

NATIONAL QUALITY FORUM

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MULTISTAKEHOLDER INPUT ON PERFORMANCE
MEASUREMENT FOR RURAL SMALL-PRACTICE AND
LOW-VOLUME PROVIDERS
RURAL HEALTH COMMITTEE

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FRIDAY
FEBRUARY 6, 2015

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The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:37 a.m., Kelly Court and Ira Moscovice, Co-Chairs, presiding.

PRESENT:

KELLY COURT, MBA, Co-Chair
IRA MOSCOVICE, PhD, Co-Chair
ANN ABDELLA, Executive Director, Chautauqua
County Health Network
MICHAEL BAER, MD, Network Medical Director,
AmeriHealth Caritas Pennsylvania
TONYA BARTHOLOMEW, OTR, Registered Occupational
Therapist, Platte Valley Medical Clinic
JOHN GALE, MS, Research Associate, Maine Rural
Health Research Center, University of
Southern Maine
AARON GARMAN, MD, Medical Director, Coal Country
Community Health Center
GREGORY IRVINE, MD, St. Luke's McCall
Orthopedics Clinic
JASON KESSLER, MD, Medical Director, Iowa
Medicaid Enterprise
JASON LANDERS, MBA, Director of Provider
Strategic Initiatives, Highmark West
Virginia

BRUCE LANDON, MD, MBA, MSc, Professor of Health
Care Policy and Medicine, Harvard Medical
School

JONATHAN MERRELL, RN, BSN, MBA, IA, President,
Profound Knowledge Products, Inc.

GUY NUKI, MD, Regional Medical Director,
BlueWater Emergency Partners

KIMBERLY RASK, MD, PhD, Chief Data Officer,
Alliant Health Solutions

ROBERT RAUNER, MD, MPH, Medical Director, SERPA-
ACO

SHEILA ROMAN, MD, MPH, Consultant

SUSAN SAUNDERS, MSN, CNM, WHNP-BC, Rush Health
CNM, American College of Nurse-Midwives

STEPHEN SCHMALTZ, MS, MPH, PhD, Associate
Director and Senior Biostatistician,
The Joint Commission

TIM SIZE, BSE, MBA, Executive Director, Rural
Wisconsin Health Cooperative

BROCK SLABACH, MPH, FACHE, Senior Vice
President, National Rural Health
Association

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer

SEVERA CHAVEZ, Project Analyst

MITRA GHAZINOUR, Project Manager

KAREN JOHNSON, Senior Director

MARCIA WILSON, MBA, PhD Senior Vice President,
Quality Measurement

ALSO PRESENT:

GIRMA ALEMU, MD, MPH, Health Resources and
Services Administration

CURT MUELLER, PhD, Health Resources and Services
Administration

MARTIN RICE, RN, MS, Health Resources and
Services Administration *

* Present via teleconference

CONTENTS

Review of Recommendations from Day 1 6

Discussion of Potential Solutions:

Additional Challenges. 8

Break

Identify Additional Recommendations. 114

Lunch

Round-Robin: Reflections on Recommendations
and Future Work. 177

Opportunity for Public Comment 217

Wrap Up/Next Steps 217

Adjourn

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

2 8:37 a.m.

3 MS. JOHNSON: Well good morning,
4 everybody. Thank you for coming back to Day 2 of
5 our Rural Health Committee Meeting, and thank you
6 for your patience.

7 I know we started a little bit later
8 than we had initially planned on. I hope most of
9 you at least got our email. We decided that
10 after everybody had scattered yesterday
11 afternoon, but that gave us the time, the
12 Committee and the Co-Chairs and I, to get our
13 ducks in a row and get something set up so that
14 we can respond to things.

15 So Kelly is going to go through in
16 just a second. We're uploading our new slides,
17 our additional slides, but we've modified the
18 agenda somewhat to take care of the things that
19 we think we still need to discuss, so a lot of
20 this morning I think is going to be making sure
21 that we understand the things that you said
22 yesterday. If there's still questions or a

1 little bit more meat on the bones that we need to
2 add, we'll try to do that.

3 And I may interject on occasion just
4 because in writing the report I need to make sure
5 that I completely understand what you're thinking
6 and saying, so I may kind of jump in on occasion.
7 I'll try to keep that to a minimum if I can.

8 So as soon as we get our slides for
9 our Day 2 Agenda, I am going to hand it over to
10 Kelly.

11 CO-CHAIR COURT: Thanks, Karen. Good
12 morning, everyone. And I said to Ira, I'm glad
13 everybody sat in the same spot because I was kind
14 of learning the names.

15 So today what we're going to do is
16 we're going to spend really the morning looking
17 back at what we think were the consensus issues
18 from yesterday, but we want to do that very
19 thoughtfully and carefully to make sure that the
20 three of us captured it correctly and we didn't
21 miss something, so we won't rush through that.

22 MS. JOHNSON: Sorry, that's

1 yesterday's agenda. We have changed it, so sorry
2 about that, Kelly.

3 CO-CHAIR COURT: Great. I think I
4 said the right thing but the slide wasn't right.

5 MS. JOHNSON: Yeah, yeah, that will
6 throw you off, so --

7 CO-CHAIR COURT: So it was like, whoa.
8 Okay. So recap, like I talked about, and then
9 after the break, we're going to talk some more
10 about the SDS discussion and exactly what we want
11 the report to include on that, and then we'll
12 have Helen or Karen or someone is going to talk
13 to us about just an overview of what the MAP
14 process is because it sounds like we all don't
15 have the same understanding of how that works,
16 and it's in one of our recommendations, so we
17 want to make sure that we know what we're
18 recommending.

19 Then we'll take lunch at noon, and
20 then we're going to kind of wrap up today round
21 robin, making sure everyone has an opportunity to
22 again reflect on the recommendations, future

1 work, just kind of give everybody one more
2 opportunity to make sure we didn't miss something
3 important. We'll do wrap-up and next steps, and
4 we'll be done by 2:00.

5 CO-CHAIR MOSCOVICE: We're going to
6 start with a discussion of our summary, at least,
7 of what we heard, and the point of this is this
8 is a learning opportunity for us, and so if we
9 didn't get it right or we really discussed
10 something yesterday that's not there, let's, you
11 know, talk about that. Feel free to just buzz
12 any time as we go through this. We really want
13 to spend enough time so we get it right.

14 And there may be things that we all
15 don't agree upon. There are a couple that we've
16 noted that we need to discuss a bit further, both
17 today and later on.

18 Ah, and we have a new guest with us,
19 Curt Mueller, so why don't you introduce yourself
20 to the group?

21 DR. MUELLER: Okay. My name is Curt
22 Mueller. I am from the federal Office of Rural

1 Health Policy, and I've done -- I did some work
2 with Marty on trying to conceptualize what this
3 might look like, so I'm excited to see what you
4 guys did yesterday, and looking forward to today.

5 CO-CHAIR MOSCOVICE: Okay. And so we
6 heard that there were four main areas in terms of
7 the challenges, the broader challenges that we
8 face, one of which was the whole issue of low
9 case-volume, and we'll have slides on that as we
10 move forward. Second was the need for meaningful
11 measures for rural providers, and that really
12 related both to our discussion on the relevancy
13 of measures, but also the gaps, and it was
14 interesting, as we all went through our notes
15 last night, we probably did more in gaps than I
16 would have guessed, and there was a lot of
17 discussion on that, so that's great, and we'll
18 get to that later.

19 The whole issue of alignment came up
20 across sectors and even within sector. We'll be
21 discussing that. And then the notion of
22 voluntary versus mandatory participation, and a

1 lot of rich discussion on what appeared, I think,
2 was a consensus in terms of focus on mandatory
3 participation.

4 So why don't I stop there, and if
5 anybody has any comments on that slide, we'd love
6 to hear them.

7 (No audible response)

8 CO-CHAIR MOSCOVICE: Okay. And so we
9 moved into low case-volume discussion, and the
10 way we summarized it is as follows: broad set of
11 measures that would be applicable beyond
12 condition-specific, and not that we won't have
13 some condition-specific measures, but that what's
14 clear in rural because of the low case-volume, we
15 need a broader set -- we need measures that are
16 more broadly applicable than to one condition.

17 Having said that, Bob I think
18 suggested yesterday there are some good measures
19 out there that he has to report on, but there are
20 others that aren't as good, and the ones he
21 mentioned that were quite useful that they were
22 using were handwashing, vaccinations, blood

1 pressure control, diabetes control, medication
2 reconciliation. And I'm just wondering in terms
3 of these broadly applicable measures if people
4 have comments on that or thoughts about that, how
5 they would like that introduced.

6 DR. RAUNER: Just to clarify, the
7 handwashing was just an example from the Peter
8 Provonost central line --

9 CO-CHAIR MOSCOVICE: Right.

10 DR. RAUNER: -- but we actually don't
11 use handwashing, just to clarify that.

12 CO-CHAIR MOSCOVICE: That the broad
13 set of measures must be relevant to the rural
14 environment, we want to consider measures that
15 also reflect the community good, so we had a
16 small discussion about that as we were going
17 through that, particularly as we move towards
18 population health indicators, this notion of
19 community good, measures can become more useful
20 at that point.

21 Focus on outcomes, but consider other
22 types of measures: we had a discussion at various

1 points about the patient-centered medical home
2 and the measures that they're using and being
3 mandated to report on. Perhaps some structural
4 measures in -- the example that was brought up
5 was the value of the AHRQ Culture of Safety
6 Survey, and I'd like some discussion in terms of
7 sort of how you think we should address this in
8 the report in terms of outcome measures certainly
9 are useful, but there are really sets of other
10 measures that are quite relevant for rural
11 environments. Any thoughts on that? Steve.

12 DR. SCHMALTZ: Outcome measures are
13 desirable, but there's really a lot of technical
14 difficulties in how you risk adjust because most
15 outcome measures require some kind of risk
16 adjustment. We had talked about social
17 demographic factors as far as risk adjustment,
18 but you really, for a number of outcome measures,
19 you also need to adjust for severity of illness,
20 and that type of data is not usually available
21 through administrative data, you have to go in
22 the medical record for it.

1 CO-CHAIR MOSCOVICE: Is there a rural
2 context for that, or is that just really
3 something --

4 DR. SCHMALTZ: That's across the
5 board. I think it would be even more difficult
6 for a rural, given their difficulty in doing data
7 collection.

8 CO-CHAIR MOSCOVICE: All right. Other
9 thoughts? Yes, Tim.

10 MR. SIZE: This is maybe just more of
11 a question of context, but also, I think, to the
12 rural issue: in our conversation about metrics, I
13 realized in the call-in meeting it had a lot to
14 do about informing CMS on pay-for-performance,
15 but it seems some of our conversations, we might
16 be hesitant to make a proposal that this is a
17 metric to be part of a pay-for-performance, but
18 we might be very comfortable with it being
19 something as part of public reporting.

20 And like maybe what we were talking
21 about yesterday in terms of advanced directives
22 might fall into that category. So I just -- if

1 we can try to tease that out at the appropriate
2 point.

3 CO-CHAIR MOSCOVICE: Yes, I was going
4 to say to Karen, actually, if I recollect, in the
5 slides, we don't really talk -- I don't think
6 we've addressed the whole focus on pay-for-
7 performance perhaps as much as was originally
8 suggested. That's something we might, as a
9 group, want to talk about.

10 DR. BURSTIN: Just a quick add-on to
11 that because that's a really good point, Tim,
12 we're increasingly trying to think about measures
13 for intended use. So I think what you're really
14 saying is there are some measures that may be
15 appropriate for different uses, but maybe not
16 all. And sometimes there's a shift over time. A
17 measure that might be appropriate for public
18 reporting with greater comfort, and over years of
19 seeing there's not unintended consequences could
20 move to payment, but I think perhaps reflecting
21 that transition in intended use in the report
22 would be useful.

1 MR. SIZE: Yes, and I think the real
2 hook on that is that -- at least my impression is
3 we still have less hospital clinic integration in
4 rural areas, and I'll hear some of our rural
5 hospital CEOs, well how could I possibly be held
6 responsible for that because that's the doctors?

7 Now the response is, you know, you're
8 going to rise or fall as a team, and whether or
9 not you're corporately integrated or not really
10 isn't the point. But as a half-step, I think
11 public reporting versus pay-for-performance opens
12 up the conversation.

13 CO-CHAIR MOSCOVICE: Yeah, Bob.

14 DR. RAUNER: Yeah, I was just going to
15 use an example on what -- I think what you're
16 talking about with the socially economic risk
17 factors, and I also have sort of a question that
18 maybe you guys can answer.

19 Two communities we have, McCook and
20 Lexington, Nebraska. Similar size, similar
21 practice, same electronic medical record, but one
22 is a town that's fifth and sixth generation

1 German and Swedish immigrants, the other one had
2 a meat packing plant move in 25 years ago, so
3 it's about one-third German and Swedish fifth
4 generation immigrants, about one-third Hispanics
5 that moved in with the first wave, now first and
6 second generation Hispanics, and another third
7 that's more recent Somali. So very different on
8 the sociodemographic side.

9 From our Blue Cross data, we actually
10 risk score each town based on our Blues, and most
11 of the -- most of our clinics are 0.9 to 1.2 on
12 their risk score. Lexington with the meat
13 packing plant, it was 1.7 something. I'm not
14 sure if the risk adjustment captures all of that,
15 or is there even more based on all these cultural
16 things?

17 Those are some things I think that --
18 and listen, I may be raising more questions, a
19 lot more questions than answers, but it's an
20 issue, and I don't -- we're struggling to --

21 CO-CHAIR MOSCOVICE: I think it's
22 central to the SDS discussion we're going to have

1 this afternoon, so we have, I think, an hour for
2 that.

3 Other comments on this? Okay. Kelly?

4 CO-CHAIR COURT: So on the second
5 bullet point, "Must be relevant to rural
6 environment," how would we coach CMS to make sure
7 that that's done correctly?

8 CO-CHAIR MOSCOVICE: Yes, Brock.

9 MR. SLABACH: You asked on the rural
10 relevancy? Yes, I guess I'll reiterate and it
11 may be in another slide, but I think a MAP
12 process for small volumes would be an appropriate
13 way for that adjudication to be made going
14 forward.

15 CO-CHAIR MOSCOVICE: And we will be
16 discussing that a bit later, but I would agree
17 that that's the way to move forward.

18 What about -- you know we had the
19 discussion about patient-centered medical homes,
20 and I know in our state, in Minnesota, they're
21 certified by the state and there's a mandate to
22 report certain data elements, and Tonya certainly

1 was advocating for this yesterday. How -- I mean
2 are there specific measures that are well
3 accepted across the patient-centered medical home
4 movement in the U.S.? Is it -- could we identify
5 in the report, here's the ten things about
6 patient-centered medical homes that quite
7 frankly, even if you aren't a patient-centered
8 medical home but you're doing primary care, it
9 would be useful? Bruce.

10 DR. LANDON: So the issue with PCMH is
11 so there's this very involved recognition process
12 that was created by the NCQA. It sounds like
13 Tonya actually went through that and filled out
14 that application, which has a reasonably high
15 fee, and it takes many man hours to complete it.

16 So a lot of places where they're
17 trying to go toward the tenants of the patient-
18 centered homes, they've not either had the
19 resources or the time to fill that out.

20 A lot of states are taking their own
21 independent approaches to certifying medical
22 homes. For instance, the DPH in Massachusetts is

1 developing their own sort of gliding path where
2 people aren't required to do that.

3 There are other assessment tools from
4 TransforMED and others that try to do this in the
5 sort of simple way, and there are a few other
6 states that are doing it as well.

7 I'd say, you know, the one nationally
8 recognized thing is NCQA, and NCQA has issues.

9 CO-CHAIR MOSCOVICE: Okay. And I
10 think maybe for the final report, it would be
11 useful if Karen and staff talked to Bruce, to
12 maybe get examples of good state efforts in that
13 arena.

14 So I have Jason, then Bob again, and
15 then Tonya.

16 MR. LANDERS: Again, I've spent the
17 greater part of the last three years establishing
18 Highmark Quality Blue PCMHs, so I'm fairly
19 passionate about it.

20 Your specific question was what are
21 the measures that work or are generally accepted?
22 I would say that most -- the most generally

1 accepted measures are those ones that are very,
2 very steeped in good medicine, good science, you
3 know, things like -- and things that are very
4 evident that they can clearly be successful of
5 their own accord: the cancer measures,
6 breast/cervical/colon, things like that, that
7 they -- there's good science behind it and all I
8 have to do is draw those people in to get them.

9 The things that are very unaccepted
10 are the things like -- and that's why I mentioned
11 yesterday antibiotic usage, because the things
12 that hold a provider accountable for something
13 that may happen in another setting -- we were
14 talking about retinal eye exams, but even in a
15 different way, periodic screening because what
16 generally happens is mom just wants the kid to
17 get better, she goes to the primary care
18 physician, primary care says let's not give you
19 an antibiotic right now, he'll get better in two
20 days anyway, she leaves there and goes to an
21 urgent care. Well I capture all that data as an
22 insurance company, so that's a ding, and things

1 like that are the things that are really -- where
2 it's out of their control, those are the things
3 that they don't like.

4 But the things that -- I've got to
5 bring someone in and do a fall risk assessment,
6 okay, I get that. I can do that. I can build
7 that into my annual well visit, or I can -- but
8 the things that fall outside of their scope are
9 the things that they really kind of --

10 CO-CHAIR MOSCOVICE: Okay. Tonya?

11 MS. BARTHOLOMEW: I guess what I was
12 really trying to emphasize with looking into the
13 PCMH model is that we were talking about both
14 clinical and non-clinical measures yesterday, and
15 truly, that model of care captures everything
16 that we discussed. So I think it would be
17 interesting to look at the PCMH model and see
18 that they do want us to track access to care,
19 they want us to track overutilization of labs and
20 imaging, ER readmissions within 30 days, the
21 preventative care measures with your cancer
22 screenings, chronic care measures.

1 So it really does a good job of
2 capturing both clinical and non-clinical
3 measures, and I think that would kind of be a
4 nice guideline to look into.

5 CO-CHAIR MOSCOVICE: Okay. Bob?

6 DR. RAUNER: Yes, I'm really a huge
7 fan of patient-centered medical home, but not a
8 fan of the NCQA certification process.

9 And then some of you have probably
10 read studies where they show that it doesn't seem
11 to correlate, and I think the problem is that the
12 NCQA certification is so broad that it under-
13 emphasizes some of the key points, and there's a
14 great editorial by Barbara Starfield like five
15 years ago basically criticizing this exact
16 factor.

17 A lot of states -- I think that's why
18 they've developed their own processes. The one I
19 know of that's the most mature and most solid and
20 broad is Michigan's, and they specifically have
21 their own process as well, and there's a gal, her
22 name is Mary Ellen Benzik, who has been really

1 involved. I would actually highly recommend
2 contacting her because she can talk a lot about
3 the same issues.

4 They've actually started where they --
5 they started where you have to certify, then they
6 moved to outcomes, and once you've got your
7 outcomes, they actually kind of give you a gold
8 card status and they don't worry about the
9 certification anymore, and that's kind of what
10 we've sort of done. And, you know, Nebraska
11 developed its own criteria, again, just because
12 the NCQA is too cumbersome and costly to do.

13 So I'd recommend -- I'd study, like
14 Bruce was saying, each state -- a lot of states
15 have done their own. Michigan is the one, I
16 think, that I -- that I'm aware of is most
17 advanced. But to really study those core things,
18 and they boil down to things like access -- the
19 Barbara Starfield things, that's what it really
20 should be, not the whole NCQA, everything-
21 including-the-kitchen-sink approach.

22 CO-CHAIR MOSCOVICE: Okay. I have

1 John and then Tim and then Brock.

2 MR. GALE: I agree with you completely
3 on the NCQA process. You know, I kind of look
4 back, and PCMH was really evolved as a way of
5 sort of reasserting the core values of primary
6 care, but to the extent that NCQA and others are
7 beginning to overlap with meaningful use measures
8 and others, I think if we do anything from that
9 set, that we look to make sure that we're pulling
10 those that are most representative from multiple
11 measure sets so that we can maximize that, and
12 then focus on the things that are core and
13 central to good clinical medicine.

14 CO-CHAIR MOSCOVICE: Okay. Tim?

15 MR. SIZE: Yes, I'm a little confused.
16 The focus on outcomes, I thought we were talking
17 a lot yesterday that while that is nirvana, that
18 with the low-volume issue, we frequently are
19 going to be dependent on process measures. In
20 fact, I just counted up all the process versus
21 outcome measures in here, and it's like three-
22 quarters process and one-quarter outcome, so I

1 don't understand your header.

2 CO-CHAIR MOSCOVICE: And so, yes, I
3 think the issue is how we word it. I think we
4 agree with what -- my sense is that we agree with
5 what you're saying.

6 Outcome measures, well, let me throw
7 this out, are preferable, but it's going to be
8 difficult to do because the low-volume issue.

9 MR. SIZE: I think we give a nod to
10 the field, but then you didn't make the argument
11 why here's our constraints, and where possible,
12 we like outcomes, but we frequently can be more
13 dependent on process -- okay.

14 CO-CHAIR MOSCOVICE: Brock?

15 MR. SLABACH: So I like the direction
16 on the PCMH. In our presentations from our
17 association, in terms of transitioning to
18 population health, we use RPRI panels. The RPRI
19 is the Rural Policy Research Institute. And
20 their recommendation is the entry point to
21 population health could be for many rural
22 communities the PCMH model. So I think that this

1 sends us into the direction of that reaching set
2 of standards that could help make some of those
3 transitions possible going forward.

4 I am in complete agreement on NCQA.
5 I do not advise members in my presentations to
6 pursue NCQA certification, and not to be daunted
7 by going the whole hundred yards, but just
8 download the materials that are freely available
9 on the website and begin the process of studying
10 what that is, and that's the entry point, then,
11 to population health.

12 CO-CHAIR MOSCOVICE: Tonya?

13 MS. BARTHOLOMEW: I think something to
14 be encouraged by, feeding off of Brock, is that I
15 think in speaking with NCQA and a lot of people
16 in my state, they do understand the amount of
17 time and work it takes to be NCQA certified, and
18 so I think they are looking into more of phasing
19 those infrastructures in, and you don't
20 necessarily have to be certified, but the more
21 that we can include meaningful use requirements,
22 PCMH requirements, all of those reporting

1 requirements, going back to alignment into one
2 place, same measures, I think you're going to
3 have more participation.

4 CO-CHAIR MOSCOVICE: Okay. Some more
5 on low case-volume in terms of measure
6 construction. We brought up the whole issue that
7 some of the measure specifications include
8 exclusions at this point that make it difficult
9 for rural providers to reach the necessary
10 volume, and whether it's on CAHPS excluding
11 discharges to nursing homes and so forth, so
12 forth, that we need to think about that carefully
13 in the context of rural environments.

