 87:17,18 109:22 110:9,22 113:17 121:8 147:17 253:21
strongly 22:4 38:16 73:1 114:16 224:3
struck 23:16 224:6
structure 143:21
structured 188:5
struggle 188:12 191:3
struggling 115:5
stuck 215:13
student 237:13
studied 91:16 94:8 189:13
studies 13:15
study 238:19
sub-bullet 149:8 167:4
subject 205:17
subjected 57:22
subjecting 263:9
submission 17:7 44:9 85:19 145:1
submit 35:8 36:16 115:14 145:9
submits 137:18
submitted 21:1,6 144:17
submitting 33:18
subsequent 171:12
subsequently 259:2
subsidy 183:12 231:9
substance 185:4 240:2
substantial 91:21
successful 103:21
succinct 126:1,4
such-and-such 43:16
SUGG 2:10 27:21 73:8 77:7,12 116:22 202:22 254:11
suggest 52:20 83:2 119:13 134:9 145:14 229:14
suggested 85:3 117:19 258:1
suggesting 25:16 29:22 82:15 94:22 109:2 182:15 250:20
suggestion 106:5 198:8
suggestions 49:22 114:21
suggests 67:11 232:4
sum 211:8
summary 6:20 33:9 101:6
sun 60:19
supply 230:18
support 44:19 58:22 90:22 102:14 111:18,20 113:17 127:6 184:13 191:17 197:1,2 213:4,5
supporting 265:18
suppose 12:9
supposed 47:8 111:3,5
sure 8:6 25:15 34:9 42:5 62:10 64:22 66:3 67:13 82:4 88:15 102:13 107:21 125:17 151:3,15 158:15 163:21 171:1 179:17 193:3 199:5 202:3 207:7 209:19 210:3,5 215:22 219:5 232:17,22 236:1 236:18 240:14 252:19 279:10
surgeon 206:13
surgeons 2:1 258:1
surgeries 257:2
surgery 146:17 206:12 257:1,13 257:16 259:5,10 259:11,14
surplus 230:20
surprises 167:20
surprisingly 249:21
Susannah 1:17 65:14 66:18 101:15 118:5 157:12 165:11,16 252:2 254:3 261:1 275:4
Susannah's 46:21 247:10
suspect 167:21 281:10
suspects 276:13 277:4
Suzanne 2:15 88:13 137:22 139:8 278:9
Suzanne's 278:5
switch 140:10
system 1:13 65:19 87:8 96:7 179:12 180:22 181:13,16 190:20 225:13 229:10 236:20
systematic 100:18
systems 78:12

T

table 32:1 63:21 102:20 157:4 168:20 211:3 219:3 221:12 269:2
tables 129:1
tackle 6:2 137:15
tackling 233:5
take 5:2 58:22 61:18 66:7 72:11 80:21 87:9 88:9 95:3 102:20 103:10 107:1 122:9 126:9 133:21 152:3 171:19 193:17 201:4 217:3 219:22 247:1 252:10,22
taken 102:11 104:6 195:1
takes 180:21 280:22
talk 6:10 29:11 36:16 37:12 40:9 41:18 49:5 85:13 148:11 156:14 161:22 170:12 176:3 180:9 185:21 218:14 254:12 262:19
talked 12:1 19:10 31:6 55:9 78:3 90:3 95:21 106:2 146:11 154:10 159:14,17,19 166:12 168:7 169:9 174:18 175:7 183:14 184:10 185:1,3 187:8,21 191:11 191:21 248:12 249:5 276:9 282:19
talking 8:7 10:18 20:10 30:15 31:5 31:15 32:5 33:1 34:20 35:4 49:15 64:14 67:10 69:13 80:11,12 110:5,14 110:16 125:7,7 127:22 128:11,17 128:21 129:2,6 133:13,16 138:6 148:21 164:18 169:11 178:6 179:21 182:6 211:16 220:15 222:18 225:16 228:2 232:13 248:9,10 262:7 280:1
tandem 130:22
tangled 235:15
targeted 99:2
Taroon 2:13 139:3 157:8
task 21:13 47:7,9 125:19 187:16 193:8 194:16 277:16
tax 59:1 90:22 127:5,6 147:3
taxes 58:2
taxing 104:4
taxpayer 57:20
teaching 24:20,21 75:15
technical 65:19,22 141:10 249:7 273:20
technological 142:2
teleconference 2:19
telephone 102:3 223:14
tell 9:22 68:20 69:8 114:13 156:5,12
telling 69:7 181:2 266:20
Temp 139:9 143:4
tend 184:13 194:10
tends 18:20
tens 255:1
TEPs 249:6
term 32:6,18 150:21
terminology 31:22 151:2
terms 11:6 21:5,14