14 We would like more measures that are
15 continuous. Examples that were brought up
16 yesterday were timing measures, but they may not
17 always be optimal. They don't -- quicker isn't
18 always better. Most of us think the less time we
19 spend to get something done is better, but
20 particularly if you have issues like weather
21 conditions or other factors in rural environments
22 that you don't control, the notion is that there

1 may be a good reason why something didn't get
2 done as quickly as one might like. It's also not
3 easy to necessarily collect the timing measures
4 as readily as they did it, happen or not.

5 And then finally here we said
6 consider the social determinants of health and
7 the implications for risk adjustment, and we'll
8 have a much broader discussion of that in the
9 afternoon with Helen. But in terms of these
10 final comments on low case-volume, any thoughts
11 about the comments here? Okay, Guy.

12 DR. NUKI: So we talked a lot about,
13 and we did not come to an agreement, about
14 whether we pool data across clinics or across
15 systems.

16 CO-CHAIR MOSCOVICE: We're going to
17 come to that.

18 DR. NUKI: Okay.

19 CO-CHAIR MOSCOVICE: Okay. Yes, that
20 was one of the main areas that we need more
21 discussion on.

22 I guess another slide on low case-

1 volume. In the context of the level of analysis,
2 and this is what Guy just brought up so we'll
3 come back to it, and we couch it as people saying
4 that we need reporting feedback at the clinician
5 level, but payment could be at higher levels.

6 Discussion of perhaps allowing
7 informal grouping of providers for payment, and
8 there was a give-and-take on that. Thoughts
9 were, that came out yesterday, was that this
10 should be voluntary. Encourage neutral learning
11 opportunities between providers. And that
12 smaller facilities for hospitals or physician
13 practices should be allowed to opt in, i.e., it's
14 not just focused on CAHs or Rural Health Clinics
15 and community health centers.

16 Comments or thoughts on this slide,
17 reactions to it? Yes, Steve.

18 DR. SCHMALTZ: Actually a comment on
19 type of measures. Another type of measure we
20 haven't considered yet are ratio measures where
21 the numerator is not necessarily a part of the
22 denominator, an example being bloodstream

1 infections, where the numerator is the number of
2 bloodstream infections and the denominator is --
3 might be device days or something like that. Or
4 in mental health, we have a couple of measures
5 that look at seclusion time versus number of
6 patient hours.

7 So those type of measures tend to have
8 big denominators, and if we can find something
9 with -- where the numerator is relatively high,
10 then I think you would kind of circumvent the
11 small sample size issue.

12 CO-CHAIR MOSCOVICE: Okay. Other
13 thoughts on this one?

14 (No audible response)

15 CO-CHAIR MOSCOVICE: Okay. And so one
16 of the issues we discussed yesterday was what are
17 the criteria that underlie meaningful or relevant
18 measurement development and use in rural
19 environments? And some of this obviously
20 overlaps with other environments, but a fairly
21 rich list here, and it makes you wonder if we
22 have any measures that address all of those

1 bullets, but let's go through them, and your
2 thoughts about which are most important, et
3 cetera, because we probably want to winnow this
4 down a little bit.

5 That they be evidence based; support
6 the triple aim; address the low-volume problem;
7 the data availability issue, i.e., the data is
8 feasible to collect; they're relevant internally
9 for providers for quality improvement purposes;
10 they're relevant externally for public reporting;
11 focus on outcomes, and we have question marks
12 there, and it relates to Tim's earlier comment;
13 we talked about comparability across relevant
14 peer groups, so we can accomplish that; that
15 they're actionable, we can do something with
16 these measures; they address areas of both risk
17 and opportunities for quality improvement; and
18 that they support local access to care. And that
19 is the end of the list, yes.

20 So thoughts on these, which are quite
21 important. We'll start with Greg and go to Bob
22 and then come around.

1 DR. IRVINE: I am going to have
2 another contrarian point of view in terms of
3 focusing on outcomes, in that even though it's
4 hard to do and statistically difficult to correct
5 for, sometimes we risk becoming paralyzed by
6 process if we focus too much on process.

7 A good example is the timeout in the
8 operating room, which has become first one
9 timeout, then two timeouts, then mark the
10 patient, and pretty soon the nurses are spending
11 all their time and I'm spending all my time doing
12 the timeout. I've threatened to just come in and
13 do a timeout and leave, forget the operation,
14 it's safer that way.

15 We sometimes -- when mistakes keep
16 happening, we think that the response is to add
17 more process. And that, adding more process,
18 sometimes causes people's eyes to glaze over and
19 to stop thinking. And if we focus more on
20 outcomes, we avoid that issue of too much
21 process.

22 CO-CHAIR MOSCOVICE: Bob?

1 DR. RAUNER: I guess kind of along
2 that line, too, I do think things get sometimes
3 too cumbersome, and that's the problem with the
4 NCQA process. It got too crazy cumbersome.

5 On the other side, I do think -- you
6 know, to cover all of this, I liked the concept
7 of the balanced scorecard where you have a mix of
8 one or two from here, one or two from here, not
9 100, but maybe 10 to 20ish, where you can have a
10 little bit of patient experience, which I think
11 is very valid; some revenue and utilization, like
12 complications and total cost, which I actually
13 like in the Medicare Shared Savings Program
14 because we get, really, a pretty good balance to
15 compare ourselves, which is helpful. Even though
16 individual measures I have criticisms with,
17 overall, it achieves a really good aim, and it
18 has process, like screening, but even outcome,
19 like was the blood pressure actually under
20 control? And I think maintaining that mix is
21 really helpful because it gives you the broad
22 view of you compared to your peers, and it's

1 really been helpful for us, so I guess walking
2 that balance and fine line between enough but not
3 too much is hard.

4 CO-CHAIR MOSCOVICE: Tim and then
5 Steven.

6 MR. SIZE: To that point, I mean, I
7 actually agree with both of you, but at least
8 when I spoke up before, it was in the context
9 where there is not an outcome measure available,
10 then we would consider a process measure.

11 I mean, I wish we lived in a world
12 with no process measures. That would be ideal
13 for me. But the reality is because of our low-
14 volumes, there's frequently domains where we
15 simply can't show the outcome, so we default to
16 process, and that's a slightly different context
17 than I think you were alluding to.

18 The second thing is, and I think the
19 wording is important, there is no reference to
20 metrics appropriate for P4P or whatever, and that
21 was one of our reasons we were called, and that's
22 certainly what I'm having to deal with locally,

1 so that seems to be oddly missing on the list.

2 CO-CHAIR MOSCOVICE: Yes, we -- my
3 sense was we didn't really address that bullet a
4 whole lot yesterday in terms of the focus on P4P,
5 and so you're suggesting maybe we want to add
6 that to this list in the context of what the
7 charge was to the Committee.

8 MR. SIZE: There may be parts of our
9 work that we're not able to complete even in a
10 rough draft version here. I just don't think we
11 can be silent on it since it's (a) one of the
12 main reasons we were called together, and (b),
13 it's something many of us are having to deal
14 with.

15 MS. JOHNSON: So I have a question.
16 I guess, in my mind, I'm completely opposite of
17 Ira's perspective or perception. I guess I was
18 thinking that this measure selection principles
19 was only in the context of P4P, so then my
20 question would be would the list be different if
21 it's payment versus public reporting or something
22 even just reporting? So now I'm a little bit

1 mixed up, and I'd like to --

2 CO-CHAIR COURT: I think it's the same
3 list. Now but it --

4 MR. SIZE: It needs to be explicit
5 because it's -- implicitly, you're saying our
6 work is related to that, I mean --

7 CO-CHAIR COURT: Well I think the
8 criteria are the same, however, how they get used
9 over time may start as reporting, and then
10 eventually it becomes pay-for-performance.

11 MR. SIZE: There's a logical
12 inconsistency -- then you've got to take off the
13 "relevant internally for providers," "relevant
14 externally for public reporting," because those
15 are other uses.

16 CO-CHAIR MOSCOVICE: So we need to
17 think through exactly how we want to present this
18 because yes, I put those forward, and that's just
19 in a much broader context. So it's a fair point.

20 I had Steve and then Guy.

21 DR. SCHMALTZ: I think another
22 principle you need to add is that you need to

1 exclude measures that have unintended
2 consequences. An example would be antibiotic
3 timing for pneumonia where hospitals were rushing
4 to give antibiotics where it wasn't appropriate.

5 And I think maybe in the rural
6 setting, because there are so many other
7 considerations, you might have more of a danger
8 of having unintended consequences.

9 CO-CHAIR MOSCOVICE: Guy?

10 (No audible response)

11 CO-CHAIR MOSCOVICE: Okay. We have
12 John, Tim -- John and Kelly and then Tim. Tim
13 put it down. John and Kelly and then Brock.

14 MR. GALE: In thinking about the mix
15 of measures, we're obviously going, at some point
16 probably likely to have some process measures
17 because that's what we have, and in thinking
18 about how you use some of these measures in a
19 low-volume practice in disadvantaged rural
20 communities, at least to my way of thinking, some
21 of the process measures ought to be almost in
22 some ways a threshold characteristic. You know,

1 there are certain things that we expect practices
2 and providers to do. They ought to be doing the
3 med reconciliation. There are other measures
4 that just, if they're not doing it, or they're
5 performing poorly, that's a problem.

6 But in thinking about moving towards
7 some outcome measures, one way of looking at pay-
8 for-performance in the outcomes is to measure
9 changes in performance over time. Now it doesn't
10 help so much if you're trying to compare urban
11 practices and rural practices because you've got
12 the case mix and the complexity issues, but
13 looking at rewarding them, I think you almost set
14 a threshold and a bar on the process measures and
15 then start looking at a select number of outcome
16 measures that you can begin tracking improvements
17 in performance to combine them.

18 CO-CHAIR MOSCOVICE: Kelly.

19 CO-CHAIR COURT: I think Jason, excuse
20 me, made a really good point earlier that if this
21 is a phased approach, I think the initial
22 measures need to be ones that are totally within

1 the scope of what the rural provider can control,
2 and then Karen and I had a little side
3 conversation that, you know, about care
4 coordination, and, you know, you need to -- it's
5 really, I think there's a lot of debate about no
6 we need measures that you're influencing beyond
7 your, you know, your four walls, but I think --
8 and I agree with that, but I think those come
9 later, and initial measures need to be ones that
10 you can control.

11 CO-CHAIR MOSCOVICE: Okay, I have
12 Brock and then Susan.

13 MR. SLABACH: I'm not sure if this is
14 the place for this, but I'll say it and then
15 we'll place it where it needs to be, and that is
16 a timely loop of data reporting and feedback to
17 the provider for relevant performance
18 improvement, so whatever we develop and however
19 the data warehouses are set up, I think it's
20 important to see that we shorten that turnaround
21 time.

22 And there was something else I was

1 going to say, but I forgot, so I'll stop there.

2 CO-CHAIR MOSCOVICE: Susan.

3 DR. ROMAN: Okay, I'm going to put a
4 little bit different hat on for a moment. As we
5 look at measures, I think as we collect them and
6 put them forth, we've got to stop and think who
7 is going to be doing the work of the collection
8 or the implementation? And, you know, just to
9 kind of put the nurse, former nurse manager hat
10 on, and like Greg says, if we put forth five new
11 measures and the burden of work falls back to
12 nursing or falls back to one individual group
13 when it comes down to the implementation, have we
14 accomplished anything, you know, for relative
15 good for the overall, for patient safety?

16 CO-CHAIR MOSCOVICE: I have Guy and
17 then Aaron and then Jason.

18 DR. NUKI: I guess I'm trying to get
19 my head around this as a presentation to CMS, and
20 the way I would see it is what's here on this
21 slide is a list of criteria of an ideal measure.
22 It's a little bit like a pharmaceutical company

1 trying to create an ideal drug. The ideal drug
2 will never cause an allergy, you can take the
3 same dose no matter how old you are, renal
4 failure doesn't matter -- you know, there's no
5 such thing as the ideal drug, but you, as you
6 design the medicine, you come as close as you can
7 to that.

8 And so we have these lists of things
9 that we find important when you're creating a
10 measure. An outcome obviously is great, but not
11 all measures are going to be able to be done in
12 outcomes.

13 And then I think that the whole pay-
14 for-performance thing is -- I think what this
15 group said yesterday was there's pretty good
16 agreement that at the individual level, that
17 should not be pay-for-performance, not now, and
18 not in the future. We may want to start off with
19 some of the system-oriented pay-for-performance
20 as a pay-for-reporting and move that into pay-
21 for-performance or something like that.

22 Maybe I misheard the group, but that's

1 -- now I would be very worried about saying okay,
2 we're going to march these things forward, and
3 then all of a sudden, at the individual level,
4 we're doing pay-for-performance over
5 vaccinations, and that might not be where we
6 would -- it sounded to me yesterday, and I
7 personally believe, that paying physicians for
8 performance measures is not necessarily the way
9 to go. Reporting, yes.

10 CO-CHAIR MOSCOVICE: Reactions to
11 Guy's comments? And I won't forget the two of
12 you over there, but reactions to what Guy just
13 said? Yes.

14 DR. ROMAN: Yes. I, too, am a little
15 bit confused as to whether we're talking here
16 about a transition from public reporting to pay-
17 for-reporting to pay-for-performance or whether
18 we're just talking about rolling right into pay-
19 for-performance.

20 I think that there's a lot of pressure
21 at the national level to move very quickly to
22 pay-for-performance, but historically, the

1 programs for both hospital and physician have
2 taken years to move into pay-for-performance, and
3 I think it's worth some discussion here as to --
4 and I think this is relevant to the point you
5 were making, Guy, what are we talking about here?
6 Are we talking about measure criteria for pay-
7 for-performance or for pay-for-reporting? And
8 are we talking about a transition, or are we just
9 jumping into pay-for-performance, and if we are,
10 what kind of parameters are we going to put on
11 that for local providers in rural settings?

12 CO-CHAIR MOSCOVICE: And so I am -- we
13 have it on a later slide, but the discussion --
14 let's keep the discussion going now, and we'll
15 get to the later slide.

16 What do people think about that?
17 Because the charge was, you know, to focus on
18 pay-for-performance relevant measures, but
19 certainly we can feed back to CMS we think this
20 needs to be a planned transition, and here's
21 where we are now, and so forth, so forth.
22 Anybody not want to talk on that?

1 (Laughter)

2 MS. JOHNSON: Can I --

3 CO-CHAIR MOSCOVICE: At least on this
4 it's --

5 MS. JOHNSON: Can I interject --

6 CO-CHAIR MOSCOVICE: Sure.

7 MS. JOHNSON: -- just real quickly?

8 P4P is not here yet for the CAHs or CHCs, but for
9 the small hospitals and practices, it is here
10 already, right? So maybe we need to have this
11 conversation about split between, but I think
12 definitely it's on the later side, as Ira said,
13 this idea of an approach, a phased approach. But
14 again, it's already here for some of the
15 providers. That's part of our scope today.

16 CO-CHAIR MOSCOVICE: So let's get the
17 comments now, since it's of interest, and we'll
18 go down that side, and then we'll come to this
19 side. So why don't we start at the back. Jason?
20 What do you have?

21 MR. LANDERS: I -- this may not be the
22 right place either, but this notion of these

1 underlying measures come up, things like med rec.
2 Would it be appropriate to have those base,
3 underlying measures that are weighted more
4 heavily, then you could augment with the other
5 measures?

6 That's just kind of a thought, because
7 certain things really make sense across the gamut
8 for all practices, and you know, if you're doing
9 one patient or ten patients, it always makes
10 sense.

11 So that's just a thought, and to just
12 briefly comment on what Sheila said, the one
13 thing that I always see is that being on the
14 commercial side, we tend to try to jam things
15 down people's throat. It does take time, and
16 there's a real art to reporting, as you well
17 learned in your PCMH process, that you kind of
18 have to learn how to report from a practice, and
19 so it does take time.

20 I don't know that it necessarily has
21 to be a step-step-step process, but you probably
22 have to acknowledge that, and at least initially,

1 the standards may be a little different, or the
2 data collection may be a little different, and
3 then it kind of ratchets up as it goes, but it
4 does take time, and it is a skill that has to be
5 learned.

6 CO-CHAIR MOSCOVICE: Okay, Aaron had
7 his card up for a long while.

8 DR. GARMAN: One of the things that I
9 don't see on this list that I think is very
10 relevant, and I think it was really stated well
11 yesterday, is alignment. Unless we have
12 alignment of measures and have one core set that
13 we can report to the federal government for
14 everything, I don't think we should look at pay-
15 for-performance.

16 CO-CHAIR MOSCOVICE: And so we have
17 some discussion later on alignment also, but
18 that's clearly an important part.

19 Michael?

20 DR. BAER: Yeah, just for the phased
21 in concept, I think we need to remember also
22 something happening in the very near future which

1 could have a huge impact on this potentially
2 would be the implementation of ICD-10, and so you
3 know we're going to be struggling, providers will
4 be struggling, hospital systems will be
5 struggling with trying to learn, you know, what
6 the new law is for CMS while at the same time
7 they're going to be struggling with ICD-10, so to
8 pay for reporting might be, you know, I think a
9 great way to start and take the -- take it sort
10 of in a quantum step-like fashion where, you
11 know, pay-for-reporting and then pay-for-
12 performance later, but I think we need to keep
13 that in mind too.

14 CO-CHAIR MOSCOVICE: Okay. Bob?

15 DR. RAUNER: I guess kind of like some
16 similar comments: we essentially are already in
17 this world, some of us -- Ann and I with our
18 ACOs, we're already in pay-for-performance. I am
19 happy with it on the ACO level, actually. I
20 agree that I don't think it should be done on the
21 physician level, actually, because of the local
22 factors, the uniqueness. We as an ACO decided

1 we're not going to do it on the clinical level --
2 on the physician level, but the clinic itself may
3 decide to do that. I think there's enough unique
4 things that frankly I probably can't account for
5 those, but the people within the clinic probably
6 could.

7 I am worried this year, actually,
8 because we are potentially going to go to pay-
9 for-performance on the clinic level. We've
10 actually written that into our previous
11 discussions. So if we get a bonus from Medicare,
12 part of that is contingent on the clinic's
13 performance, and some people may get more money
14 than others, and I'm worried that that could pull
15 us apart, actually. So I honestly don't have the
16 answer here.

17 I am fine with it on the ACO level.
18 I think we're there whether we like it or not
19 already anyway. I really think we have to be
20 careful about ever going to pay-for-performance
21 on the physician level because of the bad
22 unintended consequences. On the clinic level, I

1 will have to say I don't know yet, and I'll --
2 maybe a year from now, I'll be able to answer how
3 well that went, but so --

4 CO-CHAIR MOSCOVICE: Greg.

5 DR. IRVINE: Just a brief digression,
6 going back to Guy's comments about using process
7 versus outcomes.

8 At least in surgery, I constantly tell
9 patients that I shoot for zero, I never achieve
10 zero, when it comes to potential complications.
11 We try very hard. We keep our processes correct
12 and whatnot, but we're never -- you know,
13 statistically, we can never achieve zero.

14 Going back to pay-for-performance, I
15 see this -- these measures as being something
16 like an unfunded mandate. For small hospitals
17 like mine, at least, we're financially on a knife
18 edge. We're constantly battling over budget
19 items and how we're going to afford to keep the
20 place open, and it's a month-to-month financial
21 struggle.

22 We sit in meetings and talk about

1 whether we're going to buy an incubator or a
2 pediatric fracture set, and when that included --
3 that discussion includes whether we're going to
4 hire another nurse to do data collection, it gets
5 very real, and that's something we have to think
6 about when it comes to PFP. If CMS is going to
7 have us give them more data, they at least need
8 to fund it.

9 CO-CHAIR MOSCOVICE: Kimberly?

10 DR. RASK: Two points. First, on the
11 terms of the phasing in approach, I think that
12 the phasing in approach has been very wise for
13 what has been done for hospitals, and speaking,
14 thinking about the small rural providers that
15 we've been talking about and the issues with
16 infrastructure as well as the issues with
17 measurement, I think doing phased approaches is
18 really wise. Otherwise, we run a risk of
19 unintended consequences that hurt,
20 disproportionately, small low infrastructure
21 entities.

22 Secondly, the other thing that I think

1 that we ought to think about is that to the
2 extent that we at the federal level have payment
3 programs in place to identify particular
4 providers as being somewhat essential community
5 providers and reimbursing them in a different
6 mechanism specifically for that reason, like our
7 CAHs, our Rural Health Clinics, our Federally
8 Qualified Health Centers, then I think we need to
9 be really thoughtful about why we think we want
10 pay-for-performance, unless pay-for-reporting and
11 pay-for-performance is going to include measures
12 that capture that community benefit that we are
13 supporting them for.

14 It is not just the same as doing the
15 stuff we've done in other places and applying it
16 to them. This is a group of institutions that we
17 as an entity, as a federal government, have
18 decided needs support in a particular way in
19 order to perform a particular community function,
20 and however we choose to measure them, we need to
21 include that in our measurement and weigh however
22 we measure them appropriately.

1 CO-CHAIR MOSCOVICE: Okay. Brock and
2 then Tim.

3 MR. SLABACH: So my support for pay-
4 for-performance would be I think predicated upon
5 the entire corpus of the conversation that we've
6 had over the last couple of days, and that is
7 transitional, assuming some kind of selection,
8 criteria selection process that makes relevant
9 measures for our providers and provides technical
10 assistance to be able to make that transition
11 happen.

12 So assuming all of those predicates,
13 then I think we could move into pay-for-
14 performance in a transitional method down the
15 road.

16 Having said that, I think -- so I just
17 wanted to be clear about what I mean by
18 transitional. Secondly -- I mean pay-for-
19 performance. And I think it's another important
20 conversation in terms of picking up on what Kim
21 said, and this is relative to what type of pay-
22 for-performance, and I think that we should be

1 looking at bonus up, not penalty down.

2 So if you perform well, you get
3 additional cost-based reimbursement, for example,
4 in the CAH setting, not going below cost-based as
5 a penalty. And that preserves, I think, the
6 safety net notion that we're talking about, that
7 at least we're not going to be having unintended
8 consequences that I think are all too important.

9 CO-CHAIR MOSCOVICE: Tim?

10 MR. SIZE: Yes, I strongly agree with
11 actually Brock, Kimberly, Greg, and Bob. It's
12 like a home run thing.

13 But I want to bring another issue up.
14 Maybe it sounds like an infomercial, but I'm
15 doing for HRSA a webinar in a few weeks on
16 network adequacy, which I think is one of the
17 great sleeper issues for rural -- not frontier,
18 but what I would postulate as where most rural
19 population in that they're close enough where
20 there's competition going. And as more and more
21 closed networks get started, that's going to be a
22 bigger and bigger issue. So that's why we're

1 really focusing on network adequacy standards
2 being something that thinks through it from a
3 rural perspective.