35:15 38:8 39:22 41:7,14 46:3,6 70:17 72:7 89:5 90:1 93:4 97:1 100:16,19 115:11 122:7,13 123:9 133:11,19 138:19 139:3 144:13 145:22 146:16 147:16 148:9 154:19 169:21 174:17 176:2,9 177:20 178:3 180:16 188:14 190:14 191:10,14 191:20 195:17 198:4 201:6 205:22 210:12 211:18 221:12 226:7 228:4 231:8 234:4 254:8 256:10 259:4 271:7 274:16

terrible 217:10

terrific 157:9

territory 157:17

test 13:10 38:10,11 38:11 117:9 267:22

text 195:4,5

thank 4:3 8:8 45:12 66:13 96:12,20 106:15 140:10 141:16 143:1 226:15,16,19 231:15,16 233:4 235:5,8 237:6,14 239:6 277:22 283:6,11,13

thanks 11:3 71:9 87:13 104:7 179:2 226:14 283:15

THEBERGE 2:15 141:18 278:10 282:12

theme 94:21 95:12 209:16

themes 5:5 88:9,17 88:18 92:16 95:2 95:4 96:12

theory 127:8

they'd 245:17,22

thing 9:9 19:1 22:12 23:4 30:19 30:21 31:8 32:6 32:11 36:5 37:13 40:21 48:9 57:12 61:3 66:14 80:16 147:11 148:8 150:7 157:18 162:9 167:5 171:3 190:12 192:1 196:20 201:19 203:17 207:4 210:11,16 214:1 216:17 236:9 243:14 250:5 260:12 262:1 266:22 268:12 270:8 278:3 279:3

things 5:7 7:8,12 19:15 26:19,22 33:17 35:15 36:16 41:6,13 47:11 48:17 50:4 52:16 54:17 55:21 57:13 62:1 63:4 65:10 70:12 72:6,21 73:9 74:7,18 75:20 78:11 84:14 96:17,22 98:15,20 99:2 100:2 103:15 106:2 107:20 114:14 116:2,7 117:9,10 125:3,8 129:11 134:10,11 136:14 137:17 138:5 144:12 146:22 154:18 174:1 176:2,14,16 181:12 184:7 185:4,6 186:5,21 187:16 189:1,2,18 198:1,4,5 199:10 199:16,18 207:1 208:13 209:18 210:2 215:5 218:3 218:8 225:8,16 226:3,5 227:2,14 227:15,16 228:3 228:13 233:15 238:7 249:5 257:11 267:8 268:1,2 279:21 280:7 282:19

think 5:21 6:20 7:9 7:10 8:3,22 9:10 9:16 11:4,6 12:19 12:22 13:3,12 14:5 17:5 19:8,15 19:16 20:8,13 21:18 22:4,13,14 22:20 23:1,3,9 25:6,10 26:5 28:6 28:18 30:8 31:14 31:17,22 32:2,12 33:6,7,8,10 35:7 35:10,22 36:2,8,9 36:11 37:1,13,15 40:14 41:7 43:22 44:3,6 45:13 46:5 46:13 47:20 48:4 48:14,20 49:2,4 50:5 51:19 52:15 53:1,4,22 54:8,21 57:8,13 59:18,19 60:18 61:6,11 62:3,18 63:4,16 64:10,14 68:18 70:10 71:17 72:17 72:20 74:2,14 77:15,20 78:7,10 78:21 79:2,3,21 80:4,5,7 82:5 84:4 84:11 86:2,13 87:8 88:3,5 92:13 92:14 93:4 95:5 98:8 101:6,10 102:15 104:12,13 105:10,10 106:4 107:22 108:8 110:4,9,10,11,17 111:12,17 113:22 114:10 115:1,4,6 115:8,21 116:13 116:18,22 117:8 118:6 119:21 120:3 121:3,8,10 121:17,21,22 122:1,2,13,21 124:13,15,17,19 127:20 128:14 129:11 133:9 134:13,22 135:2,7 135:14 140:21 145:21 146:9,21 147:11,15 148:6,8 148:20 150:8 151:21 152:1,14 152:16 153:1 154:2,3,5,17 155:10,14,16,18 156:11,15 157:10 158:13 159:4 160:18 161:6,20 163:9 164:9,15 165:10 166:5,9,19 167:7 168:1,3,8 170:19 171:8 175:2,4,6,9,12,13 176:3 177:8 180:15 182:16,21 182:21 184:8 185:11 186:12,14 186:15 187:1,9,14 187:18,19,19 188:1,7,9 189:15 190:5,21 191:8 192:9,14,17 193:7 193:8,13 194:18 195:10,11,15 197:12 198:1,5,11 199:16 200:4,10 200:17,18,21 201:11,16,21 202:12 203:4,12 203:15 204:10 205:2,15,21,21,22 206:5 207:20 208:1,4 209:10 210:10,14 211:11 211:13 212:12,22 213:11,18 215:1,3 215:6,7,11,17,21 216:3,5 217:1,2,8 217:18,20,22 218:4,5,9,17 219:2,3,6,17 220:3,8,16,20 221:9 222:4 223:3 224:2,17 225:17 226:14,22 227:5 231:3,5,11 232:16 234:16 235:4,18 236:10 237:2,22 237:22 238:17 239:3,7,9,9 241:4 241:22 242:8,16 242:17 243:5,14 244:3,22 245:7,16 246:1,2,11,16 247:9,10,11,14 248:8,18 249:4,22 250:3,11,14 251:1 251:5,11 252:8 253:18,22 254:4 254:11,16 255:3,9 256:1,9,14 258:22 259:19 260:1,13 260:18 261:7,10 261:16,19,22 262:3 264:2,9,11 264:11,13,14,18 265:12 266:1,2,4 267:3,6,11,13,13 268:4,14 269:8 270:9 271:7,10,11 275:3,11,13,22 276:7,11 277:5,6 277:17 278:6,13 280:15 281:7,12 281:14,18,20,22 282:4 283:3