4 Having said that, they are already, in
5 the Wisconsin marketplace, you know, and I
6 mentioned it briefly yesterday, metrics being
7 used not to penalize but to actually exclude. So
8 it's very important to me on the alignment issue
9 that we do the glide path, but inherent in the
10 glide path is you know where your eventual goal
11 is, so at least we know what metrics, you know,
12 are going to be prominent in Medicare so then
13 when we negotiate in work structures with
14 commercial insurers, we're kind of talking the
15 same thing -- so again, we get that alignment and
16 we get that focus. But this is much bigger than
17 pay-for-performance for many rural communities.

18 CO-CHAIR MOSCOVICE: I have Jason and
19 then Ann.

20 DR. KESSLER: Do you ever feel like
21 you turn your little thing up and the
22 conversation has gone, you know, completely

1 different directions since what you thought you
2 wanted to talk about?

3 But I am going to kind of go back in
4 time, I guess, for a moment to kind of discuss
5 some of the relevancy of some of these measures
6 because there were a few comments a while back
7 about measures that might be beyond the control
8 of a provider. And I'm -- I would be really
9 hesitant to throw out a measure for just that
10 reason.

11 And the reason for that is that
12 providers underestimate what's under their
13 control. And I realize this would be an
14 unpopular statement with many providers, but the
15 example Jason had given earlier in the morning of
16 the mom who, you know, brought her kid in with a
17 sore throat and was reassured and then went to
18 another provider -- urgent care clinic, to get an
19 antibiotic. I would make the point that if the
20 first provider had adequate -- had given adequate
21 education at the onset, that that second visit
22 would not have occurred.

1 But a better example that I can give
2 you is something that happened in our first
3 patient-centered medical home program that we did
4 in Iowa. One of the things we were scoring
5 providers on was getting patients in the door,
6 getting their members seen, and the providers
7 were saying well that's not -- it's beyond our
8 control who walks in our door. But lo and
9 behold, after a couple months, two of our centers
10 figured out that they can pick up the phone and
11 call people and say we'd like to see you, and
12 that will increase their rates by a whole lot.

13 So that was just a point that I wanted
14 to make as -- and there may be some measures that
15 don't fit in that category, but I would be very
16 cautious about excluding any measure for that
17 purpose.

18 CO-CHAIR MOSCOVICE: Ann?

19 MS. ABDELLA: At the risk of stating
20 the obvious, I want to hitchhike on what I think
21 Greg and Susan were after, and it's implied there
22 in the data availability, but the data has got to

1 be easy to collect. And in the day of the
2 electronic medical record that we're wanting and
3 hoping and praying that all of these rural
4 providers will adopt, it needs to be -- starting
5 off in this phasing process, I think it needs to
6 be structured data that they're learning to
7 enter, that they can use to easily report, and
8 that most importantly they can keep track of
9 themselves.

10 And I mean, this is -- this feedback
11 loop that we're all trying to deal with in
12 quality improvement is about giving our own
13 selves report cards, teaching ourselves to use
14 our electronic tools and registries to keep up
15 with our patients and do the care coordination.
16 So if we're sincere about wanting to do this,
17 keep it simple, use the technology that's been
18 forced down our throats, and make part of that
19 that learning curve, to use the data in a timely
20 manner and not wait for it to come to you two
21 years later.

22 CO-CHAIR MOSCOVICE: Okay. It's been

1 a good discussion. Why don't we go on to the
2 next slide?

3 So we're going to talk a little bit
4 about program design. Participation in programs
5 should be mandatory, and TA, as was pointed out,
6 needs to be built into this participation.

7 We need for a phased approach -- and
8 so that's the discussion we've just been having.

9 Allow a menu of measures to choose
10 from, such as perhaps by service line. Set up a
11 waiting scheme so that scores are not dependent
12 on just a few measures. Facilitate a faster
13 cycle time between performance and use in the
14 programs, and include a component for
15 improvement, not just meeting a threshold.

16 So why don't we open the floor for
17 discussion on some of these themes and anything
18 people would like to add, edit, technical
19 assistance. Brock.

20 MR. SLABACH: Somebody must have been
21 typing awfully fast after that last conversation,
22 because I think it, just to -- it mirrors exactly

1 what we just talked about, so that's good to
2 know.

3 I guess it's maybe an important moment
4 to offer a perspective, I think, that just hit me
5 yesterday evening, and that is that we have a
6 real opportunity, and we don't want to lose this
7 moment in terms of our reporting to CMS about an
8 opportunity that we can design something in a
9 tabula rosa form because CAHs and RACs are
10 completely, you know, outside of a lot of these
11 programs. And we can actually build this, I
12 think, in a way that will make sense rather than
13 kind of the hodgepodge growth of pay-for-
14 performance reporting that's occurred over the
15 last decade or so with the other federal programs
16 of reimbursement.

17 And I think giving CMS an opportunity
18 to learn from the mistakes that they've made in
19 other programs and then build that and learn from
20 that in this, I think, is really important. And
21 they only get a chance to do this once, so let's
22 do it right.

1 CO-CHAIR MOSCOVICE: Yes, I think
2 that's a really important point that we
3 discussed. That we don't feel that the
4 constraints of sort of here's what we have now
5 and how do we fit into it? I think what you've
6 said, Brock, is right on, and I think it will be
7 an important part of the context of the report.

8 I have Tim.

9 MR. SIZE: Yes, two things. It
10 relates specifically to what Brock just said, but
11 also, Ira, what you said at the end of our call
12 we had a month ago, and that was -- well I guess
13 maybe our first recommendation is to be
14 recommending to CMS that they do something.

15 So we -- I guess we had a -- it's
16 either now or for after lunch, what would be
17 evidence that CMS gives respectful consideration
18 over recommendations? I mean, how do we know if
19 we're successful in what we've done? I mean,
20 we're having a great conversation and stuff, but
21 we came here for a purpose, and it's dependent
22 upon CMS at least actually reading our report,

1 and then hopefully acting on it.

2 So what are our indicators of success
3 that our mission is completed in terms of at
4 least getting the ideas -- appropriately,
5 respectfully, considered. How will we know we've
6 done that?

7 CO-CHAIR MOSCOVICE: Yes, all I can
8 say at this point is that we have heard back from
9 CMS that they are going to be looking at this,
10 this isn't just let's do something for the sake
11 of doing something, and that my sense is that CMS
12 right now is more open to rural considerations
13 than they have been in the past, but I don't know
14 if we can just have a list of criteria that CMS
15 has to meet so that we're comfortable with
16 appropriate use, but I think we --

17 MR. SIZE: I mean I know they're
18 masters of intimate lip service --

19 CO-CHAIR MOSCOVICE: Yes, no ---
20 you've got that down?

21 CO-CHAIR COURT: By Tim's eyes.

22 CO-CHAIR MOSCOVICE: But two things.

1 I think, you know, a lot of us know that it's
2 taken a while to get both NQF and CMS and others
3 interested in the rural issue, and I think that
4 it's just much more open as we need to figure out
5 perhaps a strategy we can lay out in the report
6 that at least some of the recommendation is
7 clear, either you're moving forward or not, and
8 the timing aspect is probably as important as are
9 you going to do it, i.e., we want it done in our
10 lifetime, so --

11 MR. SIZE: Yes, all right.

12 CO-CHAIR MOSCOVICE: We need to have
13 some --

14 MR. SIZE: I leave that in your hands,
15 good.

16 CO-CHAIR MOSCOVICE: Yes. It --

17 MR. RICE: Ira?

18 CO-CHAIR MOSCOVICE: Oh, Marty.

19 MR. RICE: Hey, Ira. One of the
20 things that -- and I'm sorry I'm not there today,
21 but I am listening and it sounds like a really
22 good conversation. There are some really --

1 there are some processes that you can get
2 involved with after this is over with. Also you
3 can get measures into what they call, as bad as
4 it sounds, it is a real project, the MUC list,
5 which is Measures Under Consideration.

6 And there are some processes to get
7 measures that you recommend into the hopper to be
8 considered into the federal incentive programs.
9 So that's something we can make sure happens.

10 CO-CHAIR MOSCOVICE: That's a great
11 point --

12 MR. RICE: My dog. He says yes, too.

13 CO-CHAIR MOSCOVICE: I think that's a
14 good point, and we will duly follow up on that
15 one.

16 I've got -- that's what -- I didn't
17 realize you were on the phone, Marty, but we're
18 glad to have you, and we'll go from there.

19 I have Michael and then Greg.

20 DR. BAER: Oh, going back to Tim's --
21 or I forget who just made that comment. Maybe
22 what would be a good idea is if when CMS is going

1 to be debating or creating this program, if there
2 are public meetings that we could attend that we
3 could be made aware of those meetings.

4 Would that be something that the
5 Chairs would do for us? If there are open
6 meetings for CMS when they are going over this,
7 if you become aware of them, that you would make
8 us aware of them?

9 CO-CHAIR MOSCOVICE: Yes, I'm not
10 exactly sure of the process, but I think what
11 we're hearing is we don't want your involvement
12 to end just --

13 DR. BAER: Yes. And if there's a
14 public forum where we could be a part of that,
15 you know. If there's interest, and it sounds
16 like there's a lot of interest in that group,
17 that maybe if we knew about when it's happening,
18 that could be something we could do.

19 CO-CHAIR MOSCOVICE: Okay.

20 MS. JOHNSON: And I can go out on a
21 little bit of a limb here, Marcia, I hope this is
22 okay. We are piloting, and it's more for

1 members, I think, NQF members. But we're
2 piloting some of what we're calling network
3 groups, I forget what our name is, where we want
4 to build communities basically within our
5 membership about certain activities, and rural
6 health might be one that would be an option.

7 So that, again, that's kind of a
8 membership thing, but we could at least play with
9 that as a way. And then, of course, if you know
10 members or you are a member, then you could --

11 DR. BAER: Yes, I'm just aware that
12 there are, you know, a lot of federal meetings.
13 You know, when they're developing CPT codes and
14 stuff like that, so -- that are open to the
15 public, but to find out when they occur is the
16 difficult-type thing.

17 CO-CHAIR MOSCOVICE: Okay. And I
18 think there really is a partnership ORHP and CMS
19 in terms of this activity, and whether it's
20 webinars or other potential joint efforts, and we
21 need to get the word out, is what I'm hearing you
22 say. Greg.

1 DR. IRVINE: I'd like to make my
2 hundredth plea for flexibility, the -- in other
3 words, emphasizing the allowance of a menu of
4 measures to choose from, making that as flexible
5 as possible. If there's anything I've learned
6 yesterday about this group, it's how
7 inhomogeneous where we work is, and I think
8 that's true having worked in both an urban and a
9 rural environment.

10 I think one thing that makes rural
11 environments very unique is our diversity. We're
12 not much like each other in a lot of ways. Each
13 hospital has a unique personality, each clinic
14 has a unique personality, each population base
15 has a unique personality, and we need to be able
16 to allow for that, and the only way you're going
17 to do that is with flexibility, being able to
18 choose from what measures make sense in your
19 community, because the last thing we want to do
20 is be doing a bunch of meaningless busywork
21 again.

22 CO-CHAIR MOSCOVICE: Okay. Why don't

1 we move on to the next slide?

2 So a few more issues on program
3 design. One dealing with our discussion about
4 peer groups, and for quality improvement and
5 benchmarking, use like-to-like comparisons. It
6 could be across service lines. It could be
7 across the type of facility or the capacity or
8 capability of the facilities. For payment, not
9 so clear if peer groups are needed, and we'll get
10 into the SDS discussion in just a little bit.

11 And there is some math stats science
12 to this, and there hasn't really been all that
13 much done on the quality side with peer groups,
14 and so I think the sense I have is the report is
15 going to bring it up. But not that we have a
16 definitive answer to this, but just that we need
17 to do some work on this.

18 Comments, thoughts on the peer group
19 issue? Okay. Ah, yes, Tim.

20 MR. SIZE: I mean it's complex stuff
21 here.

22 I guess for payment unclear if peer

1 groups needed, there is a reference I think made
2 by Helen about their interpretation that CDS
3 would include maybe distance. But I think we
4 know the more remote the facility, the higher the
5 standby cost, and so I don't know how you
6 wouldn't have peer groups for that.

7 And then, and maybe I'm
8 misunderstanding the prior bullet, for QI, use
9 like-to-like comparisons. Where -- or I guess
10 I'm still back on -- I mean, I guess I'm living
11 -- because I live in a market where rural is
12 frequently compared to urban, in general, we need
13 -- we're looking for quality metrics where that
14 can be a fair comparison because that's what our
15 people are looking at, do I stay local, or do I
16 migrate?

17 CO-CHAIR MOSCOVICE: And so I think I
18 would agree with what you were just saying. And
19 I think one of the points being made is for
20 places that don't have the same kind of market
21 concerns that your hospitals have --

22 MR. SIZE: Yes.

1 CO-CHAIR MOSCOVICE: -- we don't want
2 to compare them with your hospitals, that just
3 that's not a fair comparison either. And so
4 there may well be different peer groups,
5 obviously, in terms of these like-to-like
6 comparisons. We need to just get more explicit
7 about that.

8 MR. SIZE: Yes.

9 CO-CHAIR MOSCOVICE: Because I think
10 the markets you have are perhaps a bit different
11 than some of the other places -- well certainly
12 is --

13 MR. SIZE: No, I mean that's one of my
14 takeaways is --

15 CO-CHAIR MOSCOVICE: Okay.

16 MR. SIZE: -- exactly the same thing.
17 I mean, we -- a lot of this conversation divides
18 very differently in a more frontier area --

19 CO-CHAIR MOSCOVICE: Yes.

20 MR. SIZE: -- versus where I work.

21 CO-CHAIR MOSCOVICE: I have Bruce,
22 then Tonya.

1 DR. LANDON: So I reiterate that I
2 know nothing about this, but I -- for the peer
3 groups in the first part, I actually thought we
4 explicitly said yesterday that we didn't think
5 that CAH/non-CAH is a meaningful differential,
6 but rather it's, you know, do you have a small
7 rural CAH that looks like whatever and a small
8 rural non-CAH that looks very similar? Those can
9 be compared together, I thought.

10 CO-CHAIR MOSCOVICE: And so you're
11 suggesting --- where it says "type," it's not
12 necessarily the acronym you have. It's what the
13 facility is --

14 DR. LANDON: Well that's what I felt
15 --

16 CO-CHAIR MOSCOVICE: -- capable of
17 doing.

18 DR. LANDON: -- we explicitly
19 discussed yesterday.

20 CO-CHAIR MOSCOVICE: Okay.

21 DR. LANDON: Unless I'm wrong?

22 CO-CHAIR MOSCOVICE: Okay. We're

1 getting to the -- we're getting to that
2 discussion in a little bit.

3 MR. SLABACH: For Tim's benefit, we
4 prefer not to be referred to as frontier, we
5 prefer to be geographically challenged.

6 CO-CHAIR MOSCOVICE: I have Tonya, who
7 comes from a geographically challenged area.

8 MS. BARTHOLOMEW: I was just going to
9 say exactly what Bruce said, but one other point,
10 please don't make us regionalize.

11 Going back to Greg's point yesterday,
12 there are so many differences in places nearby
13 that we don't want to be compared to, or not
14 necessarily compared to, but I have the exact
15 same problem. I have patients who say they would
16 rather die at my clinic than be sent to the
17 hospital 40 miles away, and when you're talking
18 about regionalizing that for pay-for-performance,
19 that really scares me.

20 And then I think you also have to go
21 back and consider what Bob said about being
22 careful to look at those socioeconomic

1 demographics, and usually you've got the same
2 facilities, but two very different communities,
3 so I think this is going to be hard to define.

4 CO-CHAIR MOSCOVICE: Other comments?

5 Okay.

6 So the alignment issue that's been
7 measured, we need a uniform measurement set
8 across HHS, payers, governing bodies, et cetera,
9 develop a standardized process so that data are
10 collected and reported just one time.

11 We need alignment of measures, as
12 we've been discussing, across sectors. So not
13 just within the hospital sector, but the linkage
14 to ambulatory or primary care.

15 And then improvement resources such as
16 technical assistance should be aligned also
17 across HHS.

18 And so on the alignment issue, do
19 people have any thoughts or comments about that?
20 Bruce, I assume yours is down, right? Okay. So
21 I have Bob, and then Tim.

22 DR. RAUNER: Yes, I think we kind of

1 touched on this a little bit before, but I think
2 as much as possible, if these things could
3 promote collaboration as opposed to competition.

4 So for example I've talked to some
5 folks lately about how the -- the uniqueness of
6 the advanced payment process we took actually
7 made some of the hospitals not like us because
8 they saw us as competing when we didn't even want
9 to compete, and you want as much as possible to
10 avoid some of those reasons to not like each
11 other. And if the more you can put people in the
12 same boat by aligning them around what's best for
13 the patient, like, I think, medication
14 reconciliation and the vaccination measures.

15 Those would promote cooperation
16 between the clinics and the hospitals and
17 everybody else because if we all benefit by that
18 getting better, it helps us work together and not
19 have any, you know, destructive things that some
20 measures have caused. That there's been some of
21 the unintended consequences of this ACO we
22 joined, unfortunately, is it caused some fights

1 in some of our communities that we didn't want to
2 happen, but just because of the structure, the
3 money changed, and it did push us into
4 competition we didn't want.

5 So by aligning some of these things,
6 it can help get around some of that and get
7 people focused more on the community good rather
8 than us trying to take each other's money and
9 fight for the same piece of the pie. And so I
10 think, you know, like med rec, flu shots, if we
11 can find measures that promote alignment of the
12 systems and efforts to improve the community, I
13 think that helps.

14 CO-CHAIR MOSCOVICE: Okay. I have
15 Steven, then Tim, then Brock.

16 DR. SCHMALTZ: Alignment, if it's done
17 right, is really a continuous process, so I think
18 it will encourage cooperation. It's not a one-
19 shot deal.

20 CO-CHAIR MOSCOVICE: Tim.

21 MR. SIZE: Maybe it's elsewhere and I
22 wasn't focused on it, but when I started thinking

1 about alignment -- it's the first bullet. Some
2 uniformity, but also then the question is just
3 how many measures are enough for -- I mean,
4 because you could create an infinite number of
5 measures, and there's some evidence that we've
6 been doing that as a culture. But if we're going
7 to get this right, I mean, there's a lot more in
8 life other than measurement, and we need to take
9 this seriously, but how much is enough?

10 I mean --

11 CO-CHAIR MOSCOVICE: I believe that
12 was --

13 MR. SIZE: I don't know the answer to
14 that, but it --

15 CO-CHAIR MOSCOVICE: -- the discussion
16 yesterday about having a core set that we really
17 thinking everybody should be reporting on, and
18 then these flexible modules --

19 MR. SIZE: Yes.

20 CO-CHAIR MOSCOVICE: -- and Greg will
21 say coming here will have been worthwhile if we
22 get

1 -- ever get to that point.

2 But these first couple bullets, I
3 mean, if we -- and I can't say we're going to get
4 down to one measurement set across every payer,
5 and HHS, and so forth. But if we really can
6 reduce that dramatically, and we really take into
7 account this notion of reporting ones, and having
8 a vehicle to transmit that information to these
9 various sectors, that would be worth all of the
10 time we have here, it really would be, and so
11 that's -- I mean I think that's one of the --

12 MR. SIZE: No, I like your language.
13 Just to add, and it's -- implicit to me when you
14 said core set was something other than 350.

15 CO-CHAIR MOSCOVICE: Absolutely.

16 MR. SIZE: But I think maybe we need
17 to be explicit at least in order of magnitude of
18 what, when we're talking about a core set, what
19 we think would make sense. And this gets to
20 Brock point of view of a statement about the
21 entire system and not just the rural piece.

22 CO-CHAIR COURT: So -- and I think Tim

1 makes a good point, let me jump in here, Ira.

2 I think the PPS hospitals are
3 subjected to it was at one time over 100
4 measures, mandatory measures, so what do we think
5 is a good number? Because if we say reasonable
6 number, what's reasonable to CMS might be
7 different than what's reasonable to us.

8 So I'll throw out, I mean just
9 ballpark, ten to 15 --

10 MR. SIZE: That's what I think because
11 I think --

12 CO-CHAIR COURT: -- or no more than
13 ten to 15 measures.

14 MR. SIZE: I think beyond that, payers
15 and public's eyes glaze over.

16 CO-CHAIR COURT: Well, and the
17 resources get limited, and providers don't know
18 what to improve because there's too many, and it
19 just becomes an academic exercise then.

20 CO-CHAIR MOSCOVICE: Okay, and I can
21 say, in the work we did about three years ago, we
22 came up with -- with an expert panel, came up

1 with about 20 measures. So I mean that's the
2 sphere we're talking about, we're not talking
3 three digits. It's certainly low two digits.
4 Okay.

5 I have Ann.

6 MS. ABDELLA: Just to clarify, would
7 that include the rural PPS hospitals? Are you
8 thinking that they would be able to ratchet down
9 from what they have to collect? You know, is
10 there a new definition of rural, and who is
11 included in that bucket -- rural PCPs and -- ?

12 CO-CHAIR MOSCOVICE: I think we're
13 talking about the concept applying to all
14 providers, not just what we can accomplish,
15 that's a different issue. But I think the
16 concepts should apply not just to CAHs or one
17 group, it should really be -- that's important
18 for everybody.

19 I have Brock, Kimberly, and then John.

20 MR. SLABACH: I think to correlate to
21 the conversation on the number of measures, I
22 believe that it could be tended to through a MAP

1 partnership workgroup because it's not only just
2 that you have existing measures, but you need to
3 retire measures that are no longer relevant and
4 perhaps topped out. So in other words this is an
5 ongoing process that has to have some way to make
6 that happen.

7 I want to go back, and I think it's
8 also in this category as well, when I talk about
9 bonus up. When we talk about alignment, I think
10 that it needs to be clear that we don't intend
11 and I don't believe that it's possible for this
12 to be budget neutral, and then that goes to the
13 discussion about what somebody gets in a bonus,
14 then is taken away from somebody else in order to
15 make this work from a federal budget. So that's
16 an important notion, I think, in the context of
17 this discussion.

18 CO-CHAIR MOSCOVICE: Kimberly.

19 DR. RASK: In terms of the number of
20 measures, I think you can also take as a parallel
21 what CMS has been doing with the hospitals and
22 that there were a large number of chart-

1 abstracted measures, and now they're down to 46,
2 with an increasing number of measures that are
3 being captured and calculated from claims and fed
4 back to hospitals.

5 So -- and they're also moving towards
6 more electronic submission of measures so that
7 it's not requiring the kind of chart abstraction
8 that it did in the past, and so I think a
9 recommendation in terms of -- or even some
10 clarification from our side, when we say -- are
11 we talking about chart-abstraction-type measures
12 that we want a limit of 10 to 15, but if we want
13 to capture some of those aspects of coordination
14 of care, there are opportunities for CMS to use
15 their Medicare data to be able to track people
16 across sites of care and say something about
17 access, readmissions, use of post-acute services
18 that might be helpful, informative, and relate to
19 quality as it relates to rural providers without
20 asking the rural providers to collect that data.