thinking 4:18 6:17 11:22 12:8 14:11

20:2,4 21:16,21 31:17 35:18 47:17 51:4,15 55:3,8,11 97:22 98:9 136:10 137:3,20 172:21 176:21 194:4,9 197:7 198:20 202:6 210:12 212:16 218:20 221:22 279:1 283:2
thinks 256:12
third 12:2 25:13 47:18 49:9 69:20 74:12 81:19 84:6 107:10 118:14 138:4 139:14,19 139:22 140:4,19 141:2 145:19 148:4 172:8,16 207:4 208:21
thornier 201:8
thorough 158:15 251:18
thought 14:18 37:5 45:9 70:11 78:4 79:3 143:20 157:18 165:4,13 165:20 167:1 169:4 173:1,8 182:1 213:20 220:19 221:11,20 222:17,19 242:19 243:21 245:8 258:2 275:22
thoughtful 235:11
thoughts 138:18 155:8 156:10 202:19 205:7 210:7
thousands 255:1
threads 81:1
three 6:1 8:22 9:2 19:17 25:22 34:13 47:7 54:18 55:15 55:21 71:16 72:1 72:6 107:7 136:7 177:20 191:6 194:22 195:1,1 206:1 208:7
threshold 92:22
threw 26:22 210:22
throw 30:10 101:4 176:18 273:21
throwing 122:19
THU 2:9
THURSDAY 1:6
Tia 2:9 62:15 160:18
Tia's 73:22
tie 52:19
tied 80:19 111:8 192:16
tier 173:19,22,22 175:3 217:6,6
TIGHE 2:16
time 4:19 10:1 20:2 22:10 26:5 53:4 53:10 54:3 57:15 84:21 101:17 102:1,12 106:12 106:14 122:11 124:19 125:14 131:6 138:16 142:10 143:18 157:6 163:9 173:12 174:12 178:6 179:17 181:22 182:1,15 190:9 194:6 200:2 206:4,4 207:5 211:12 213:9,14 214:10 223:12 226:18 235:5 238:14 254:7 257:7,18 263:18 276:6 277:13 280:18 282:10
times 7:19 41:1 73:11 75:11 76:18 102:11 110:13 134:14,16 138:11 189:5 235:20 250:3 278:13
tiny 24:18 179:19
tired 193:19
to-measure 90:11
tobacco 185:5 225:16,20
today 4:6,17,19 6:5 47:7 85:22 87:3 181:14 198:12
tool 55:13
tools 235:1
top 3:18 142:14 160:8 171:18,20 173:19,21 203:20
topic 47:14,16 51:2 166:19 194:1 209:10 216:19 256:2 277:14
topics 71:17 141:15
total 66:21 81:16 130:7,18
totally 100:12 137:11 187:15 195:11 200:6 202:16 216:19 266:4 275:2
touch 93:22 136:14 278:8,18 279:11
tougher 145:20
track 106:8
tract 22:18 90:21 91:15,21 177:15
traditional 181:20 221:21
train 205:19
trans-NQF 53:2
transcript 216:13
translate 45:18
transparency 102:8 103:11 204:22 224:21
transparent 205:1
Transplant 1:20
transportation 233:16
travel 230:6
travels 283:5
treated 30:5 271:16
treating 265:9
tree-type 20:10
tremendously 230:8,10
tried 58:18 157:17 171:3 214:18
tries 117:15
trouble 56:15 95:22
troubled 248:1
true 47:5 63:3 201:11 230:22 253:11
truly 148:18
trusting 133:11
truth 121:6
try 39:13 40:8 52:20 54:1 73:8 122:2 124:18 126:1 131:20 161:21 162:8 167:14 176:8 190:3 201:1 209:1 215:2,17 220:16 233:12 279:4
trying 25:8 27:20 37:10 46:6 59:9 60:11 68:7 105:11 115:17 116:19 132:19 154:13 163:8 165:16 166:1 177:13 179:20 181:11 189:2 190:21 191:3 200:15 221:16,20 222:2 223:21 226:7 230:16 238:5 244:14 255:14 269:8 270:5 272:20 273:14 275:18
turn 4:6 119:14
turned 235:21
turns 25:3 241:13
Twenty 280:3
two 9:1 24:17 25:22 31:1 34:12 47:17 49:3 54:18 55:15 55:20 63:10 66:7 69:10,11 71:20 76:22 84:11 95:7 100:1 102:8 119:10 120:10 128:4,6 130:2,10 130:13,22 133:2 139:10 150:22 169:7,15 174:4 180:7 182:20 192:15 203:10 205:4 224:16 246:19 247:3 248:17,22 249:3 252:10 271:16 280:1
two-day 277:13
two-stage 53:12
type 6:13 17:21 30:17 46:8,9 94:18 97:19 112:18 138:6 176:17 204:13 272:2
types 35:13 40:12 94:2 135:21 206:22 234:4 262:19
typically 90:14 146:5 151:1 164:12 204:19 218:19 263:21

U

UCLA 2:8
ultimate 50:10
ultimately 60:10 104:18 250:8
unadjusted 30:2 34:15 131:1 148:13,18,18 149:4 163:12,14 164:16,17 166:15 203:22 235:16 248:15
unanimously

112:16
uncertain 25:20 250:4
uncertainty 91:22
unclear 128:9
uncomfortable 250:19
uncover 269:19
under-fund 79:20
under-resourced 34:10
underlying 270:1
underserved 76:3 76:21
understand 10:6 11:7 27:11 62:10 67:9,14 68:8 121:18 135:15 151:1 203:6 205:12 227:4,7 246:3 270:5
understanding 20:19 47:21 69:17 101:1 112:3 146:2 236:6 258:16
understood 82:4 90:9 139:14
undoubtedly 188:7
uneasy 26:4
unevenly 274:17
unfair 245:16
unfairly 76:20
unfairness 244:14
unfortunately 142:1 190:15
unhappy 49:4
unintended 11:15 18:5 45:6 95:14 199:10 200:14
Union 2:4
unique 51:16
University 1:12,22 2:5,6,10,11 126:11 237:14
unknown 15:10
unmeasured 90:17 92:7 277:2
unprecedented 256:7
unscientific 247:18
update 105:14 106:7
update-able 105:5
updates 172:8 280:20
urge 25:8
use 4:18 6:13 25:9 32:18 41:4 44:17 44:20 47:19 48:6 49:22 50:10,14 51:11 55:12 69:14 82:20 84:9 91:9 91:14 92:9 94:6 96:9,10 97:18 98:12 105:21,22 110:11,14 112:22 114:18 117:9,15 130:13 132:2,7 138:7,18 143:9 146:20 147:7 149:6 153:11 154:13,16,21 161:9 162:12 163:12 167:13 168:4 171:11,12 177:14 178:7,14 181:3 185:4,5 203:7 223:7 225:16 230:1 241:1 246:12 253:7 255:4,7 258:11,17 260:19 261:13,17 270:15
useful 21:4 103:8 104:2 130:16 146:1 148:10 168:3 207:3 283:4
user 249:9,9 250:15
users 69:14
uses 28:10 35:14 49:19 94:16 98:16 129:16
usual 21:19 277:4
usually 30:21 100:8 130:14 159:10
utilization 130:20

V

vacancy 90:21
vague 10:12 161:18 215:16 216:16
valid 13:16,17 41:8 41:19 54:4 55:2 97:16 232:16 250:9
validated 235:1,2
validity 51:10 93:13 118:12 253:21 258:17 262:5
validly 13:19 210:2
valuable 261:20
value 154:9 224:17
value-based 24:1 40:6
values 61:1
variability 22:21 91:22
variable 16:12 27:5 29:13,16 38:1 43:5,6,10 47:2 60:6,7 61:21 69:8 128:19 159:16 160:4 170:10 171:5 176:12,17 177:6,7 185:1 219:16 245:2 247:12 251:13 253:19 256:11 263:10,14 274:1,3 274:4
variables 37:6,6 38:3,9 39:2 55:2 60:2 99:18 122:20 126:16 127:18,18 131:16 133:10 144:19 145:11 148:5 153:19 158:6,10,13,16 159:19 160:7,9 169:19 170:12 171:6 176:22 177:4,15 178:1 181:3 182:10 185:13 190:22 191:3 219:12 232:5 233:14 237:20 244:2 247:18 252:9 253:20 254:5 262:19 263:13 265:8,10,13 267:18 269:13,14 269:17,18,20 270:3,19 271:2 272:21 274:11,13 275:7 280:13
variance 127:16 169:1
variation 91:11
variations 129:10
variety 11:13 16:20 90:3
various 19:20 49:18 172:21 177:15 236:16
vary 231:7
varying 132:11
vast 240:1
VBP 24:2 155:15
veered 161:3
version 279:15
versions 130:10
versus 5:17 6:5 29:22 33:22 35:14 41:6,10 62:17,22 82:22 105:19 106:10 108:2 112:9 122:7 123:16 136:19 154:4,14 168:11 173:17 176:10 182:17 183:3 184:11 187:20 192:5 197:17,22 206:20 211:4,6,7 214:20 220:6 238:11 259:5
viable 28:5
view 75:3 87:17 93:2 224:12 266:19,22 267:10
viewpoint 42:22 224:10,11,14
viewpoints 223:21 224:5 225:7
views 81:4 122:6
violence 150:15 233:17
vis-a-vis 184:12
visiting 51:19
visits 103:17
visual 70:21
voice 9:3
voices 224:5
vote 9:17 38:9 64:4 77:9 83:3 86:3 113:16 118:1 120:2,10 121:4 135:10
voted 147:18
voting 69:18 115:6
vulnerable 95:15 135:20

W

waiting 249:18
walk 239:20
walked 7:5
want 5:11 7:15 8:14 9:10 10:15 14:20 16:4 20:12 25:1 28:15,21 29:4,10 30:7,13 32:11 34:9,10 37:20 38:11 39:9 40:17 43:9,15 48:5 50:15 54:21 57:9 58:2 59:9 60:1 61:4,7 64:8,15 65:14 68:12 70:16 73:11,13,15 78:1 78:19,22 79:8,12 79:19 80:2,20 82:20 86:10 87:21