21 CO-CHAIR MOSCOVICE: Okay. Karen
22 wanted to jump in.

1 MS. JOHNSON: Well thank you. Just a
2 couple points.

3 One, just to let you know that there's
4 work happening now, and maybe many of you already
5 know about this. I don't know much about it, but
6 the IOM is actually working to come up with a
7 core set of measures, so I'm a little curious if
8 you guys have even heard that that work is going
9 on. It was supposed to be released, I think, at
10 the end of last year. It has not been released
11 yet, so we don't know what that is going to look
12 like, but other people are thinking about this.

13 The second thing is more of a
14 question, and it came up yesterday, and I was a
15 little confused, and it's probably a rural issue.
16 It gets to Brock's comment about the topped out
17 measures, and someone said yesterday they might
18 be topped out in urban but not in rural. So
19 maybe somebody can explain that to me just a
20 little bit. If you're looking at performance of
21 95, 96 percent from across the board, how is
22 rural not topped out? So --

1 CO-CHAIR MOSCOVICE: So I was the one
2 who mentioned it, and if you look at individual
3 measures that are in Hospital Compare, so many of
4 -- for some of the measures the urban facilities
5 are at 95, 96 percent and the rurals have
6 improved over time fairly substantially, but
7 they're still, say, in the high 80s. And there's
8 more room for improvement left there.

9 And, I mean, CMS, obviously relating
10 to the comments here, they don't want to just
11 keep enlarging the data set. And so they've sort
12 of been trading, getting -- they're retiring one
13 and bringing on a new one.

14 The other part of it is the new
15 measure often is not relevant to rural at all,
16 and they're taking out measures from pneumonia or
17 from other areas that are more relevant, so
18 that's the trade-off.

19 MS. JOHNSON: Okay, so I get it. It's
20 the idea that if CAHs aren't reporting, then CMS
21 thinks that things are topped out, and there's
22 this hole right now. That's what I was missing

1 in my --

2 CO-CHAIR MOSCOVICE: No, but the data
3 I'm giving you is for the CAHs that are
4 reporting.

5 MS. JOHNSON: Okay.

6 CO-CHAIR MOSCOVICE: And they're not
7 quite at the level that other facilities are --

8 MS. JOHNSON: Okay, okay.

9 CO-CHAIR MOSCOVICE: -- it's going up,
10 but they might need a little bit more time, and
11 some of us feel that when you don't have to
12 report, guess what, you don't pay as much
13 attention to these measures as if you do.

14 But there's a trade-off. We want to
15 keep a core set at a reasonable scale.

16 MR. RICE: Ira is very correct about
17 that. We found that out in the MBQIP program,
18 and what they're doing is the inpatient measures,
19 they're retiring, but they've left them open so
20 that we can still use it in the --- our MBQIP
21 program for a short period of time, but they will
22 retire them eventually.

1 CO-CHAIR MOSCOVICE: That's a good
2 point, Marty.

3 Bob, Michael, and then Kelly.

4 DR. RAUNER: Somewhat tangential, but
5 I would ask if in addition to sending this report
6 to CMS, if we could also send it to ONC, because
7 going back to Ann's earlier comment, still --- I
8 said this kind of yesterday so maybe I'm being
9 redundant, but the biggest failing of meaningful
10 use is they didn't get interoperability fixed
11 out, and they didn't get registries and reporting
12 fixed in our EHRs.

13 This would -- if we could get those
14 two things fixed, it would make this so much
15 easier and turn meaningful use from a big load
16 off our backs to something actually helpful. And
17 so if we could cc the ONC, I'm not sure if we
18 could do that, but I think that might help.

19 CO-CHAIR MOSCOVICE: We can certainly
20 disseminate the report to ONC, not a problem.

21 Michael and then Kelly and then John.

22 DR. BAER: This goes back to Bruce's

1 comment yesterday about aligning across HHS
2 payers and accrediting bodies, that's nirvana.

3 But looking at -- in AmeriHealth
4 Caritas, who I work for, is strictly Medicaid and
5 a little Medicare. So you know, I think aligning
6 the feds is probably a little bit easier than
7 pulling in the commercial.

8 So I don't know how, you know, the --
9 how we can wag that dog, but if there's any way
10 to somehow -- and this would not -- this would
11 not be for those insurers who don't get federal
12 dollars, but if they get federal dollars, is
13 there some way to ensure better alignment?

14 CO-CHAIR MOSCOVICE: Kelly.

15 CO-CHAIR COURT: Just something we
16 need to think about is as measures get retired,
17 it doesn't always reduce the data collection
18 burden. So for instance, if there's
19 five pneumonia measures, five heart failure
20 measures, five acute MI measures, and five skip
21 measures, so the burden doesn't necessarily come
22 from the number of measures within a group, the

1 burden comes from the number of groups of
2 measures.

3 So for every clinical condition or --
4 it's the how many different denominators do you
5 have to collect that creates the burden. And so
6 if we still have one measure in each of those
7 groups, you have a very similar data collection
8 burden as if you looked at four or five measures.

9 So I don't think enough consideration
10 is given to the different populations we have to
11 look at. So until you retire all the pneumonia
12 measures, all the heart failure measures, that
13 data collection burden stays somewhat similar --
14 so if you have to look at all your diabetics, all
15 your hypertensives.

16 CO-CHAIR MOSCOVICE: So John will have
17 the last comment on this slide.

18 MR. GALE: This one will be very
19 quick. Have we -- and I apologize if I missed
20 this, but have we missed the concept of keeping a
21 recommendation of core measures in an optional
22 subset? I don't know that we've explicitly

1 stated it in these slides, and I think we should.

2 CO-CHAIR MOSCOVICE: Yes, I think it
3 was on a previous slide.

4 MR. GALE: Oh, okay, just making sure.

5 CO-CHAIR MOSCOVICE: But we'll
6 certainly make sure it's there. Okay.

7 Okay. We're running a little bit
8 over, but we'll get there soon. So in terms of
9 gaps, we had a rich list starting with more
10 measures about handoffs and transitions,
11 including the timeliness aspects. Alcohol and
12 drug screening was mentioned. Telehealth quality
13 issues as measurement needs.

14 Access and timeliness issues in terms
15 of just the broader notion, as was discussed I
16 think, by Kimberly, recently. Are you serving
17 your community? Can the community get care in a
18 timely manner, and as we move towards population
19 health, those measures certainly are going to be
20 important. The relationship, access to care and
21 cost measures to this whole issue of gaps in
22 quality measures. We talked about population

1 health just now.

2 For hospitals, some people pointed out
3 the lack of measures for specific procedures and
4 the challenges there with OP/PT imaging. We had
5 a pretty rich discussion yesterday about advanced
6 directives and end-of-life measures as an area
7 that's important for us to consider.

8 Appropriateness measures, alignment with choosing
9 wisely, and there's a couple question marks
10 there, and to be honest I'm not 100 percent sure
11 what that one's about, but we can -- we'll talk
12 as a group.

13 And then I think several folks said,
14 you know, there's a lot of focus on the primary
15 care side, but we really, other than a few
16 specialties like oncology, cardiology, there's
17 really a need for more measures with respect to
18 specialty care.

19 I don't know, is there another slide,
20 or was that --

21 MS. JOHNSON: Yes, there's one more.

22 CO-CHAIR MOSCOVICE: On gaps, or -- ?

1 MS. JOHNSON: Yes, Helen gave us a
2 list that came out of the MAP that if -- it's the
3 next slide --

4 CO-CHAIR MOSCOVICE: Okay.

5 MS. JOHNSON: -- for your
6 consideration. There's some --- a little bit of
7 overlap here, but there's a few different things
8 there --

9 CO-CHAIR MOSCOVICE: Is this just one
10 slide or -- ?

11 DR. BURSTIN: Hi everybody, sorry for
12 popping in and out. We have three meetings this
13 morning.

14 So this is a list of the measurement
15 gaps that have been identified actually by the
16 MAP that we'll be talking about later this
17 morning as well. Very high level across with a
18 view of the National Quality Strategy, and again,
19 they were not developed with a sense that these
20 are particular to a given community or rural or
21 not, but I thought since these are the ones we
22 all have identified as being really important

1 ones broadly, it might be helpful to get a sense
2 from the rural community in particular, do some
3 of these rise to the top in particular through
4 the lens of providing care in rural communities?

5 So first of all, again, this sense of
6 it's really difficult to look at measures that
7 relate to patients with multiple chronic
8 conditions. We're still very condition focused.
9 As you mentioned on the prior slide, a great deal
10 of interest in end-of-life care and in
11 inappropriate non-palliative services.

12 Appropriateness we talked a lot about
13 yesterday as well. There are almost really few
14 if none measures of diagnostic accuracy and a lot
15 of concerns about diagnostic errors.

16 From the purchaser perspective,
17 concerns that there aren't measures that really
18 reflect lost productivity. So as we think about
19 our broad-based view of -- I see Ann shaking her
20 head there, but for example, days missed from
21 school, days missed from work due to illness, for
22 example.

1 Patient out of pocket costs has been
2 one that keeps coming up. And then there are key
3 areas like -- just two examples I pulled here:
4 Alzheimer's, where we have really very few
5 therapies. So not very good in terms of
6 effectiveness measures, but might there be
7 opportunities around quality of life or
8 experience of care including with caregivers.

9 Outcome measures for cancer, including
10 cancer in a stage-specific survival and patient-
11 reported measure. Really very few systematic
12 ways of getting at adverse drug events, and a
13 great deal of interest in pain and symptom
14 management and patient-centered care planning.

15 So you'll see this a lot here that
16 kind of come from the voice of the patient or
17 family in particular. So I thought we would just
18 put that forward and see if any of these sort of
19 raise discussion among this group as well.

20 CO-CHAIR MOSCOVICE: Since we are on
21 this slide and there are certainly some that
22 overlap and there are a decent number that don't

1 overlap with the comments we had, let's focus on
2 this one first.

3 Are there areas here that we didn't
4 mention that you think really are important in a
5 rural environment? We'll start with Kelly.

6 CO-CHAIR COURT: Not that question,
7 but I think the second bullet point there, and
8 we've studied this in Wisconsin, that end-of-life
9 care in the rural setting happens differently
10 than it does in the urban setting.

11 So there's less access to hospice care
12 and other alternatives. So it's more common for
13 -- and the cultural differences of dying at home
14 with help versus coming back to the hospital to
15 die. So mortality rates, we've studied that
16 really carefully, and it's different in rural.
17 So access to resources at the end of life is very
18 different, and that needs to be considered.

19 CO-CHAIR MOSCOVICE: And we had that
20 on our list also, so that's clearly an important
21 area. I've got Tim, Tonya, and then Bob.

22 MR. SIZE: A serious question, I'm not

1 meaning to be cute, what's the relationship of
2 this conversation with the one we just had around
3 smaller, more finite number of core measures?
4 How do we integrate the two conversations?

5 CO-CHAIR MOSCOVICE: Well, I think we
6 need to prioritize is what I'm hearing you folks
7 say.

8 I think it's important for NQF to hear
9 from us in terms of what are the areas specific
10 to rural that we think really need to be looked
11 at further, and the reality of it is you're going
12 to have a finite number, you're going to have to
13 be retiring some and replacing with others.

14 So I think it's good for us to at
15 least identify the areas that we think are
16 important, and then the decision is going to have
17 to be made down the road about which are the ones
18 that are most relevant. Ten years from now, it
19 might be a completely different list up here.

20 So we're not just saying add to it,
21 but I think in terms of research that needs to be
22 done et cetera, et cetera. So that we have a

1 menu of important areas, I think that's the
2 purpose of this rather than simply saying we're
3 going to triple the list of measures. But I hear
4 your fear --

5 DR. BURSTIN: And just to add to that,
6 I'm sorry, some of these -- I mean most of these,
7 have not been developed yet. So there is a
8 pretty significant lag to get them out into the
9 field.

10 So again, it's more so a sense of if
11 some of these were developed, which ones would be
12 of highest value? Again, hopefully, to a
13 parsimonious list of core measures, you might
14 take some others off the list if some of these
15 are perhaps more relevant.

16 And again, this is not meant to be
17 exhaustive, but just to give you a sense across
18 the major National Quality Strategy areas where
19 we know there are important gaps.

20 CO-CHAIR MOSCOVICE: So I have Tonya
21 and then we'll come down this side.

22 MS. BARTHOLOMEW: Two comments.

1 First, to just reiterate what Kelly said about
2 end-of-life care. In a rural setting, it is
3 very, very different. We do not have the money
4 to pay to hire a social worker, and all of the
5 staff that are required to become hospice
6 certified.

7 So what happens in my clinic is that
8 my husband goes and sets up a hospital bed at
9 home and sits with the patient and family. It's
10 very, very different. But like Kelly was saying,
11 people want to be home. They don't want to go to
12 the hospice center. They don't want to go to the
13 hospital. And so I think that's something very
14 important to consider and something that I think
15 we can highlight as rural areas and be proud of.

16 The second thing is the patient out of
17 pocket costs. I know when it comes to
18 measurement, especially clinical measures, now
19 with the new high deductible plans, it's very,
20 very difficult to get our patients to come in.
21 For example, diabetic patients to come in every
22 six months for their A1C.

1 We run our registries, they're due for
2 their labs, they're due for their office visit.
3 Not coming in, I have to pay for it. So that is
4 a huge barrier I see to collecting and reporting
5 good measures and having an impact on these
6 patients because you have to get them in the door
7 first, and that's -- the out of pocket cost is a
8 huge challenge and barrier to that.

9 CO-CHAIR MOSCOVICE: So I have Greg,
10 Guy, and Bob.

11 DR. IRVINE: To the third -- the next-
12 to-the-last bullet point regarding pain
13 management. I think we need to use great caution
14 with trying to objectify pain management with
15 pain scores and the like.

16 Pain management as reported by
17 patients, all the rage a few years ago was that
18 pain was the fifth vital sign, and pain
19 management has probably as much -- as much to do
20 with the art of medicine as anything we do. It's
21 very difficult to objectify, and I think making
22 pain the fifth vital sign has had the unintended

1 consequence of leading to what we're now seeing
2 with this prescription drug epidemic that we see
3 a lot in rural areas.

4 And I think trying to objectify this
5 and make the patient have the right to have their
6 pain controlled and therefore throwing narcotics
7 at it, for example, creates horrible unintended
8 consequences.

9 CO-CHAIR MOSCOVICE: Guy.

10 DR. NUKI: I think I see our job here
11 today as taking things off this list.

12 And so just -- cancer patients, that's
13 not a rural issue. I mean, we help in the care,
14 but we're not managing their care. I mean, there
15 might be some rural communities that have an
16 oncologist, but I -- that's going to be so sparse
17 that it's --- that's not worth it.

18 And so things like that -- I think the
19 patient out of pocket cost should probably come
20 off the list. Measures of lost productivity: I
21 don't think that the volume is going to be there
22 to really be very helpful.

1 Measures of diagnostic accuracy, are
2 you talking about under- and over-utilization of
3 diagnostic testing? Is that what that refers to?

4 DR. BURSTIN: Somewhat, although it's
5 intended to be broader than that. I mean, we
6 really have very few measures that begin with a
7 symptom and consider whether the diagnosis was
8 correct. There's actually a whole IOM committee
9 working on this right now.

10 DR. NUKI: That actually, I think,
11 would be interesting work, but obviously, this
12 has a lot of work, yes.

13 DR. BURSTIN: Oh yes, sure.

14 CO-CHAIR MOSCOVICE: I have Bob and
15 then Bruce.

16 DR. RAUNER: This is actually kind of
17 a question in response to clarifying something
18 you said, and that is, is the end-of-life care
19 really worse in rural areas? I know the
20 resources aren't there, but my gut feeling as
21 based on an n of 1 is despite the lack of
22 resources, when I was in my hometown, I thought

1 the end-of-life care was a lot better than it was
2 in the urban area I am now, although some people
3 might not consider Lincoln urban.

4 So -- because there's a lot of rural
5 measures where people assume it must be worse
6 because they don't have as much stuff, yet
7 despite it, because of the resourcefulness, the
8 cohesiveness of the community, the outcome
9 actually ends up being better despite the lack of
10 resources. So does anybody have any solid data
11 on end of life, whether it's better or worse,
12 rural versus urban? So it's I guess more of a
13 question.

14 CO-CHAIR COURT: Well I think the work
15 we did, and it was actually with a purchasing
16 group. So they were using mortality as like an
17 ultimate quality measure, but what we helped them
18 understand was the mortality rates in our rural
19 hospitals were higher partly because of low
20 volume and partly because there was a lack of --
21 I mean, that's what the patient chose.

22 So it wasn't a measure of the quality

1 of the death, if you will, but it was like the
2 patient died in the hospital, therefore you are a
3 bad provider. And so I think we need to make
4 sure that the measures reflect something that's
5 truly meaningful.

6 CO-CHAIR MOSCOVICE: Okay. We have
7 Bruce and Brock, and then we're going to move on.

8 DR. LANDON: So I didn't -- I wasn't
9 planning to comment on the end-of-life issue,
10 but, you know, it wouldn't surprise me if end-of-
11 life care was better by a lot of objective
12 measures, i.e. less intensive use of resources
13 and whatnot in these areas. And probably worse
14 if you're going to count something like, you
15 know, enrollment in hospice because of not good
16 availability. But as Tonya was mentioning, that
17 sort of hospice care by a non-hospice, I mean,
18 it's sort of the same thing.

19 What I was just going to comment with
20 on this list. I guess to me this list is sort of
21 orthogonal to the main issues that we were
22 discussing yesterday, and in fact all the main

1 issues sort of apply to all of these things.
2 Like, you know, so the paramount one that we
3 spent a lot of time on yesterday was, you know,
4 basically just low-volume services. So you can
5 apply that to each one of these going down the
6 line.

7 So -- and I think we should
8 understand, obviously, we're looking, you know,
9 for better measures and whatnot across the board
10 and in here, but I think the job of our Committee
11 is more to sort of think about the special
12 circumstances related to measurement in rural
13 low-volume settings as they apply to any
14 potential new measure and existing measures.

15 And someone mentioned this a little
16 bit. So, to me, patient out of pocket costs
17 would be -- well first of all, you know, for the
18 Medicare program or for the Medicaid program,
19 that's going to be relatively somewhat standard,
20 not exactly for Medicare.

21 And second, I would consider that, if
22 anything it would be an adjustment thing, but not

1 a measure in and of itself, right? Because
2 that's not -- yes, that's going to be a function
3 of whatever someone's insurance coverage is, and
4 that's not something that can be influenced by
5 the rural provider.

6 Now if in fact there are more --
7 there's a higher prevalence of people with high
8 deductible health plans, and we're talking about
9 commercial and Medicare and Medicaid measurement
10 and not just Medicare and Medicaid, then that
11 could be an adjustment factor, but it's not a
12 measurement itself, I don't believe.

13 CO-CHAIR MOSCOVICE: Okay, Brock has
14 the last comment on this one.

15 MR. SLABACH: I think it is important
16 to note, and I don't believe we had a specific
17 conversation about this yesterday or this
18 morning, and that is multiple chronic conditions.
19 And in my work around the rural community, more
20 and more providers are moving into chronic
21 disease management and trying to move upstream on
22 the correction of those before they become acute

1 exacerbations of disease -- of that disease.

2 And so -- but I've heard there's a
3 dearth of measures that provide guidance in terms
4 of whether these programs are successful and how
5 do they compare with other programs of such.

6 So I think for the rural community,
7 the only thing really on this list that I see
8 that's probably a major gap that we haven't
9 discussed is the measurement of chronic
10 conditions and the treatment of those.

11 CO-CHAIR MOSCOVICE: Okay. Let's just
12 go back to our list that you folks came up with
13 yesterday, and we are going to take a break by no
14 later than 10:30, promise. We will wheel through
15 this.

16 But are there any other comments about
17 the gap list we put together that you'd like to
18 offer at this point? Kelly.

19 CO-CHAIR COURT: I just have concerns
20 about population health measures in a pay-for --
21 even pay-for-reporting or pay-for-performance
22 attributed to a provider group.

1 So the group in Wisconsin, the
2 Population Health Institute, has got some really
3 good data that says when you look at the health
4 of a population, the providers, the care provided
5 only contributes 15 percent to the health of the
6 population.

7 And so there's so many other social
8 determinants and behaviors that are -- and things
9 like water and, you know, that just the providers
10 don't control. So I think we have to be very
11 cautious what we mean about population health
12 measures.

13 CO-CHAIR MOSCOVICE: Any other
14 comments on this one.

15 MR. SIZE: On that one? Yes, and I
16 mean, I've been on that Institute since the
17 beginning, and I agree with what Kelly said, and
18 it's in part what I was thinking before, the
19 importance of being clear about what metrics for
20 what purposes.

21 And I am not uncomfortable with
22 provider-specific metrics being reported for this

1 as part of awareness. And the reality is in
2 rural communities, providers are a core if not
3 dominant part of leadership. And so I'm not so
4 hung up on -- if we're talking about public
5 reporting of areas where you have influence but
6 not control, then hospitals don't control all the
7 elements in the community that contribute to 30
8 day return rate. So we've already set that as a
9 precedent.

10 So now having said that, I mean, the
11 same Population Health Institute with major
12 funding from Robert Wood Johnson, we put out the
13 County Health Rankings. So in fact, this stuff
14 is already out there, probably at the level that
15 is meaningful. We've got some other projects
16 that I'm starting with Karen on next month in
17 terms of going down to sub-county levels, but
18 that's really below the radar of metrics.

19 CO-CHAIR MOSCOVICE: Okay. Brock?

20 MR. SLABACH: I wanted to make a
21 comment about the transitions of care and the
22 measurement of care coordination, and it may be a

1 good place to insert --- and maybe if we're going
2 to make a comment to CMS. They have not figured
3 out where Rural Health Clinics and Critical
4 Access Hospitals fits in terms of care
5 coordination reimbursement in the new codes that
6 have been established.

7 And so, again, this is kind of a
8 deficit of where Critical Access Hospitals and
9 Rural Health Clinics kind of get left out of the
10 conversation. And because of their payment
11 types, the application of those payments are not
12 considered, and then afterwards, they --- oh,
13 it's like, now what are we going to do? And they
14 have to find ways to work around.

15 And I think that, again, that care
16 coordination payment would be critically helpful
17 to being able to provide the resources to make
18 this happen in these rural communities.