97:14 99:12
100:14 101:4,12
101:19,21 103:7
109:22 113:4
114:11 118:1,5
119:16,18 120:2
131:3 134:9,17,20
135:9,9 136:11,14
136:16 137:14
138:14,16 143:7,9
143:11,18 144:13
145:15 148:22
149:2,13 151:12
151:15 152:3
154:2,3,16 155:1
155:3 157:5 160:3
163:15 166:1,3,4
170:11 171:15,22
172:2,19 174:22
186:17,18,22
189:21 190:1
193:6,13,14
194:21 199:22
200:2 205:10
210:3,16 214:8
216:7 223:10
225:18 226:9,21
227:20,22 228:20
229:13 232:16
235:8 241:10,15
241:17 242:3,4
248:6 251:6 263:1
264:12,19,20
265:22 269:1
271:22 277:10,22
279:9 280:16
281:5
wanted 9:16 73:9
86:21 88:16 96:1
102:7 111:21
134:8 143:2
145:13 148:15
150:4 153:7 164:9
175:3 176:18
192:10,11 202:22
232:12 234:13
235:13 238:16
261:6 263:5
266:13 278:2
wanting 42:11
89:21 263:18
wants 72:2 102:16
155:12 237:8
warm 273:12
Washington 1:9
2:10 237:14
wasn't 43:3 68:16
202:10 204:3
241:6 258:15
275:19,20
wave 102:7 152:4
188:7 223:17
way 11:7,9 12:7
13:17 19:19 22:2
24:13 28:18 31:3
31:6,17 32:3,12
32:22 35:6,20
36:1,10 41:14
52:16 54:15 62:7
68:3 71:16 72:13
74:15 75:16 76:5
104:22 106:8
113:12 117:11
121:10,11 128:2
129:19 131:2
132:13 143:20
150:4 167:10
174:6 176:4
178:10 180:16
181:1,14 190:16
191:11 197:7
198:8,14 200:15
204:2,2,14 207:6
209:4 212:19,20
212:20,20 214:6
217:2 219:6 221:7
221:21 228:4
231:9 232:21
234:8 237:4
240:15 249:16
252:2 254:10
266:12 271:4
273:8 279:21
281:9 282:2
ways 12:3,6 33:15
34:13,13 36:21
38:20 53:22 64:10
75:5 101:12
114:15 128:13
129:14 130:21
131:22 153:21
155:22 166:16
190:20,21 209:7
212:15 218:4
236:21 256:7
260:22 261:9
272:7
we'll 5:2,21 6:1,16
47:18 85:20 88:9
102:4 111:22
112:11 138:21
140:10 142:4,7,12
142:17,22 175:9
193:17 223:8,14
232:7 269:5
278:16,17,20
279:4,11 281:20
282:5 283:9
we're 4:16,20 5:20
9:1,13 13:4 19:8
20:9 30:14,15
32:5 34:11 35:4
35:10,17 36:1,10
39:6,18 43:7,17
47:20 51:5,19
52:12 59:4,9
60:11 63:10,13
64:16 66:3,6,8
67:9 69:6,7,13
74:16 76:11 80:22
83:22 85:21 87:4
94:22 101:7
106:20 107:1,2,5
109:4 110:4
112:14 113:1
114:8 115:11,17
116:1 118:7
121:17 122:11
124:2,15 125:6,6
125:7,7 127:11
128:17 133:10,13
136:5,5,7,8
137:20 143:3,4,16
144:5 151:21
154:5 187:11
189:9 190:18
191:3 192:18
203:16 212:16
215:7,13,21 217:2
217:4 218:20
226:7 228:2,11,22
232:8 248:9,10
250:2,4 252:2,4,5
252:12 253:6,8
263:8 264:4
266:20 267:18,22
269:8,12 274:15
we've 53:14 55:9
56:14 62:6 68:18
88:20 97:10 99:17
112:15 122:6
127:22 131:15
138:5 156:6 169:9
169:21,22 177:20
184:10 187:21
192:14 193:12
194:7 196:12,13
198:11,21 202:1
205:18 214:13,16
214:17,18 229:21
254:1 267:3
270:19 273:8
276:6 277:14
282:19
weak 131:8
Web 203:9
webinar 142:1
website 278:17
week 223:19 224:7
224:13 278:19
weigh 8:19 48:16
161:19 166:3
188:1 204:17
210:16
weigh-in 261:2
weight 41:15 90:17
Weill 1:20
welcome 3:5 4:9
141:19 157:14
Wellbeing 223:20
went 21:19 106:18
143:14 167:10
172:18,20 173:6
175:22 205:13
265:3
weren't 155:4
164:17 201:9
203:21
Werner 2:11 82:18
110:8 111:7 115:1
115:19 118:16
256:19 258:7,19
259:8,12
whatnot 244:20
whatsoever 211:21
wheel 20:1
whites 257:16
whitewash 200:1
wide 152:4
wider 168:10 238:4
willing 43:17 48:12
48:16 49:7 75:19
87:12 93:14
157:13 185:14
264:15
wind 121:6,9
winds 152:2
wisdom 237:16
wise 200:22
wish 214:10 245:1
women 150:15,17
wonder 10:3 67:8
230:12 259:17
wondered 177:18
wonderful 106:2
267:8
wondering 8:10
14:6 112:17 179:9
185:1 240:10
260:6
word 16:9 60:15
149:19 175:17
176:4 196:17
242:1,22 243:22
246:12