19 CO-CHAIR MOSCOVICE: Okay. Tonya.

20 MS. BARTHOLOMEW: Brock just sparked
21 a thought in my head about the care coordination
22 fees of Medicare and the difficulty to accomplish

1 what is required to get paid for those care
2 coordination fees. I don't know how many people
3 have looked into that, but is it a long laundry
4 list of things that you have to complete in order
5 to get that \$46?

6 I don't know if rural clinics --
7 again, we're talking about those infrastructure
8 abilities and technology abilities, having an
9 HIE. All of that stuff is required to get that
10 care coordination fee, so I don't know how
11 feasible that's going to be for small rural
12 places to collect that.

13 CO-CHAIR MOSCOVICE: Okay. Last
14 comment on this slide, from Bob?

15 DR. RAUNER: I am going to dovetail on
16 that because that's one of our core issues right
17 now, is how do we make that happen? You know, I
18 was talking to Bruce about this last night, that
19 potentially, this is a huge sustainability thing
20 for the clinic if we can get it to work, and can
21 we make that sale to the patient that it's worth
22 paying \$8 a month out of their pocket for this?

1 And so we're actually trying to figure
2 out how do we make that sale? Because we're
3 going to have to package it in such a way that
4 the patient is getting something they really
5 want.

6 Is it a gold card with direct access,
7 phone number, to the care coordinator that their
8 daughter from California can use? Or the -- you
9 know, the doc in Arizona when they're
10 snowboarding down south can, you know, get their
11 -- I mean, are there things that we can provide
12 to convince enough patients to sign up for this?
13 I think that's our biggest problem, because it
14 pays for the documentation, actually. When you
15 run the numbers, we can have -- we thought it was
16 probably 80 to 100 -- if we got 80 to 100
17 patients to sign up for this in a clinic, that
18 alone would fund a full-time care coordinator.

19 So -- but again, can you make that
20 sale to the patient that it's worth \$8, another
21 \$8 compared to everything else they're spending
22 on health care? I don't know yet. We'll --

1 again, we'll find out in about six months whether
2 we can make it work.

3 CO-CHAIR MOSCOVICE: Okay. So just a
4 couple of other additional recommendations the
5 group made. Create a MAP workgroup for rural
6 providers, and Helen is going to talk a little
7 bit in general about the concept of MAPs, a
8 little bit later.

9 Relax requirements for use of vendors
10 for the CAHPS surveys, or offer alternative data
11 collection mechanisms similar to a CART tool for
12 hospitals, given the cost of all these things;
13 and then there's a point which I'm not sure what
14 it means, is allow access to Medicare claims
15 data.

16 So -- but those are three things on
17 this chart, and Brock seems to want to go first.

18 MR. SLABACH: Well to add to the third
19 point that I guess -- so Medicare Insurance
20 Savings Program has produced data sets that are
21 incredibly valuable to providers that are
22 participating in accountable care organizations,

1 and that data allows them to see the patients in
2 their service area and the sources of care and
3 the locations of care that they're receiving.

4 We know providers -- I know providers,
5 I know Bob and Ann as well, but when they have
6 access to this information, they can rapidly
7 improve the care of the coordination of those
8 patients and reduce the overall cost to Medicare,
9 in this case, for the care that these patients
10 are receiving.

11 We have anecdotal evidence at the same
12 time. We don't have -- I know it's not
13 researched yet, but we have anecdotal evidence
14 that it's also increasing the volume in these
15 rural community hospitals and clinics because
16 patients are now staying closer to home rather
17 than getting turned into urban systems of care.

18 So if we could find a way to use
19 Medicare claims data maybe outside of -- I mean,
20 using Shared Savings data to improve care beyond
21 just, say, the ACO context, I think it would be
22 incredibly valuable.

1 CO-CHAIR MOSCOVICE: The timeliness
2 issue comes into play here. Having a one-year
3 timeline is not going to work for this. You're
4 almost talking real time or very close to real
5 time.

6 MR. SLABACH: I'm not sure what the
7 lag time is on the production of that. I think
8 once you get the data from CMMI, I think then if
9 you have to have a data vendor that translates it
10 for you, and I -- apparently, no matter what the
11 time lag is, it's still very valuable
12 information.

13 CO-CHAIR MOSCOVICE: Okay. Really,
14 it's only -- any other comments on this slide?

15 Okay, the last slide before we -- oh,
16 Tim.

17 MR. SIZE: Sorry, it's just a quick
18 one, that Medicare -- I mean, you know a lot of
19 us drool when we hear Bob and others talk about
20 their access to Medicare data. We all in our
21 states, with other similar groups around the
22 country, have been fighting to try to get access

1 to Medicare data. So we have a totally
2 contradictory public policy going on.

3 In our state, for a number of reasons,
4 rural I don't think fit as neatly into rural ACO,
5 and we've been looking for the WHIO to be
6 successful --- and our state medical society is
7 fighting for it --- and I think we ought to just
8 call that out. That's a major policy that is
9 affecting a lot of us that's just stupid.

10 CO-CHAIR COURT: So WHIO is an all-
11 payer claims database --

12 MR. SIZE: Yes.

13 CO-CHAIR COURT: -- that has most of
14 the commercial Medicaid, no Medicare yet, and
15 none of the self-insured plans.

16 You know, so I think we need access to
17 data like that, you know, so it's really
18 difficult for providers to use that data because
19 there's -- and for looking at quality, because
20 there's no Medicare data. And so, you know, I
21 don't know what the answer is, but the challenge
22 is to have all this data segmented in different

1 places to try to use it either for creation of
2 measures or when pay-for-performance is judgment,
3 it's very difficult.

4 MR. SIZE: And it's -- yes, I mean
5 WHIO has its problems, but in our state, it's a
6 major player, which rural are largely locked out
7 of because without the Medicare data being part
8 of that all-payer system, it's not particularly
9 meaningful.

10 CO-CHAIR MOSCOVICE: Okay. And the
11 last slide, further discussion, and we'll be able
12 to address this at the end of the day also.

13 We need to discuss a bit further the
14 aggregation issues that were brought up earlier
15 in a good conversation and the appropriateness of
16 doing this at the particular levels. We've
17 talked about this in terms of measure retirement
18 and new measures, it creates a bit of instability
19 to look at things longitudinally.

20 We mentioned this also, and we'll be
21 talking about this a bit I think in the SDS,
22 relationship of quality to the access and cost

1 dimensions. Part A and B difficulties, there
2 could be a lot under that, I'm not sure what
3 exactly is meant by that, but we can address that
4 a bit later. Technical assistance across
5 entities and concrete suggestions.

6 And so these are all things that we're
7 not going to discuss right now, but it's on the
8 list, and I think as we get towards the end of
9 the day, we can come back to this in terms of
10 additional responsibilities.

11 So it's 10:29. Why don't we take
12 about a 15 minute break? We'll come back, and
13 then we'll split up about -- oh, it's about 80
14 minutes or so, it will be between the two topics,
15 the SDS and the MAP. Okay? Does that work for
16 you?

17 (Whereupon, the meeting went off the
18 record at 10:29 a.m. and resumed at 10:51 a.m.)

19 MS. JOHNSON: Helen is here and she's
20 ready to give us a primer on NQF's SDS work.
21 Hopefully that will be interesting to you. And
22 then that will help kick us off and we can talk

1 about specifics on SDS and rural issues.

2 Okay, SDS first Mitra?

3 DR. BURSTIN: So, since we had some of
4 these discussions have sort of peppered the
5 conversations for the last couple of days, I
6 thought it would probably be useful just to go
7 over where we are in terms of this risk
8 adjustment for socioeconomic status and other
9 sociodemographic factors.

10 There is a final report from August 15
11 on our website. I was also a coauthor on a paper
12 with the co-chairs. That was just a JAMA
13 viewpoint, just right before the holidays on To
14 Adjust or Not to Adjust, that is the Question.
15 They actually let us call it that.

16 So a little bit of background. Part
17 of what we've been trying to really understand
18 has been whether particularly given the way
19 measures are used these days and particularly
20 these higher stakes financial uses associated
21 with measures, whether it was time to take
22 another look at how we adjust measures.

1 So, fully recognize there's lots of
2 these patient -- and it really should be patient
3 and community factors, that clearly influence
4 outcomes through a lot of different pathways.
5 The concern has also been some of these very
6 factors may be the reasons related to disparities
7 in health and healthcare as well.

8 So there's always been somewhat of a
9 concern that if we consider these factors in risk
10 adjustment, we would mask disparities. And we
11 were like that was one of the driving forces of
12 not doing this for years.

13 So to date, our policy has prohibited
14 the inclusion of these factors in risk models.
15 And just definitional here, we actually
16 ultimately called it SDS although that doesn't
17 roll of the tongue quite as easily as SES, mainly
18 because SES is really quite limiting in terms of
19 income, education, occupation.

20 And we're really thinking about the
21 broad range of factors, both individual and
22 patient. And this is just a short list. I went

1 back through the report this morning, we have a
2 very long list of variables.

3 And, in fact, we really didn't have
4 any discussion of specific factors around rural
5 care. In fact, there was much more an urban
6 disparities, racial optic disparities focus. So
7 I'm actually really glad we have an opportunity
8 to talk about this, because it was really not
9 very much present in the report, but something we
10 knew we wanted to get back to. So I think this
11 is a good opportunity.

12 Ultimately what the report said is
13 that this should really be on an individual,
14 measure by measure determination. It's not a
15 blanket. Not every measure should be adjusted
16 for SDS.

17 And really, they should really only be
18 adjusted if there's a logical rationale or a
19 theory of why these factors would influence the
20 outcomes. A conceptual basis, as we called it.
21 As well as empirical evidence, meaning you could
22 actually look at data, put those variables in a

1 risk model, and in fact see there is a
2 relationship.

3 We gave the example of -- for example,
4 central line infections in a hospital probably
5 wouldn't really have association with patient
6 level sociodemographics. It was not a conceptual
7 -- yes?

8 (Off mic comment.)

9 DR. BURSTIN: Well, I'd love to hear
10 more about that. But in general, things that
11 happen inside the walls of a hospital. There was
12 a sense that many of those other factors probably
13 are not as relevant. And, as opposed to measures
14 like readmissions or something where there's 30
15 days when somebody leaves the door of a facility
16 and a whole lot else happens when they leave
17 those doors.

18 And again, the recommendations were
19 not just for hospitals, though I think that was a
20 big part of the focus, particularly around
21 readmission and cost measures. But really,
22 thinking about it across the board, health plans,

1 facilities, individual clinicians, et cetera.

2 So ultimately, what we decided to do,
3 is the report came out from the expert panel
4 saying you know, adjust with these caveats when
5 appropriate. But ultimately, the Board decided
6 that it was really most appropriate that we do
7 this in a pretty measured way. And we've now
8 undertaken a two-year trial period that's already
9 launched, as of January 1.

10 We will be accepting measures that
11 come in that now have these sociodemographic
12 adjustments. And really begin a process of
13 comparing and understanding what the differences
14 are really between the usually clinically
15 adjusted kind of risk factor models versus ones
16 that then also include adjustment for SDS. Part
17 of what we'll also do for transparency, and
18 really hopefully so we can all learn a lot, we'll
19 actually endorse one measure. But it will have
20 multiple required specifications.

21 So we'll be able to see in fact the risk
22 model that is adjusted for SDS. A risk model

1 that isn't, that's just clinically adjusted, as
2 well as stratification. To be able to see the
3 differences by whatever group it turns out to be
4 significant in.

5 Bruce already has a comment. Do you
6 have a comment about this in particular? Okay,
7 that's fine. It's almost done. Next slide.

8 The other piece of this is we'll be
9 convening a new Disparity Standing Committee to
10 help us implement this revised policy. And a
11 whole lot of important issues like how do you
12 stratify, what sample sizes are sufficient for a
13 strata, things like that. And we'll look to that
14 group to help us think it through.

15 But I specifically wanted to focus in
16 on one of the other recommendations of the expert
17 panel, which is that there should be a group of
18 sort of national leaders and others who would
19 come together to think about what is a standard
20 set of these sociodemographic variables, both
21 patient and community level, that should be made
22 available to really make us -- help us understand

1 what these differences are?

2 And as I mentioned, I looked through
3 it and there's really nothing that I could see
4 that really called out, in particular, what would
5 be unique community level variables from a rural
6 perspective. So I thought that might be a useful
7 discussion for us to have today. So with that,
8 Bruce?

9 DR. LANDON: So I just wanted to ask,
10 so one of the issues that at least I've noted in
11 my own work is that the relative lack of
12 availability of reasonably good measures of this.
13 You know, so often we end up sort of adopting the
14 mean income or racial classifications and the
15 CTSA, ZCTSA, whatever those things are. And to
16 me, that's always been a relatively unsatisfying
17 thing.

18 We do often have data about whether
19 someone qualifies for Medicaid or not. Which is
20 again, okay, but a little bit unsatisfying. The
21 one exception I would say where I think we could
22 do a reasonably good job is like on survey

1 measures, like on CAHPS. There's at least a
2 question about education, which is their proxy
3 for SAS. And there's some health status stuff.
4 But, in general, I've been pretty frustrated with
5 the ability to do this. And I was hoping you
6 would comment on this just where do you think the
7 measures are going to come from?

8 DR. BURSTIN: Yes, so this has been an
9 issue. There's a limited amount of these data
10 you can certainly get from claims. Which is
11 where a lot of the measures in question are still
12 pretty -- relying on hospital claims in
13 particular.

14 And that's been part of the reason for
15 thinking about it being not just an individual
16 level characteristic of a patient. But also
17 thinking about community level factors. And
18 that's where I think in fact the urban-rural kind
19 of issues are particularly interesting, and
20 whether there are variables.

21 So we had, one of the members of the
22 panel was the CEO of BJC Health System in St.

1 Louis for example, who presented some work they
2 had done looking at -- within their system. They
3 have got hospitals that are in you know, pretty
4 high end communities. They've got very urban
5 hospitals.

6 And even within their own hospital,
7 they had pretty significant differences in
8 readmission rates that they didn't think had
9 anything to do with. You know, they had the same
10 systems, they had the same doctors, they had the
11 same providers.

12 And part of what they were able to do
13 was actually use census data. And one of the
14 most important factors they found was as an
15 example, factors like being in a community that
16 has a high rate of vacancies. You know, lots of
17 boarded up places. People are kind of --

18 So again, there may be other creative
19 ways to think about what are factors that perhaps
20 give a sense, particularly at a community level,
21 of vulnerability, of lack of access to resources,
22 perhaps lack of access to what you might need to

1 have sufficient support to avoid bouncing back in
2 the hospital, to make sure you can get your
3 prescriptions filled, make sure you can in fact
4 buy your fresh fruits and vegetables.

5 But it's going to be a complicated
6 issue. No question. And I think the fear is
7 going to be, there will be a lot of measures that
8 people will say conceptually, these make sense.
9 We should adjust them, and then we're not going
10 to find the data yet to say which variables you
11 would use, because they're just not reaching the
12 collected. Which is why thinking about what the
13 standard set of variables would be, and including
14 the rural perspective would be very useful.

15 CO-CHAIR MOSCOVICE: So we have Greg,
16 and Bob, and then Tim.

17 DR. IRVINE: Going back, I'm sorry I
18 interrupted you earlier, by the way. It just --
19 when I was an attending at the University of
20 Michigan, I was assigned at Wayne County General
21 Hospital, and I actually wrote a paper on
22 complications of central lines in surgical

1 patients. And our number one cause for catheter
2 sepsis at the county hospital were visitors
3 coming in and injecting the catheter with drugs.
4 Like, usually, heroin. So there are
5 socioeconomic factors, even on hospital acquired
6 circumstances. But that was our number one cause
7 of catheter sepsis, so.

8 CO-CHAIR MOSCOVICE: Bob?

9 DR. RAUNER: I have a question and a
10 side reflection. One question is to the
11 statisticians is that you correct for stuff to
12 remove as much other explanation as possible. So
13 going from zero to 100 does for example, the risk
14 adjustments like Lexington where it went up, the
15 risk score is 1.7, does that remove, say, 80
16 percent of the variable with only 20 percent
17 residual left over?

18 And then by adding socioeconomics, do
19 you get rid of say another ten percent, almost
20 all the rest? Does anybody have any sense for
21 that? Like how much more are we explaining by
22 adding these? It's obviously statistically

1 significant, but how clinically significant is
2 it?

3 And then some reflections. Is that
4 there are measures we can pull. The problem is
5 they are not in claims. So, with meaningful use
6 we now capture race and ethnicity, for example,
7 but that's probably not in claims. How are you
8 going to merge some of these things which you
9 might be able to do on a community level? But
10 it's better if it's on the patient level.

11 And then I would argue for this,
12 because I do my ACO job half time. My other half
13 time I work with our school system. And we pull
14 in a data set that includes -- it's mostly around
15 obesity and fitness. We pull in ethnicity, free
16 meal cost lunch data, which is our
17 socioeconomic, academics, everything. And you -
18 - and a lot of our racial disparities go away
19 with correction for free meal cost lunch, but not
20 all.

21 And then sometimes there's granular
22 things such that, for example, we don't see

1 gender disparities on the overall level. But on
2 the ethnic level, we still don't see them for
3 Caucasians and Asians, but we do see them for
4 Hispanics and African Americans, but in opposite
5 directions.

6 And so sometimes there is a lot of
7 uniqueness in there. And I think you are going
8 to have to look at them individually. Some
9 things it may not matter, where others -- and you
10 may get conflicting results too. So, but it gets
11 complicated. But the stats guys, do you know
12 what -- how much is explained away by just actual
13 risk adjustment? How much more is explained away
14 by that? Is there any sense for that?

15 DR. SCHMALTZ: I think you'd have to
16 give a range, because it varies widely by what
17 type of outcome measure you're looking at. I
18 mean, you can go from three percent to 15 percent
19 from what I've seen. That could be explained by
20 other factors, such as severity of illness, which
21 tends to be the highest.

22 DR. BURSTIN: And I'll just add, when

1 we look at the R-squares of models submitted to
2 us for measures, oftentimes it's very disturbing
3 to clinicians and others when they see in fact,
4 how little is explained by the -- what the
5 clinical factor is in a model.

6 So there's always a lot of concern.
7 Some of that could be the actual of care
8 provided, and I think some of it is also one of
9 these other factors that we're not measuring. So
10 I think that's part of what we're trying to learn
11 through this trial period is in fact, what is the
12 additive effect of adding these variables in?
13 And how much more of the explanatory variation
14 can you look at?

15 DR. RAUNER: Yes, but I think -- there
16 was a Health Affairs article about four to six
17 months ago, where they actually added, it turned
18 out that marital status was huge for
19 readmissions, especially if you were an African
20 male with no wife. It was very high. I mean it
21 was -- I was really surprised at how much I
22 didn't realize that made that big a difference.

1 It was kind of eye opening.

2 CO-CHAIR MOSCOVICE: I have Tim, and
3 then Guy.

4 MR. SIZE: As some may have, the
5 careful listener would have noted, I have
6 interest in this issue.

7 (Laughter.)

8 MR. SIZE: I just, I think this
9 arguably may be the most important work NQF has
10 ever done. I think that's my feeling on how
11 important it is. I go back to IOM Health
12 Literacy Report, because a friend of mine, Dave
13 Kindig chaired it. And my favorite part of that
14 report I think is relevant, because he talks
15 about the concept of co-production of care. And
16 that's -- it's our arrogance as providers that
17 you know, we're just helping them out and then we
18 zap people and they get better.

19 Well, the reality is it's not that
20 way. And I served for years on the Crowley
21 Committee, the HMO we started years ago. And we
22 did some studies about you know, what the

1 compliance was. And this was for a relatively
2 diverse population across the SDS background --
3 on you know, the patient following through and
4 actually taking the whole line of medication they
5 were prescribed.

6 For a lay person, it just blew me out
7 of the water. And my sense is from that study
8 that it did have SDS implications. So anyway,
9 really, really, important work. I think it's
10 really relevant to rural. And it came to me in
11 some of our work in Wisconsin as we've started to
12 get public reporting with smaller clinics.

13 I mean obviously, as you get a smaller
14 clinic, the randomness of them having to be --
15 with a patient population that's you know, well
16 off suburban, versus struggling rural. I mean,
17 those things really start to matter and get
18 amplified.

19 And I mentioned to Ira in the break
20 that right before the break we talked about the
21 gap. Well I think actually it's going to be the
22 gap in those metrics that we adjust between the

1 adjusted metric and the non-adjusted metric will
2 then create a whole other sense of one, if we're
3 judging physician to physician behavior, I think
4 it's very -- just to be fair that it's SDS
5 adjusted.

6 But if we're looking at what are the
7 ethical and professional responsibilities of the
8 hospital and the clinic to try to address the
9 unique issues of the population, you look at the
10 other metric and you look at the gap. So it's
11 going to create a whole other major gap
12 opportunity. But I'm really, really glad you're
13 doing this work.

14 CO-CHAIR MOSCOVICE: We have Guy and
15 then Aaron.

16 DR. NUKI: So one of the things that
17 we talked about yesterday was the peer group. So
18 this is a risk adjustment, a measurement
19 adjustment. You get numbers different, as
20 opposed to using SDS for developing peer groups.
21 Which is really a very unique rural issue. And I
22 think that's going to be very important that we

1 figure out what are the most important you know,
2 environmental factors, is almost maybe a better
3 way to put it to create those peer groups.

4 DR. BURSTIN: And do you have a sense
5 of what those might be, from a rural perspective?

6 DR. NUKI: Clearly distance to
7 referral hospital. Income you know, of the --
8 general income of the region. I mean some of the
9 just pretty much basic things. I wouldn't make
10 them -- I wouldn't have 50. I'd have a few that
11 we think are important. I think size of the
12 medical staff, population size, distance to the
13 hospital and the average income. Percent of
14 Medicaid patients, percent of no insurance.
15 Average education level. I think the more you
16 throw in, you'll start to get -- because we want
17 to clump them, then, into groups.

18 So you'd have to figure out, do we
19 create a score? Or is it you know, one group is
20 between the -- you know, in this economic you
21 know, at this economic level from average income
22 being from \$20 to \$30 thousand. Plus hospital

1 being more than 60 miles away or something like
2 that. I'm not quite sure.

3 CO-CHAIR MOSCOVICE: So one of the
4 things I was going to ask you Helen, is the
5 distance issue. Because you didn't discuss that
6 in urban, or in these other things that you
7 mentioned are discussed with urban. Do you see
8 distance as a central part of this discussion?

9 DR. BURSTIN: So everything you said
10 over the last two days, it sounds like the answer
11 is yes. And I guess the question is distance to
12 what? If it is a referral center are there other
13 considerations as well? And rural communities
14 where that may actually be almost a bridge too
15 far for some.

16 CO-CHAIR MOSCOVICE: Yes, I would say
17 to a referral center. But I'd also use size of
18 medical staff. Because if you have six people on
19 the medical staff, that's very different then if
20 you have even 15 or 20. I mean it really, that
21 changes what the hospital -- the resources and
22 what the hospital can do.

1 DR. NUKI: Does it matter who is on
2 the medical staff as compared to how many?

3 CO-CHAIR MOSCOVICE: Probably. But
4 I'm not sure how you would -- you'd have to
5 think, how would you, you know, I don't know how
6 you'd divide that up. That would be tough.
7 Okay. Aaron?

8 DR. GARMAN: On somewhat of a clinical
9 note regarding this, as you know, I belong to an
10 FQHC, and I mentioned the UDS. The UDS collects
11 a lot of demographic data, and it breaks it down
12 by race and ethnicity. It could be a starting
13 point at least to look at that data. And perhaps
14 give you some better ideas of where to focus your
15 attention.

16 CO-CHAIR MOSCOVICE: We have Kimberly
17 and then Tonya.

18 DR. RASK: I think the other piece
19 that could come in is some of the -- along with
20 distance, the availability of other healthcare
21 resources in the area. Are there any PCPs in the
22 country? What is the density of PCPs? Is there

1 home health in the county or whatever region that
2 you're in?

3 Are there long term care facilities?

4 All those other things that would be other
5 potential sites of care or referral of care that
6 may or may not be available to whatever provider.
7 And I think you could really think about those,
8 not just at the hospital level, but also at the
9 practitioner level.

10 Because to you know, go with what some
11 of what Tonya said, part of what you're picking
12 up is a PCP who's in an isolated rural community,
13 is going to have a broader scope of practice,
14 because they're doing all those other things that
15 elsewhere might be referred to hospice, home
16 health or other options which are simply not
17 available.

18 CO-CHAIR MOSCOVICE: And so, do you --
19 and I'm not putting you on the spot. Just your
20 gut reaction, the supply side issue, you view as
21 part of this. Once again, very different for
22 rural then urban. And so we're not talking about

1 patient characteristics as much as really the
2 environment output.

3 DR. BURSTIN: Absolutely. And I think
4 more on the urban side there was a lot of
5 discussion of neighborhood or census track. So
6 you know, it's basically this is sort of a macro,
7 blowing out that from a very urban perspective to
8 something a whole lot bigger.

9 But I still think you know, the
10 question is, are they directly effecting the
11 outcome measures we'd potentially be using for
12 accountability for rural providers. And more
13 than anything else, I think we just want to make
14 sure that as you know, we start thinking about
15 some of these measures coming forward, that might
16 ultimately get used in these communities, how do
17 we make sure that in fact are getting fair
18 comparisons?

19 CO-CHAIR MOSCOVICE: Okay. I had
20 Tonya then Brock.

21 MS. BARTHOLOMEW: I know I sound like
22 a broken record, but we were talking during break

1 about how, you know, Greg and I come from very,
2 very unique areas where we're not only a rural
3 community, but we are rural states. The State of
4 Wyoming doesn't even have a psychiatrist, okay.

5 So when we're talking about
6 telemedicine, we're talking about all of the
7 stuff that distance is tied to access. So when
8 we're talking about getting these patients these
9 services, they can't afford to drive to Salt Lake
10 City, four hours away, to Denver, Colorado, four
11 hours away, to get mental health services.

12 And so, going back what Kimberly was
13 saying, our scope of practice is so much bigger.
14 But when you're talking about you know, ability
15 to get access to services, I think you really
16 have to even broaden your perspective of what
17 rural communities are setting in rural States,
18 which are settings set in rural regions. And it
19 becomes an access issue.

20 CO-CHAIR MOSCOVICE: Okay. And Brock?

21 MR. SLABACH: One possible designation
22 that could be capable of making, maybe, some of

1 these distinctions, because I'm -- my quandary
2 here is data collection and how is all of this
3 achieved through reporting. The HPSA, the Health
4 Professional Shortage Area, medically under-
5 served areas, and medically under-served
6 populations are three designations that HRSA uses
7 and defines, that could be a way to distinguish
8 this.

9 Also, I know Greg doesn't like the
10 term frontier, we can call it geographically
11 challenged, but there are frontier definitions
12 that are used in Federal policy that could be
13 used to distinguish those that are more remote,
14 in terms of their access to other services, or
15 more distance shall we say. So going back to
16 your census tracks, it's a similar notion except
17 only in the rural context.

18 Again, I'll echo, I mean this is an
19 incredibly important piece. My work in
20 Mississippi as a rural hospital administrator
21 with a 70 percent, 60 to 70 percent African
22 American population, it was extremely frustrating

1 to have applications of certain measures,
2 perhaps, that wouldn't be possibly comparable in
3 a real literal sense to another location. When
4 we closed our OB program in 2003 that didn't stop
5 our delivery of babies, because they came to the
6 emergency department. And so we were delivering
7 a fair number of babies in the emergency
8 department because they didn't have rides to get
9 to the urban area.

10 That was a reality that we had to deal
11 with. So you know, it -- were we going to turn
12 them away or not serve them? Of course not. And
13 I think that's really what we come down to in
14 terms of the reality.

15 CO-CHAIR MOSCOVICE: Kelly?

16 CO-CHAIR COURT: Brock stole my first
17 point, so thank you. The second point though is
18 distance isn't always distance. And so 30 miles
19 down the interstate is different than 30 miles up
20 over the mountain pass on a two-lane highway
21 that's maybe not so great. But it maybe needs to
22 be time of travel. Yes, by time versus by miles.

1 And I know we've talked about that in Wisconsin
2 with the critical access designation and the
3 miles limits. So that's something that probably
4 should be considered.

5 CO-CHAIR MOSCOVICE: I haven't gotten
6 to the big mountains in Wisconsin. But I look
7 forward to seeing them.

8 (Laughter.)

9 CO-CHAIR MOSCOVICE: We talk about
10 those hills in Minnesota also. And seasonality
11 also is certainly an interest.

12 CO-CHAIR COURT: If you have to cross
13 country ski there, you're in trouble.

14 CO-CHAIR MOSCOVICE: Other comments?
15 So, what about the other side of this? So this
16 has been a real debate in general, in terms of
17 should we be using these kinds of variables in
18 terms of how we pay folks?

19 And on the one side, what everybody's
20 been saying, it affects. We believe it affects
21 outcomes. The other side is, well if we do this,
22 you know, there are some people saying well, you

1 know, what we're saying is, it's okay to have
2 disparities and that we're going to create
3 disincentives for people to try to overcome that.
4 I'm just wondering what, sort of how NQF has
5 responded to that.

6 DR. BURSTIN: Well, that's been the
7 crux of the debate from day one of the question
8 of you know, is this appropriate because for
9 fairness, versus you know, what's the potential
10 downside. Which is ultimately why we decided to
11 study it for a couple of years and not just whole
12 hog say we're just doing it in all measures, will
13 be SDS adjust it?

14 And frankly, we want to be able to see
15 what those differences are. I mean, we honestly
16 don't know what that gap will be, to the question
17 raised earlier between the measures that are
18 clinically -- you know, usually adjusted, versus
19 those that add in these factors.

20 So you know, it's still early. And I
21 think the thought was, given the complexity in
22 this day and age, to simply say we won't look at

1 it, didn't make sense anymore. And it just
2 seemed like it was time to look. And that's been
3 part of the reason as well for saying, you should
4 also have the stratified result. Because then if
5 you have the SDS adjusted result, you'll then be
6 able to look at whatever those significant
7 factors were in the model.

8 I mean, if distance or time was the
9 significant factor in the model that's being
10 adjusted for, you'll then be able to see what the
11 rates in fact were. So it's that transparency we
12 hope will help.

13 CO-CHAIR MOSCOVICE: And how does that
14 interact with the low volume issue we talked
15 about? When you talk about stratification, et
16 cetera?

17 DR. BURSTIN: It's going to be even
18 harder.

19 CO-CHAIR MOSCOVICE: Okay.

20 DR. BURSTIN: Yes, it's going to make
21 it you know, small cells even smaller.

22 CO-CHAIR MOSCOVICE: That's tricky.

1 DR. BURSTIN: So, it's not going to be
2 easy. I would be very -- it would be very
3 interesting for example, to look at some of the
4 measures that are you know, pretty controversial.

5 The HRRP and IPPS/LTCH for example,
6 the readmission measures. And see if you know,
7 I'm not sure I've ever heard this researched, or
8 has anybody actually been out there looking at
9 some of these measures and seeing whether some of
10 these kind of more rurally oriented factors would
11 have made a difference in those rates and the
12 penalties?

13 CO-CHAIR MOSCOVICE: I mean, to get
14 the low volume, aren't we talking about all cause
15 readmission as compared to you know, particular
16 backgrounds?

17 DR. BURSTIN: Right. We've got that
18 measure now, of all cause. So that's an
19 interesting idea.

20 CO-CHAIR MOSCOVICE: All right. I
21 have Bruce and then Bob.

22 DR. LANDON: So just in response to

1 your last comments. One of my colleagues and a
2 fellow are looking using HRS data, that model
3 readmissions including all the stuff available in
4 HRS like cognition, social supports, and whatnot.
5 And actually, I haven't looked at the most recent
6 version, although it's pretty close, and my
7 understanding was that in a fairly saturated
8 model with sort of clinical predictors and
9 whatnot, it added less than we would have
10 thought.

11 And it does improve the R square, but
12 didn't actually change around the possibles all
13 that much in another way. More importantly
14 though is you know, I think there are a lot of
15 challenges to doing this. And I think one of the
16 things that where this is particularly relevant
17 as sort of getting at the way control groups are
18 compared to groups.

19 So for instance, if you know, being in
20 a rural area is a big disadvantage in terms of
21 distance and access to specialists versus an
22 urban area, and I buy that, then that's one of

1 the reasons why we want to you know, compare
2 small rural hospitals to one another, instead of
3 to the big academic tertiary medical center.

4 And I guess I'm worried about all the
5 sort of complexities and really lack of good data
6 on some of these things, such that my preference
7 would be to try to take care of as much as we can
8 of this issue using appropriate comparator
9 groups, instead of putting additional data in the
10 model.

11 CO-CHAIR MOSCOVICE: So I can't pass
12 this opportunity to simply say some of your
13 colleagues at Harvard don't get that, in terms of
14 some of the work they've been doing over the last
15 couple of years with the critical access
16 hospitals. I'll just leave it.

17 (Laughter)

18 CO-CHAIR MOSCOVICE: I think you know
19 the names. Bob.

20 CO-CHAIR COURT: I even know the
21 names.

22 (Laughter)

1 CO-CHAIR MOSCOVICE: All right, Bob
2 then Tim.

3 DR. RAUNER: This is something that I
4 think style of practice has a huge effect on
5 this. And that one of the reasons our ACO has
6 very low readmission rates. But I think is
7 partly an effect of cherry picking. And that the
8 people who we asked to join us, who we start off
9 with are all physicians who do their own hospital
10 work.

11 And several of them, not only do they
12 do their own hospital work, they also cover the
13 ER. So there is no handoff essentially. And I
14 actually think that is the main explanation for
15 our low readmission rate, is because there's just
16 less opportunity for things to not get handed
17 off.

18 I mean, and our ER load utilization is
19 very low as well, because they can call in. And
20 then when they call in, they call their own
21 doctor who says, no, see me at 8:00 tomorrow
22 morning. And so our ER rates are also really,

1 really low compared to our peers.

2 And it's that style of practice which,
3 unfortunately, is starting to go away more and
4 more where they're getting the hospitalists and
5 then random contracted ER people coming in from
6 who knows where. That's something that has to be
7 studied actually, because I think it is why some
8 of our results are what they are. It's that
9 style of practice. And that varies from
10 community to community.

11 CO-CHAIR MOSCOVICE: That's an
12 interesting point, but I would assume you don't
13 do that as part of it as well.

14 DR. BURSTIN: Not part of it, but it's
15 a really important issue. But obviously effects
16 measurement. I mean if you're doing all of it,
17 you don't have handoffs, you're going to -- it
18 just logically makes sense your rates would be
19 better. But how do you operationalize that
20 across the U.S.? It would be pretty hard to do
21 in this day and age, so.

22 CO-CHAIR MOSCOVICE: Oh. And Jason

1 back there.

2 MR. LANDERS: But wouldn't you measure
3 against your peers that maybe aren't part of your
4 ACO that maybe do send their patients to the
5 hospitalist and don't have total control over
6 them? And I mean, that's I think they would be
7 factored into your peer group.

8 DR. RAUNER: That's a matter of
9 intense debate internally right now. Because we
10 have -- we've just added a practice that doesn't
11 do that. And we're not sure that they're going
12 to drag us down because of that.

13 And so, it doesn't necessarily call --
14 and actually the case that I told you, the three
15 -- the care coordinators who had those three
16 problems within one or two weeks, they're that
17 new group that doesn't do their own hospital, and
18 doesn't do their own ER. And that's maybe why
19 the found so much so fast. And so it's hard. We
20 are struggling with that. Do we let those people
21 in, because we know they're probably going to
22 have higher readmission rates and higher ER

1 utilization. And I don't know.

2 MR. LANDERS: For the success of your
3 ACO it makes sense, but for regional measurement,
4 it -- cherry picking was the right word.

5 CO-CHAIR MOSCOVICE: I have Kimberly,
6 Brock and Tim. And Bruce, I assume yours is?
7 Kimberly?

8 DR. RASK: And then the only other
9 point I bring in from the QI perspective is in
10 terms of either finding good comparators, or
11 doing great risk adjustment. There are reasons
12 to do it for methodologic purposes, and for the
13 scientific validity.

14 The other thing is with all of the
15 stuff when it's reported publically, or if you
16 want people to act on it, they have to believe in
17 what they see. And if people believe that
18 they're different, and if people believe that
19 they're being unfairly compared, it's really
20 difficult to motivate them to accept the data
21 that you present to them. Or to motivate them
22 for change.

1 So, even thinking about what we've
2 heard in all the discussions and to me if there's
3 one theme I've heard over this last day, is
4 there's a gigantic heterogeneity issue with these
5 very small volume providers all over these 50
6 States.

7 And so if we don't have a measurement
8 process or a reporting process that at least
9 acknowledges that, even if over time we are able
10 to say no, actually it turns out you all are the
11 same, you're just wrong. But, if we go in with
12 that attitude, it's going to be difficult to have
13 all of these individual providers really believe
14 that they have been appropriately assessed.

15 CO-CHAIR MOSCOVICE: And I think the
16 other thing I want to point out, as Helen
17 mentioned, we all have our preconceived notion
18 about how this is all going to work out. You
19 know, guess what folks, it might not. And you
20 might not like the statistics. You might not like
21 whatever, you know, how we conceptualize it. But
22 we also all have to keep an open mind that as to

1 you know, how this all plays out. We -- it's one
2 of the reasons to study it. Tim?

3 MR. SIZE: I tell you, I mean there
4 are initially winners and losers, and I know in
5 our -- my own state included. I have just a
6 couple of comments that you know, just comparing
7 like CAHS to CAHS, or rural center, that doesn't
8 get it.

9 I mean, I just know the variability in
10 small towns I work with. And some are actually
11 pretty middle class. And others are really,
12 really struggling. And so, same -- they're going
13 to have the same provider types, but very, very
14 different population and at least on my
15 hypothesis is very different compliance rates on
16 a whole bunch of stuff.

17 I think the other thing I like about
18 it from a population health perspective, and I'm
19 not talking about the medicalized population
20 health definition, but the more traditional David
21 Kindig kind of population health thing. Is that
22 we actually then start to see provider specific

1 metrics. How they're affected by the community.

2 And I would never say well, they
3 should be responsible to control the unadjusted
4 score. But at least they could start to manage
5 the gap and ask questions where they have the
6 opportunity to influence the community to improve
7 actually the raw score. And I think that's going
8 to be very, very powerful.

9 CO-CHAIR MOSCOVICE: Brock?

10 MR. SLABACH: I agree with Kim
11 completely, that the conversation would be why
12 we're different, and not the focuses on
13 improvement. And I think that's critical. The
14 unintended consequences, and we talked about this
15 about not doing SDS adjustment, I was struck
16 really profoundly when I was listening to a
17 professor of medicine at the University of -- is
18 that Pittsburgh? University of Pittsburgh or
19 University of Pennsylvania at Pittsburgh, one of
20 those. Anyway, someplace in Pennsylvania.

21 (Laughter)

22 MR. SLABACH: And she was -- and she

1 was at our multiracial, multi-cultural
2 conference, and she was giving a direct impact of
3 this problem. That she was being asked to
4 discharge patients from her practice because they
5 weren't compliant. And they were not going to
6 meet the physician reporting requirements in
7 terms of standard. And they did not want to be
8 counted down in their practice as a result of
9 this population of patients that they had.

10 So this is the profound impact of how
11 these things translate into unintended
12 consequences. And there's beginning then a
13 struggle in the department about whether that's
14 in fact ethical and should that be the process
15 that they undergo their practice operation.

16 CO-CHAIR MOSCOVICE: Yes, and the
17 other side of that is, I know rural clinicians,
18 family physicians who basically say I'm scoring
19 low on terms of how I take care of you know,
20 diabetics. Well guess what? Here's the four
21 people, it's of low volume, that I take care of
22 who are out of control. Two are homeless, one

1 will not comply with anything I say.

2 But out of the kindness of my heart,
3 when they show up, I don't say I'm not going to
4 see them, I try to do what I can. And you know,
5 that's the way it is. And I know what I can do
6 if I want to look good, just get rid of those
7 three or four people from my panel, and I look
8 good. And in the rural environment, it's even
9 more telling because of low volume issues Greg
10 and Brock, yours is okay. So Greg?

11 DR. IRVINE: This is just real quick.
12 We actually see patients in our family practice
13 clinic being transferred from provider to
14 provider so that the numbers look better. And we
15 all in a small town know who the noncompliant
16 people are. And they're like a hot potato, they
17 get passed around.

18 CO-CHAIR MOSCOVICE: Any other
19 comments for Helen on the SDS issue before we
20 move onto the MAP, or all the MAPs in
21 deliberation?

22 MS. JOHNSON: I have a quick question.

1 And this is just out of curiosity about data
2 availability. Where I'm from, in the Central
3 Appalachian Region of the country, you have this
4 independent streak. And going to the doctor, my
5 father hasn't gone to the doctor in 25 years,
6 probably. At least. He went when he had
7 shingles and that's the only -- I mean, literally
8 that's the only time in probably 50 years he's
9 been to the doctor.

10 And that's probably not uncommon. Is
11 there any data that gets to that level? It's a
12 cultural kind of thing. It's probably pretty
13 important, but I'm not aware of any. And I'm
14 just curious if you guys know of any?

15 (Laughter)

16 CO-CHAIR COURT: It's a gender thing.

17 (Laughter)

18 DR. RAUNER: Okay. Well, we've been
19 struggling with that actually. Because one of
20 the things we decided to use is annual percentage
21 of wellness visit. And some of our most rural
22 places, the docs say, I said I just can't get

1 them to come in because it's not their mind set.

2 It's that fatalistic, when it's my time, it's my

3 time. So why would I come in to do this?

4 Because you know, that's why they don't wear

5 seatbelts. It's why they don't you know, and I

6 grew up with that.

7 So I mean, so I kind of understand it.

8 Although I used to throw it back, and it's like

9 not changing the oil in your tractor because when

10 it's your John Deere's time, it's your John

11 Deere's time. You don't do that with your

12 tractor, why would you do that for you? But

13 there is that prevalent fatalistic, and it's

14 really hard. And then on top of that, there's

15 the economics, because the uninsurance rate, and

16 high deductible rate is really high amongst

17 independent, self-employed farmers for example.

18 And when it's \$3,000.00 out of my

19 pocket for that colonoscopy versus the \$100.00 to

20 change the oil in my tractor, guess what wins?

21 And so it's -- so literally it's not an access

22 issue for colonoscopy in Nebraska, but it's a

1 patient attitude, because of that fatalistic mind
2 set. And it's an economic issue because of the
3 under insurance and the high deductibles.

4 CO-CHAIR MOSCOVICE: So that's not
5 going to be trivial to enter into any kind of SDS
6 model, needless to say. All right Guy?

7 DR. NUKI: You know it's interesting,
8 I think though that if you asked all of us, we
9 all think that our community that we come from is
10 the one that's the worst in that. And so I think
11 that's an everywhere issue. I'm not so concerned
12 about having to dig into that so that we can
13 compare. Because it probably is more related to
14 gender then socioeconomic status. I mean
15 although the having to pay \$100.00 to go to the
16 doctor, or pay the entire bill because you have a
17 you know, \$8,000.00 deductible, that probably
18 makes a difference.

19 But I don't think every -- I've worked
20 in a lot of states. And every place -- it's a
21 little bit like the people -- everybody in Maine
22 thinks that people move to Maine because it's

1 easy to get Maine Medicaid. When I was in
2 Washington, people thought that everybody moved
3 to Washington just to get Washington Medicaid
4 because I mean it -- I just don't think that --
5 it's just local lore.

6 CO-CHAIR MOSCOVICE: Greg?

7 DR. IRVINE: I don't have anything.

8 CO-CHAIR MOSCOVICE: Any other final
9 comments on SDS before we move on?

10 DR. BAER: Just to support what Greg
11 said. I thought that's why they built the
12 Philadelphia International Airport.

13 CO-CHAIR MOSCOVICE: All right. I
14 think it's time to move onto the -- to our
15 discussion about what exactly is a MAP, and how
16 it might fit into the future deliberations.

17 DR. BURSTIN: So we've talked a lot --
18 well, periodically about this elusive body called
19 the MAP in the last couple of days. So we
20 thought we'd just put a little more meat on the
21 bones and perhaps talk about it a bit. So this
22 is something funded by CMS to NQF where we

1 convene something called the Measures Application
2 Partnership, which we affectionately refer to as
3 the MAP. And the idea is to provide
4 multistakeholder input to HHS specifically on
5 which measures should be selected for which
6 Federal programs.

7 It includes pay for reporting, it
8 includes pay for performance as well. And
9 currently, it's over 20 Federal programs. And
10 I'll show that to you shortly.

11 And so what happens is MAP provides to
12 NQF the measures under consideration across these
13 20 different Federal programs. We then bring it
14 to these multistakeholder groups, and I'll go
15 over that in a moment, and get their input about
16 which measures they think are most appropriate,
17 which measures they have concerns about.

18 It currently includes about 150
19 healthcare leaders and experts across -- a
20 clinician workgroup, a hospital workgroup, and
21 then a post-acute long term care workgroup.
22 There are some other smaller workgroups as well.

1 And the one that to me seems most,
2 sort of, analogous potentially for sort of an
3 area that's kind of emerging is the dual
4 eligibility workgroup. And Brock's smiling
5 because he probably had the same thought. Where
6 a lot of that work has really been about what are
7 the measure gaps, what might you measure? As
8 opposed to saying here's a set of measures,
9 please select among them.