worded 167:9
wording 86:6 119:21 122:1 152:2 167:6,21 243:8
wordings 44:3
words 93:13 150:22 198:16 232:4 240:8 248:4
wordsmith 70:2,10
wordsmithing 82:6 121:17
work 25:13 51:12 85:22 94:14 125:17,20 131:12 132:22 139:6,8 143:7,9,11 158:19 169:21 171:17 180:19 196:10 206:3 213:5,8 246:12 255:14 266:11 279:7 282:5
worked 126:10 206:1 277:19
workgroups 107:5 122:12
working 3:18 15:4 18:21 19:2 63:1 105:13 189:7 198:15 228:1
works 38:22 105:22
world 13:17 53:18 129:17 146:6 183:11 219:8 239:1
worried 268:13
worries 256:3
worry 45:21 131:11 133:10 152:20,22 156:20 179:14
worse 43:18 101:8 160:21 226:11 257:4 258:3
worth 134:10
wouldn't 11:16 22:1 47:3 48:16 78:12,22 79:12 116:4 119:16,18 160:22 210:8 212:6 217:7 241:7 241:10 242:3 248:3 268:18
write 112:11 232:4
writing 112:14 166:6
written 163:17 194:18 195:6
wrong 31:10 157:16 165:14 166:20 250:14 256:18 273:21
wrote 256:20

X

X 18:1,4 44:22,22 71:9 108:17 219:16,19,20

Y

Y 18:1,4 44:22,22 71:10 108:17
Yale-New 1:17
year 24:3 51:12 131:11 171:12 172:1,1,7,8 191:7 280:1
year's 221:1
years 51:21 75:20 171:12 172:7 256:20 273:11 276:9 280:3
yesterday 4:18 5:6 5:9,14 7:19 8:15 11:22 12:19 13:14 13:21 17:11 19:10 23:2,17 28:17 33:8 45:2 48:9,22 58:18 59:2 71:3 72:10 78:3 95:13 123:13,22 127:4 156:17 167:12 171:4 174:7 197:10 199:20 210:22 234:17 239:9 244:21 272:8
York 170:16 192:5 239:10 256:22 257:5,17 258:10 259:3

Z

Z 18:1,5 44:22,22 108:17
zero 62:8
zip 22:19 275:6

0

0.001 265:4
0.05 24:7
0.14 24:7
0.2 254:21,22

1

1 3:6 23:20,20,21 24:6 37:14 102:3 112:16 142:18 223:14 233:8
1:19 143:15
10 17:3 24:6 120:21 128:20 162:17,19
10-minute 106:16
10:17 106:18
10:30 106:16
10:35 101:18
10:36 106:19
100 213:5
1030 1:9
104 3:11
10th 278:12
11 107:3,6 121:20 121:21
11:15 143:14
12 17:4
12:00 278:14
12:30 142:11,12
138 63:2
147 3:16
15 122:10,10
15th 1:9
16 1:6
17 196:18
18th 278:12
1969 273:7
198 3:19
1982 131:6 273:6

2

2 46:2 61:5 81:17 81:22 82:2 112:16 172:7 207:20 211:3,3 212:14,14 253:7
2's 259:19
2:00 278:13,14
20 24:22 25:4 219:11
2013 1:6
2016 24:3
25 24:1 229:1 273:10
263 24:15 25:2
278 3:21

3

3 14:7 23:10 28:11 36:9 37:14 40:16 46:2 61:6 67:9 82:3 84:11,17 86:3 112:2 115:4 115:10,10,20 120:11,16,22 144:6 161:4 178:9 178:17
3:29 283:17
3:30 143:18
30 11:22 219:11
30th 282:13
3M 2:2

4

4 3:6 95:6 113:5 115:4,7 118:16 120:20,22,22 121:7 178:9,17
4:00 278:13

5

5 162:16,21,22 167:15,19
5,000 249:1
50 213:9,13

6

6 13:21 109:16

7

7 95:19,19

8

8 3:9 95:21 162:21 167:15
8:30 1:9
8:33 4:2
800,000 248:20

9

9 139:9 143:4 162:19 163:2,4
90 193:9
9th 1:9

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Sociodemographic Factors
Expert Panel Meeting

Before: NQF

Date: 01-16-14

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