10 It does -- the other nice thing about
11 this is it includes both private sector, but
12 there are actually the Federal agencies sit at
13 the table with us. So CMS sits at the table,
14 HRSA, CDC, et cetera. Next.

15 So this is a list of the current
16 Federal programs that we do. So for example,
17 we've talked a lot about MSSP and PQRS and value-
18 based purchasing. Those are all among the
19 current measures that we review for CMS. And so
20 these measures go to the MAP before CMS puts out
21 their final rules, where they say which measures
22 will be used. And we're an input to them, the

1 MAP workgroups and the final coordinating
2 committee, are an input to those groups to then
3 think about which measures would be most
4 appropriate.

5 Interestingly when I was downstairs
6 with the other meeting, I was talking to Kevin
7 Larson who is head of Meaningful Use, the Medical
8 Director of Meaningful Use for the Office of the
9 National Coordinator, and I was mentioning
10 critical access hospitals, and he said you know,
11 the only program currently that includes critical
12 access hospitals is Meaningful Use.

13 And he mentioned they actually have a
14 full time analyst at ONC who could actually do
15 any analysis we would like to be able to see some
16 of the differences, for example of measures
17 submitted by critical access hospitals, for the
18 same measures against those of others. And I
19 thought might be an interesting analytic piece we
20 follow up on.

21 But it is remarkable that they are not
22 generally included in any of these other

1 programs. So, something for us to think about.
2 Next slide. And this is just an example. Part
3 of what we really try to do as part of the MAP
4 process is really focus on alignment. And so the
5 idea is both to align within the Federal programs
6 themselves, which is quite cacophonous still.
7 But also then to take it to the private sector
8 and see if we can get some alignments.

9 So just as an example there, I think
10 there are about 30 -- I think there are about 40
11 hypertension measures that were used across the
12 entire Federal Government. CDC, all the
13 different Federal programs. And then they've
14 ultimately gotten that down to I think two
15 measures in use across all the Federal programs.

16 Similarly, the list that's listed up
17 here, just a couple of other examples of risk
18 associated conditions, HIV/AIDS, perinatal and
19 obesity are some of their early focus areas. But
20 that has been our goal.

21 If we can at least get the Federal
22 Government to align internally, it then gives us

1 a better chance to work with the private payers
2 as I mentioned yesterday, to say they've aligned.
3 Now how do we get you guys to align as well? So
4 it's been a really important input.

5 Yes, I'll just repeat the question.

6 Yes, to those -- yes, so the white bars were
7 literally the number of measures in use across
8 the different Federal Programs. It is
9 remarkable. So a lot of that to the credit of
10 Kay Goodrich at AHRQ. And Nancy Wilson -- I'm
11 sorry, Kay Goodrich at CMS and Nancy Wilson at
12 AHRQ have done -- led this measurement council
13 across HHS. So there really is a great deal of
14 interest in alignment.

15 And so it is a good opportunity to
16 think potentially about you know, the rule of
17 measures. They may not always have the alignment
18 perhaps. But it would be interesting at least to
19 start from where they're beginning as a starting
20 point. I think that is -- Mary, do I have
21 anything else? I think that's it. Great.

22 So with that, questions? Thoughts?

1 And again, this is something we do under contract
2 to CMS. We would need to, if this is an interest
3 to this group, we'd be happy to certainly talk
4 with both HRSA and CMS and see if perhaps we
5 could ask them to consider for the future
6 contract, the addition of a -- more of a -- along
7 the lines of the dual eligibles workgroup, a
8 rural providers workgroup. So, questions?
9 Thoughts on that?

10 CO-CHAIR MOSCOVICE: I have Kelly and
11 Brock.

12 CO-CHAIR COURT: So a question Helen,
13 what obligation, if any, is CMS under to accept
14 the recommendations of the MAP? I mean I'm
15 familiar mostly with the hospital reporting, VBP,
16 you know, those programs. And in the proposed
17 and final rules, they often don't take into
18 consideration that you know, the MAP has said
19 this is not a recommended measure. So -- and do
20 we run that same risk with rural?

21 DR. BURSTIN: So, it is a
22 recommendation. It is not you know, it is not

1 certainly saying you must do this. For most of
2 the hospital programs, home health, nursing
3 homes, those kind of programs have very, very
4 high rates that the recommendations from MAP
5 match up quite closely.

6 There are certainly exceptions. But
7 for the most part they line up quite closely. I
8 mean if nothing else, they give them a pretty
9 good sense of the big issues that are emerging
10 that they hear from the stakeholders at the
11 table. Even if it doesn't directly translate
12 into a yes/no on particular measures. But we
13 actually study the -- their adherence to the
14 recommendations as well, is perhaps one way to
15 think about it.

16 CO-CHAIR MOSCOVICE: Okay, Brock?

17 MR. SLABACH: So this may be a
18 continuing education program for me as well
19 today. Correct me if I'm wrong, but the CMS
20 delivers to you all at NQF, the MUC list, the
21 measures under consideration. And that's what
22 then we deliberate upon at our workgroup

1 meetings.

2 What chance are there of outside
3 insertions under measures under consideration,
4 number one? And number two, how are measures
5 developed? I guess you get those input from
6 researchers around the country on various topics,
7 and then NQF as a separate process evaluates
8 those measures as well?

9 DR. BURSTIN: So there's only a couple
10 of different ways this is done. And again,
11 there's a pretty big difference between the
12 physician programs and the other programs, to be
13 honest. But as an example, for the PQRS program,
14 for all the physician programs, there is actually
15 a tool that they have open that anybody can
16 submit a measure for consideration into this
17 process. So it doesn't always require that CMS
18 says we want to use this measure. Anybody can
19 bring that measure forward. And that's a lot of
20 what's on the MUC list.

21 In fact, increasingly -- and certainly
22 Severa and Mitra could jump in, they've both been

1 very involved in the MAP process as well -- we
2 are getting measures that are under development
3 still. So it's actually interesting to see
4 measures that are still at a pretty early
5 conceptual level, where part of what they're
6 asking for is this a reasonable direction to go?
7 And any specific suggestions for how to move
8 forward.

9 So, that might actually be a really
10 interesting role for a rural group to look at
11 some thoughts about what measures are under
12 consideration or under development that might
13 move forward.

14 But for some of the groups like for
15 example, the dual eligible group, and correct me
16 if I'm wrong Mitra or Severa, there's been less
17 about looking at a list of measures for
18 consideration and more about saying here are the
19 gaps. Here's what we think a core list would
20 look like for this group. Even in advance of
21 measures necessarily put on a list by CMS for
22 consideration.

1 So some of them are pretty early --
2 some of them are earlier in the process than
3 others. And actually Ira sat on that, so Ira may
4 have some thoughts on that too.

5 CO-CHAIR MOSCOVICE: Yes, the only
6 thing I would say is so the dual eligibles are a
7 subpopulation. But cause or if we wanted to look
8 at it that way, or rural providers are subgroups
9 of other provider groups. And so -- and from
10 having sat on the MAP and from Brock being on it
11 also, most of the measures there that get
12 discussed are not very relevant for rural.

13 And so we need to think -- I think
14 it's really important. I think that's really the
15 next step after this group puts their report out.
16 But it's really important to try to understand
17 how those two different provider groups, with
18 very different membership, would interact with
19 each other. So they're not necessarily -- they
20 may have different opinions about the value of
21 some measures versus others.

22 Other comments about MAPs? And before

1 we said you know, that -- a couple of people said
2 well, gee it would be you know, that is the
3 logical next step for this group. That's what we
4 said yesterday.

5 Now having heard from Helen, do you
6 feel just as strongly about that? Are there
7 other next steps? And I guess we'll be talking
8 about that at the very end. But any other
9 questions, really, relative to how MAPs fit into
10 this? Or the value of them as the next step?
11 Brock, is yours still up? Or are you down?

12 MR. SLABACH: Since the -- I'll take
13 advantage of my raised card. Having been able to
14 participate in the hospital workgroup and
15 understand the process, I think that if we
16 recommend mandatory reporting for these groups,
17 and this is the process under which these rural
18 relevant programs would be selected, I think it
19 would be a very nice combination to be able to
20 convince, or to satisfy, our colleagues that this
21 is going to be done hopefully appropriately.

22 CO-CHAIR MOSCOVICE: Okay. Other

1 final comments for Helen? Okay.

2 DR. NUKI: I'll just word the same
3 thing a little differently. It's terrifying to
4 think that you would make these measures without
5 a group like this at the table.

6 DR. BURSTIN: And I've just been --
7 the person who leads our dual workgroup wasn't
8 available to come up. But part of what she
9 pointed out as well as a lot of that group's
10 actions have them thinking about how to generate
11 measures that are more directly relevant to the
12 population.

13 So I think that would be kind of
14 building on some of the work we've done for the
15 last couple of days. And then asking how
16 existing measures could be modified or stratified
17 to make sense to be perhaps more actionable to a
18 given community.

19 So I think there are some nice
20 analogies there. And we'd certainly be happy to
21 follow up with CMS.

22 CO-CHAIR COURT: So question then,

1 Helen. How -- if NQF develops a rural MAP, how do
2 you ensure that you have rural people and that it
3 doesn't get sidetracked with non-rural people or
4 people that don't understand the rural
5 perspective?

6 DR. BURSTIN: Yes, again, this is
7 pretty premature because we don't have one yet.
8 But we would definitely do a call for nominees.
9 We would make sure that it's appropriately
10 populated.

11 We'd probably take a subsample of some
12 folks. If it winds up being mainly critical
13 access hospitals, it would be helpful to have
14 some overlap. Because some folks already sit on
15 a hospital workgroup for example. Just to
16 understand the broader issues.

17 But you know, I think if you look at
18 the Medicaid group we put together or the dual
19 eligible group we put together, they really bring
20 that expertise to the table.

21 CO-CHAIR MOSCOVICE: I'm not seeing
22 any other comments. I'll turn it back maybe to

1 Karen to talk about lunch and that other.

2 MS. JOHNSON: About lunch, yes.

3 Before we do that, I think do we have a public
4 comment scheduled now or is that a little bit
5 later?

6 MS. GHAZINOUR: No, that's at the end
7 of the meeting.

8 MS. JOHNSON: Okay. I want to get a
9 quick read of people around the table. I know at
10 least one or two of you may need to leave early.
11 And I'm not sure how early is early.

12 So the idea is we will have lunch and
13 then come back and do a round robin, kind of your
14 final say. How many of you need to leave before
15 12:30 to 1:30 when we're doing the round robin?
16 Okay, three of you.

17 I'm wondering if we were scheduled to
18 have lunch at noon I believe. Perhaps now would
19 be a good time for you guys to give us your final
20 round robin reflections. And I know you didn't
21 have lunch to think about it. But we'd hate to
22 miss yours just because of your travel plans.

1 So I guess the idea here is really,
2 whatever you feel like you would like to go on
3 the record for. If we've missed something. If
4 you want to emphasize something. If you want to
5 just comment on the process. Whatever you feel
6 like sharing. And if you don't feel like
7 sharing, that's fine too.

8 DR. KESSLER: I'd like to go first
9 just because I really need to be leaving right
10 about now. And it is difficult to try and you
11 know, put a summarization of my thoughts through
12 this, the whole couple days -- couple day
13 process.

14 And I think we've done a whole lot
15 here in terms of really getting out there what
16 some of our major issues and thoughts are
17 regarding quality measurement for rural medicine.
18 At the same time, I don't think we've solved any
19 problems.

20 I think that, you know, our friends
21 from NQF have a lot of work to do in terms of
22 synthesizing our thoughts. And we yet have some

1 work to do in terms of, you know, working with
2 that information once it comes along.

3 Being part of a process like this kind
4 of almost puts a whole new spin on measurement in
5 general. Because I think there's just -- there's
6 so many facets to it. And so many facets to any
7 given population or any group that it really is
8 difficult to, you know, to pick a limited set of
9 measures and say yes, these are the important
10 ones.

11 And these are the important ones in
12 any setting. But these are the important ones
13 for a rural setting. These are the important
14 ones for an urban setting. You know, it's a
15 difficult process.

16 And I think we've shed some light on
17 it here today and yesterday. And I think it's an
18 ongoing process. And I think no matter what
19 happens coming out of this in terms of our
20 recommendations, what we, you know, what gets
21 passed on down and what gets accepted of our
22 recommendations. I think you really have to look

1 at this in the same way I think that we have to
2 look at the world of healthcare in general.

3 It is an evolving thing. It is going
4 to change. And what we recommend now may not be
5 what we would recommend in five years. So I
6 guess that's a little bit kind of my perspective
7 has been really in this whole process is just
8 that we've accomplished a lot. There's a lot yet
9 to come. But it's all -- it's all a work in
10 progress and it always will be.

11 MS. JOHNSON: Thank you. Susan?

12 MS. SAUNDERS: I'm going to say much
13 the same in a little different words. The last
14 two days has been really incredible to hear the
15 conversation and the dialogue. I think when you
16 look to sum it you know, all up, this is the
17 beginning of a long work in progress. Or the
18 first step so to speak.

19 A couple of things that you know, I
20 hope that we all walk away with is that the
21 measures that come forth from this have got to be
22 centered around the patient and the patient's

1 safety. They have to be something that is
2 applicable to rural health, but to multiple types
3 of providers. You know, the generalist, you
4 know, there will be some specialists. The ones
5 in patient-centered medical home, the rural
6 health clinics. You know, it has to be something
7 that can cross all of those lines.

8 And then also, I think that there has
9 to be thought and consideration as to the burden
10 of work. And how does that you know, distribute
11 when they are implemented.

12 MS. JOHNSON: Thank you Susan. And
13 Ann?

14 MS. ABDELLA: All right. A couple of
15 thoughts. Number one, thank you all so very,
16 very much for fighting the good fight and leading
17 this to get it organized. I don't know who is --
18 who are the mouthpieces across the country who
19 are advocating for this, but well done. And
20 thank you to NQF for -- and HRSA for taking it
21 on.

22 It's been an incredible opportunity to

1 -- and very comforting frankly, to know that the
2 things that we are all facing, as much as there
3 is heterogeneity, there is homogeneous issues and
4 things that we're all facing. And I think there
5 is a solution in all of this. There is an answer
6 that we're going to be able to get to and find.

7 I think we have gained a little and
8 pretty flexible and facile. I think that rural
9 could take on a real important role in the future
10 in the transition of care in the whole model of
11 what happens in the country. We're like a great
12 little Petri dish for you all to put stuff out
13 and see if it's going to work as a pilot.

14 And you know, I think to the point of
15 one of you gentlemen over there was saying about
16 your network, your docs are all doing it all.
17 You know, you are already locally integrated.
18 You are doing all of the things that we are
19 supposed to be doing. We lose it when we get
20 outside of the hood.

21 And so I think there's a lot for
22 everybody to learn from what it is we're doing

1 and how we're doing it and marry that to the
2 bigger picture.

3 But thanks for the opportunity. It's
4 been tremendous.

5 MS. JOHNSON: Great. Well, we don't
6 need to belabor. Let's come back at 12:30. I
7 believe, it looks like lunch is out. So, enjoy
8 your lunch.

9 (Whereupon, the above-entitled matter
10 went off the record at 11:50 a.m. and
11 resumed at 12:28 p.m.)

12 MS. JOHNSON: Okay everybody, let's go
13 ahead and reconvene. I hope you enjoyed your
14 lunch. I hope you had a chance to talk with your
15 neighbors and now your friends.

16 So the rest of our time really is
17 going to be the round robin portion. So we've
18 already got a start with Ann and Susan and Jason
19 who had to leave already. But we are just going
20 to ask you to give us your last final thoughts.
21 Anything you want us to make sure that we get in
22 the record and understand your feelings.

1 And then we will -- before we let you
2 go, we'll have an opportunity for public comment
3 and then Severa will tell us about next steps.
4 So the things that we're going to be ask of you
5 next. And then we'll leave.

6 We'll definitely be out of here by
7 2:00. We certainly won't keep you any later than
8 that. We may even possibly get to go a little
9 bit early. So, it's up to you in how this goes
10 in the reflection section.

11 So with that, I'm going to start over
12 here to my right with Stephen.

13 DR. SCHMALTZ: It's interesting to
14 contrast this group with a group that met at the
15 Joint Commission to consider measures for
16 critical access hospitals, which I can talk about
17 as well.

18 I think the task force really wanted
19 to consider measures that were already being used
20 in hospitals. So looking at this alignment
21 issue. But I think at the end of it, what we got
22 were measures that were used in the hospital that

1 were adjusted somewhat, but they weren't really
2 different enough to be considered on their own.
3 Plus you still had the small sample problem.

4 So I see this group looking broader
5 and looking at maybe starting from scratch. And
6 looking at a blank slate and considering other
7 types of measures, other types of settings. And
8 I think that's a good thing.

9 MS. JOHNSON: Thank you so much. And
10 it looks like John is next.

11 Oh, okay. So this is your time for
12 reflection. So, this could be your last word to
13 the group, to us. Whatever you would like to
14 say. If there's something that we missed that
15 you want to make sure that you get on the table.

16 MR. GALE: Well, I am -- not that I
17 can let lack of preparation get in my way.

18 My interest and my concern with this
19 process, and I -- is that as we approach the
20 report and we approach our recommendations, we
21 begin to think about separating the types of
22 providers that have been -- and the interests

1 that have been represented around the table.

2 Because I do think we have some differences that
3 if we discuss across all low volume rural
4 providers, may get lost.

5 That we should probably look at
6 hospitals separately from FQHCs, RACs, small
7 volume providers. And then begin to think about
8 sort of teasing out, if we can and probably
9 through the editing and review process, some of
10 the way that those two groups -- primary groups
11 are different.

12 And then even within the medical
13 practice side, clinical practice -- the clinics,
14 you'll have the differences between physician --
15 different types of providers, specialists versus
16 primary care. And think about how those
17 differences play out. And I think to me that's
18 an important point of what we need to do.

19 MS. JOHNSON: Thank you. And Tim?

20 MR. SIZE: Two thoughts. One just to
21 follow up on John. I mean, I agree with what he
22 said, except that the direction overall is for

1 integration at the local level, notwithstanding
2 different payment types. And so a cautionary
3 note.

4 As some of you know, I had the
5 opportunity in public to have a little back and
6 forth with Patrick Conway at the NRHA Conference.
7 And the thought I wanted to leave us with, is I
8 think this is incredibly, incredibly important
9 work. And I think it's good that CMS hears from
10 a cross section of rural. That they need to
11 catch up and bring us into the fold.

12 And what I said to Conway, and I used
13 the term and I think the audience with 700 people
14 seemed to appreciate it. I think if we fail to
15 do this work, we increasingly are consigning our
16 provider colleagues, clinicians and communities
17 to a backwater which they don't deserve.

18 So I think this is really important
19 work.

20 MS. JOHNSON: Brock?

21 MR. SLABACH: Well, I've been
22 reflecting I guess throughout the two days. And

1 so I don't want to repeat everything that's been
2 said heretofore.

3 But I think that from our
4 Association's point of view and from my personal
5 point of view, I agree that this is very
6 important work. And as we look ahead and see the
7 trending in terms of hospital closures in rural
8 communities, the concomitant economic decline
9 that that presents in terms of community health,
10 it is very important that we get this right
11 because of the interface with potential pay-for-
12 performance and making sure that these
13 communities have the resources that they need in
14 order to thrive in these environments.

15 So, I think that when I tie this
16 together, I see this in the bigger picture. And
17 at the same time, I am extremely concerned. And
18 I think we need to be aware that we have to have
19 quality facilities in these areas.

20 So it's not just one -- it's just not
21 access or quality. I think it's access and
22 quality. And I think that that's the message

1 that we need to send to those in our -- those who
2 are going to be the recipients if you will, of
3 these requirements if it ever gets to that point.

4 Secondly, I think that we need to be
5 very sensitive to providers. Both hospitals,
6 clinics and others that are going to be subject
7 to these. And making sure that we follow through
8 with our commitments in terms of technical
9 assistance and process that will enable this to
10 work.

11 And then lastly, making sure that we
12 appreciate as I suppose, the differences. And we
13 talked about that. And I think our discussion
14 about SDS will help to alleviate possibly some of
15 the concerns.

16 And I agree too that if you're
17 comparing cohorts that are equivalent that could
18 help, but then there's different populations
19 within those cohorts for each of these
20 facilities. So this is all very important as we
21 move forward. Thank you.

22 MS. JOHNSON: Kim?

1 DR. RASK: One of my pet peeves when
2 I go and work with physicians and hospitals about
3 performance measurement and their data is, but
4 we're different. The risk adjustment isn't the
5 same.

6 So I just want you to know that my
7 eyes are rolling too when I hear myself say this.
8 I think as we talk about performance measurement
9 for our rural providers, we really need to be
10 careful. Because there are aspects of the
11 measurement process that are going to be
12 particularly problematic for these folks because
13 of the low volume. And these folks also serve a
14 different social mission in terms of being
15 essential community providers. That we need to
16 make sure it's captured or protected in the
17 measurement process.

18 And so I think it behooves us to be
19 particularly careful with the measures we choose
20 and the way in which we apply them so that we
21 don't have unintended consequences towards --
22 that will impact community rural health and

1 access to quality healthcare in rural
2 communities.

3 MS. JOHNSON: Tonya?

4 MS. BARTHOLOMEW: Well first of all I
5 hope I didn't scare you guys too much when I said
6 that we don't have a psychiatrist in our State.

7 CO-CHAIR COURT: I think it explains
8 a lot.

9 MS. BARTHOLOMEW: I really, really
10 appreciate the privilege of being here. And I am
11 kind of the elephant in the room I've noticed.
12 Because I represent maybe frontier healthcare
13 more than rural healthcare.

14 And so I do appreciate the opportunity
15 to comment on my story and give you a perspective
16 of what rural healthcare is in a rural state and
17 how difficult that is.

18 I guess my two take away points or two
19 main recommendations from my perspective are, can
20 we please have alignment? Can we please have one
21 reporting system, and the phase in? Those I
22 think would be most successful in recruiting

1 practices in small hospitals to comply and
2 participate.

3 MS. JOHNSON: Thank you. Jonathan?

4 MR. MERRELL: I'll just begin by
5 saying thank you to everyone in the room for
6 openly sharing, having professional dialogue.
7 And I'll just say that I've learned a great deal
8 just hearing the conversations and hearing from
9 the different perspectives and the experiences in
10 the room.

11 I think I just have a couple of
12 highlights. I think the conversation that I
13 believe Stephen led, and recommendations to move
14 toward more continuous data collection. And
15 maybe recognize the limitations of classification
16 data. And the discussions on the social
17 determinants. And I'm very excited to see what
18 we learn from that type of data collection and
19 use in the future.

20 And just thanks again for the
21 invitation. Thanks.

22 MS. JOHNSON: Thank you. Jason?

1 MR. LANDERS: I'm the other
2 Pennsylvania insurer. And we're a fairly big
3 enterprise, covering Pennsylvania, West Virginia
4 and Delaware.

5 And West Virginia, kind of our main
6 leadership base is in Pittsburgh. By the way, as
7 a Highmark employee, I feel that I'm uniquely
8 qualified to say that it's the University of
9 Pittsburgh Medical Center, but.

10 The -- I'm continually the what about
11 West Virginia guy because there are such
12 differences in rural measurement. Just that the
13 delivery system in general than in urban areas
14 and it's really nice to be in a room with a lot
15 of people that have probably raised their hands
16 at a lot of times and said this doesn't work for
17 me.

18 So, that was a great pleasure. And I
19 agree, the probably -- I don't think we said the
20 word alignment enough and you know, I'm on both
21 sides of this issue. I've been on the -- or
22 practitioner's side and now the payer side. And

1 I can tell you that I sense everyone's concern
2 when somebody says, why can't we just do the same
3 way we do for this? And it makes no sense.

4 So, if we can underline that word
5 alignment, I think that's probably one of the
6 most important things that I think we could push
7 forward to CMS. So, thank you guys.

8 MS. JOHNSON: Thank you. Sheila?

9 DR. ROMAN: First I'd like to thank
10 everybody for a really rich discussion. I've
11 learned a lot over these past two days.

12 I've been a clinician in under-served
13 urban areas, but not in rural areas. And I think
14 I've really come to appreciate the heterogeneity
15 within the rural communities and their absolute
16 necessity as a safety net for the care of people
17 in those communities.

18 Having come from CMS, I think one of
19 the things that's most important to me is the
20 transitional aspect into pay-for-performance. I
21 would remind people here that Hospital Compare
22 started in 2003. HVBP did not come until 2010.

1 I believe that the PQRS program was an incentive
2 program for probably seven years and is only now
3 becoming a disincentive program.

4 So I think when you're dealing with a
5 community of providers that has been eliminated
6 from the programs that have been ongoing for such
7 long periods of time that they can't just jump in
8 at the top of the ladder and be expected to go.
9 That there will be a lot of need for help with
10 reporting and collecting.

11 And I would also echo -- I think Brock
12 said this several times -- that unlike the
13 physician value-based payment modifier, which is
14 a budget neutral program, that I don't think this
15 can be a budget neutral program. And that it
16 really does need to reward the high efficiency,
17 high quality providers for probably many years.

18 And there is some precedent in the
19 VBPM program where for the second year in order
20 to get the small groups in, they'll just be
21 giving bonuses and not giving disincentives.

22 I would also echo the whole alignment

1 issue. I know with Hospital Compare that
2 hospital reporting would have never moved from
3 public reporting to pay-for-reporting to VBP
4 without alignment of measures. And I think
5 that's crucial. But I think we also need to
6 understand the vast amount of work that actually
7 goes into the alignment process.

8 And finally, I think that I would say
9 that in order to make this work, that measures
10 would need to be mandatory with the core set and
11 flexible modules. And that you then have to have
12 some evaluation along the way to see how it
13 works. And I think CMS should build into their
14 process some task force evaluation project along
15 the way after they begin this process.

16 Thanks again for inviting me.

17 MS. JOHNSON: Thank you Sheila.

18 DR. BAER: I'll echo that thank you.

19 And it also has been an eye opener for me.

20 While Jason says I'm the other payer
21 in the state of Pennsylvania, there are lots of
22 other managed care organization payers in

1 Pennsylvania. You have one, part of his company
2 is a managed care, Medicaid company, but you
3 know, a very large Medicare and commercial
4 program they have.

5 So, one of my concerns you know, being
6 a Medicaid only program, is that there -- and
7 this is not just for me. This is just my
8 personal opinion. When you've seen one program,
9 you've seen them all. And when we talk about
10 alignment, which I think is very important, I
11 don't know how you translate something like this
12 where I think it's easy to translate into a
13 program in Medicare. But how do you get it out
14 there in the 50 different Medicaid programs where
15 there are carve outs and you know, mandatory
16 managed care, and fee for service?

17 So is the program kind of administered
18 at the state level? Or is it pushed out to
19 whatever program is delivering the services? But
20 I do think that we were talking a little bit
21 about budget neutral. I think there needs to be
22 additional dollars because the dollars that are

1 being used and pushed out to whatever delivery
2 systems that are in the state right now, are
3 severely stressed because of the ongoing
4 comorbidities of our population.

5 But also the expansion of that
6 population, whether it's in the -- under the ACA
7 or some other waiver program that the states have
8 developed in some kind of private coverage
9 options that states may have. So I think
10 alignment is so key.

11 And the other things that we really
12 didn't talk about are alignments among other
13 parts of the federal government. I think it's
14 good to keep it at the HHS level, but what about
15 the VA? The Indian Health Service? You know,
16 there are folks over there too that would need to
17 be aligned.

18 The other thing that I guess I
19 struggled with a lot this whole meeting was, you
20 know, what is the difference between a rural
21 patient and a non-rural patient? I don't see
22 much of a difference from a clinical standpoint

1 between the two. Boy, but the stuff that's
2 around that patient, you know, the services,
3 whether it's rural, whether it's a you know, a
4 critical access hospital. How close to other
5 services are they?

6 I think there's got to be some other
7 way. I think from a clinical standpoint, you
8 know, diabetes is diabetes. But how is that care
9 delivered to that patient and how does that
10 patient get to that care is very important.

11 And somehow that has to come into the
12 equation in here in showing the difference
13 between you know, the rural patients and the non-
14 rural patients. So I think that's where I would
15 somehow put a -- whether it's SDS or some other
16 way to qualify what's different.

17 And again, thank you. It's been a
18 pleasure.

19 MS. JOHNSON: Thank you Michael. Bob?

20 DR. RAUNER: Yes. I'd actually like
21 to start first just by saying thanks. Because
22 this is -- it's rare to have a representative

1 group with this breadth. Everything from the
2 ruralist to the rural, with Greg and Tonya, to
3 CMS, Johns Hopkins and Harvard. You don't see a
4 panel like that very often.

5 And it's led to a discussion I think
6 was worth it for me to come just to hear the
7 discussion honestly. I of course had my things I
8 wanted to say to you, but I think hearing this
9 was enough of a reason of itself to come.

10 So for feedback, I'm a lumper and I'd
11 like to lump in three buckets. So first I'm
12 going to jump on the alignment bandwagon. And
13 then alignment in terms of collaboration, like
14 for example having a readmission measure that's
15 good for both you know, hospital and physician,
16 med rec in vaccinations.

17 These are things that will help us
18 work together as to some things which have
19 unfortunately driven a wedge. Our ACO metric
20 frankly drove a wedge in our communities between
21 us and some of our hospitals. And I'm still --
22 we're still trying to figure out how to fix the

1 unintended harm that that caused.

2 But also alignment in terms of what
3 the CMS wants us to report on. I mean, obviously
4 realize I don't like meaningful use at all. If
5 they could make these things more streamline.

6 And I think you're hearing everybody
7 complain about this. That I've got multiple
8 things that I have to report on that don't align.
9 Some are helpful for us, some are frankly more
10 harm -- causing more harm than good. And I think
11 if CMS could do no more harm on some of these
12 issues.

13 The second issue which we talked
14 earlier, but didn't -- I haven't heard yet, was
15 that the Part A and B issues, and how those mess
16 up a lot of incentives in the rural area.
17 Whether it be the rural health centers totally be
18 written out of meaningful use, and it took us two
19 years to get the folks at CMS to understand the
20 consequences of that, and they wouldn't listen.
21 They were condescending. They would just say, oh
22 you don't know what you're talking about.

1 Finally after two years they said, oh, wow, that
2 is a problem. Yes.

3 The same thing with you know, the ACO
4 program, Ann and I are dealing with. Literally
5 that there's a structural flaw in the
6 calculations because of critical access hospitals
7 that might make us fail. Even if we really in
8 effect win, we might still lose anyway because of
9 a structural flaw.

10 And the third thing is, that to
11 continue to garner that input from us, because in
12 our perspective rurally, is that CMS drives
13 things to us that fits for the 90 percent and
14 doesn't fit for us. And they just don't listen
15 to us. And they're the masters of ultimate lip
16 service, but in the end, this is really a
17 critical flaw and they need to listen to it so
18 that we don't end up with three to four years of
19 trying to get it fixed.

20 So I like the fact that we've had the
21 opportunity to reply because most of us don't
22 have time to read the Federal Register and write

1 long-winded explanations because we're too busy.
2 And this is for me the best way to do it because
3 I just don't have time.

4 So this interchange I hope will
5 continue. Thank you.

6 MS. JOHNSON: Thank you Bob. Aaron?

7 DR. GARMAN: I want to thank you all.
8 This has been very, very enlightening. And as a
9 rural family practice plumber, I think that it
10 shows tremendous support across the nation for
11 rural healthcare.

12 I do --

13 CO-CHAIR MOSCOVICE: Can I ask you a
14 question?

15 DR. GARMAN: Yes.

16 CO-CHAIR MOSCOVICE: Do you really do
17 the plumbing?

18 DR. GARMAN: Some. Some. What I can
19 manage I do. Yes, yes.

20 What's that? No, no, no. We actually
21 do have one plumber in the area. So if he's
22 available, he'll come over and do it. But

1 otherwise.

2 I do really appreciate the fact that
3 we are starting to address some sociodemographic
4 ideals around rural healthcare. And I do think
5 that rural healthcare does provide excellent
6 quality care. We just have to prove it.

7 And I think in -- if we can develop
8 measures that are reasonable to be able to prove
9 what we actually do, I think everybody is going
10 to be happy. And so I just hope that CMS comes
11 back and gives us a product that is reasonable
12 and useful and helpful for everyone.

13 Thank you.

14 MS. JOHNSON: Thank you. Bruce?

15 DR. LANDON: I sound like a broken
16 record a little bit. But I'll thank everybody as
17 well, but I'm not going to go into as much detail
18 because I think it's been very well said.

19 I guess I'll have a few things. So
20 the first thing is you know, it was a little bit
21 difficult at times figuring out what exactly the
22 charge to this Committee was in the following

1 way. So I think we heard a lot of instances
2 where current CMS policy and the way that they do
3 things is -- which often is suboptimal, really
4 doesn't work for particularly the tasks that we
5 have at hand.

6 So for instance, you know, the way
7 that the EHS are paid differently. The way that
8 billing in rural health centers and community
9 health centers is in the wrong place. And we
10 can't really do claims-based measurement on them.

11 And this you know, actually even feeds
12 back into the larger you know, issue at CMS.
13 Which is you know, at some point or another,
14 they're probably going to need to put together
15 Part A and Part B and have a single insurance
16 program. And you know, potentially as those
17 efforts progress, this is something that can be
18 addressed there.

19 However, I don't believe that it was
20 the purpose of this Committee to rewrite laws and
21 regulations. So it's kind of hard to do that as
22 far as I can tell. So we have to work within

1 sort of a narrow confine.

2 So I think you know, clearly there are
3 so many differences that have really been
4 expressed very well by the people who are
5 actually doing this type of medicine. And we've
6 heard lots of important things.

7 My viewpoint is you know, we have a
8 lot of challenges that we face for measuring
9 performance in these small practice settings.
10 And there's not a lot of answers. And you know,
11 so I tried to sort of think about you know, so
12 the issue now I think often is right now, you
13 know, rural providers are basically excluded from
14 a lot of these things.

15 So I think our job is to try to
16 facilitate a way or to make recommendations that
17 will at least give them a little bit of a runway
18 to potentially sort of make it attractive for
19 them to do certain things that will allow them to
20 actually start participating. So I think it's
21 really important that the recommendations really
22 take that tone in terms of being sort of urging

1 and giving incentives as opposed to penalties and
2 punishing them for not participating.

3 And I think if that's the tone that's
4 adopted, then you can make more far out
5 suggestions like you know, to the extent that
6 some of you guys can aggregate or work together,
7 that would be a good thing. But it has to be an
8 option not a you have to do it.

9 You know, I think that was stated
10 pretty clearly here. But certainly, if that is
11 one option, then some people might choose to do
12 it. And that could be a little bit of a runway.

13 Finally, I think the discussions
14 related to SDS and other types of adjustment are
15 really important. I think my -- I still believe
16 that a lot of this should for this area should be
17 the comparator groups and not necessarily
18 incorporating them.

19 But I think I very much agree with the
20 approach that NQF is taking, which is to tread
21 carefully in this area and do it in an empirical
22 data driven way. And with that I'll stop.

1 MS. JOHNSON: Thank you. Guy?

2 DR. NUKI: I think it's the last.

3 It's all been said. But first, I'd just thank
4 you very much. This is a very impressive group.
5 I'm pretty pleased to have been part of it. And
6 thanks for your listening and guidance and
7 leadership.

8 So I'm going to try say things that
9 weren't said. Because I just agreed you know, I
10 agreed with pretty much -- I had to cross things
11 off as you guys kept talking.

12 But, one is the MAP process and how
13 important it is. And I meant it when I said that
14 I'm terrified to think that the MAP will be put
15 together with a bunch of people who work in
16 Washington and you know, big cities, to come up
17 with these measures. I mean, I think we need
18 people that do that, as well involved, but you
19 really need some of us that work in rural areas.

20 The other thing I wanted to stress was
21 the technical assistance. That is so lacking in
22 rural communities that expertise in that time and

1 that energy to you know, figure out you know, how
2 are you going to manage the measures and how are
3 you going to collect the data and all of that. I
4 mean, just even the understanding of the system
5 is difficult enough. I mean, it's very
6 complicated. That's going to really be
7 important.

8 I just wanted to stress the peer
9 groups. I think one of the things hopefully you
10 heard was that rural areas can be very different
11 from one another and clumping them all together
12 is not a good idea. And we can't break them up
13 into a thousand different ones. But, trying to
14 do that.

15 And then the last thing that we didn't
16 -- I think that was maybe was just implied, we
17 didn't talk a lot about it. But the purpose of
18 these measures is not necessarily just to reward
19 people for doing a good job, I think the purpose
20 of these measures is to get people to change
21 their behavior so that they do a better job
22 taking care of patients.

1 And I think that that's going to be
2 very important to keep in mind as we put
3 together, as those measures are created and this
4 process goes forward. Because we could all
5 measure things that either A, we can't change or
6 aren't really that important to patients. And
7 none of that's going to be very useful.

8 Thank you.

9 MS. JOHNSON: Thanks. Greg?

10 DR. IRVINE: Am I last? You're going
11 to talk, good. I didn't want to be last.

12 No, I want to thank also like everyone
13 else has, the NQF for including us and bringing
14 together a diverse and interesting panel to
15 discuss these issues. It was a very brave for
16 them to put an orthoped on the panel. Probably a
17 mistake.

18 As the other frontier provider here
19 and as the only surgeon on the panel, I -- it
20 hopefully helped give a little bit different
21 perspective. My message is that critical access
22 hospitals at least in my world are critical to

1 their regions. That's why they're called that.

2 And my little hospital is absolutely
3 critical to where I live. They're also on the
4 edge. We struggle every day to keep the doors
5 open. To stay financially viable to continue to
6 give the care that we need to give. And we do
7 that by being innovative and having -- being all
8 on the same page to work.

9 And having the support of
10 organizations like the NQF and CMS are critical
11 to our ability to survive. Any measures that are
12 developed as a result of this meeting, as I've
13 said a hundred times, now a hundred and one, need
14 to be flexible and they need to be aligned. They
15 can't be one size fits all. We are so incredibly
16 different from one another. It would have to be
17 hopefully picked from a menu.

18 Pay-for-performance has to be revenue
19 positive. If we start taking money away from
20 critical access hospitals, we'll sink a whole
21 bunch of them. And no care is not an option.
22 And in frontier medicine, if our hospital goes

1 down, it means no care.

2 Quality sometimes means inventiveness.
3 We are kings and queens of inventiveness in
4 little hospitals because we have to be. You
5 can't easily put what we do into box diagrams.
6 We have to be nimble, we have to be quick, we
7 have to be inventive. And that needs to be
8 remembered in any quality measures that are
9 undertaken.

10 Before coming here I asked a number of
11 stakeholders in West Central Idaho what they want
12 -- what message they want sent to Washington.
13 Idaho's probably the most libertarian state in
14 the country. Our reputation is well deserved.
15 I'm probably the most moderate voice they could
16 have possibly sent.

17 In fact I looked at my little poll
18 that I took last night to remind myself what
19 messages they want sent. And number one on the
20 list was tell them back there to leave us the
21 hell alone.

22 Actually we've opted out of Medicaid

1 expansion, so you're getting a lot of the money
2 that we're not spending.

3 MS. JOHNSON: Okay. Ira or Kelly, I'm
4 not sure.

5 CO-CHAIR COURT: I'll go next. So a
6 couple of things. First ditto to everybody and
7 you get a group this size and there's really a
8 homogeneous group with a lot of diversity. And I
9 think everyone was very respectful and learned.
10 So, thank you for that. It made it easy to
11 facilitate.

12 Now we all after two days together
13 really understand rural and the challenges. But
14 whoever receives this report and what they're
15 going to do with it, need to understand it and
16 have the same context that we do. Or we'll
17 continue to do the same things we've always been
18 doing. So, I think we need to spend time on
19 making sure our recommendations are -- go forward
20 with context or they won't be understood
21 correctly.

22 I think we all want the same thing.

1 We want care in the rural setting because that's
2 access, but we want it to be good. One of the
3 things -- and our patients deserve that.

4 One of the things I get concerned
5 about though is -- and I understand the need for
6 pulling in other stakeholders and that is
7 important, but they don't always want that access
8 you know. Some of the solutions might be get rid
9 of those rural providers. And so I think the
10 multistakeholder process has to be done carefully
11 so that they have the same fire in their belly
12 that we have for let's do it, but let's do it
13 right. So that's got to be done carefully.

14 And we have to do this in a way that
15 we don't muck up, you know, that there continues
16 to be that real safety net because it is
17 important.

18 Also, I think we have to think about
19 the current way to get voice in the things
20 related to measures, getting on committees.
21 Responding to public comments, I don't think work
22 for rural providers. Because you got you know,

1 two docs and they're busy taking care of patients
2 and going to the hospital and going to the
3 nursing home. And there's not an administrative
4 person in the critical access hospital reading
5 the Federal Register.

6 So there might be an opportunity to
7 work with other rural partners to make sure the
8 voice -- just because there was public comment
9 doesn't mean that it actually got to the people
10 who need to comment. So, we might need to be
11 creative about that.

12 And then the last -- the last point is
13 an unfortunate part of my job is sometimes I get
14 to talk to the media. And I think there's -- and
15 it goes to the need for cross -- really good
16 cross-cutting measures because these will
17 eventually be used to perceive whether a
18 practice, a physician, a hospital, is a good
19 hospital, a good practitioner or a bad one. And
20 what I always coach the media on is they are good
21 at that measure. It doesn't mean they're a good
22 or a bad hospital.

1 So, making sure we have cross-cutting
2 measures that are a general reflection of the
3 overall care provided I think is important.
4 Because I can perceive these things are going to
5 get pulled into a one/five star rating at some
6 point. It will be used for tiered payment. You
7 know, maybe not by Medicare or Medicaid, but by
8 commercial insurers. So we need to make sure the
9 measures really reflect you know, overall what we
10 do.

11 CO-CHAIR MOSCOVICE: Well, I want to
12 thank everybody. You never know -- it's been a
13 pleasure working with Kelly, Karen and the other
14 NQF staff on this --- and you never quite know
15 when you're co-chairing a meeting like this if
16 we're going to be looking at each other about
17 half way into the meeting and going, oh, well
18 we've got eight more hours to fill up, how are we
19 going to do that?

20 And surprise, surprise, you weren't a
21 shy group. Which was -- everybody in the room
22 really had a chance and took advantage of that to

1 sort of say what was on their mind, which is the
2 whole purpose of this. It's not for any one
3 person to dominate this.

4 I've been doing work in this field for
5 about a decade now. And as you can tell, it's --
6 you need patience and it's tough slogging along
7 so to speak. And both of them in developing
8 measures and working with states to use measures
9 --- and with providers. And what I can honestly
10 say is that I think this is the most important
11 and best opportunity that we've had at the
12 federal level to try to see if we can have an
13 impact in this area.

14 And all I can say is it will be a high
15 priority for me to work with NQF, CMS and others
16 to make sure there really is a next step, that we
17 really do move into the MAP arena and hopefully
18 beyond that in terms of developing a set of
19 measures that are going to be well accepted by
20 everyone in terms of their relevance to rural and
21 their importance in terms of measuring
22 performance out there.

1 I do believe as I said earlier, that
2 I think NQF and CMS are more willing to listen
3 and -- to finally listen to folks out there in
4 rural environments and have their input to these
5 processes. So I'm impressed.

6 Helen's sincere in what she's doing.
7 And the rest of NQF. And it may be a bit harder
8 to feel that way about CMS, but I think they -- I
9 think Patrick Conway is going to be real helpful
10 in this process.

11 So I'm optimistic. I think we'll
12 probably be certainly communicating with each
13 other. I guess it's going to be at least
14 verbally once and people get a chance to look at
15 the report and provide their input and so forth.

16 And I just wanted to thank Karen and
17 the NQF staff because they really -- some of us
18 shared our thoughts with Karen last night and all
19 of a sudden we had 15 slides that we almost look
20 like we know what we're doing this morning. And
21 that's not easy to do. Because we're all
22 wondering what's going to happen this morning?

1 And she did a great job. So I really want to say
2 thanks to that.

3 And I look forward to communicating
4 with you. I also -- I got to say, I did wonder
5 what the heck an orthopedic surgeon was going to
6 do here? And you were great. And we had such
7 variation in this group.

8 You know, we had -- as someone said,
9 we had Harvard, we had psychiatrist-less Wyoming.
10 We had just -- we had a couple of regulars, but
11 it's been really refreshing and I learned a lot.
12 So it was a really great two days for me.

13 DR. BURSTIN: Can I add my thanks
14 particularly to Ira and Kelly for doing such a
15 great job of managing this. And you should know,
16 we actually intentionally picked this group to be
17 as diverse as it was. So we intentionally picked
18 an orthopedic surgeon.

19 So, thank you for applying Greg.
20 Because we knew those perspectives would be
21 incredibly different then the more usual
22 perspectives that we would hear from this field.

1 I also want to just offer Curt an
2 opportunity for any reflections. I mean the
3 reason this project is actually here is because
4 the Officer of Rural Health Policy went and asked
5 that it to be funded as part of our CMS contract.
6 So I wonder of Curt has any reflections?

7 DR. MUELLER: Three comments. Having
8 missed two thirds of the meeting, it's hard to
9 have gotten a whole perspective. But based on
10 the issues that you raised today as sort of a
11 summary and a wrap up from yesterday, I was very
12 pleased. In the office we sort of identified
13 issues that we'd like to see discussed. And they
14 pretty much were on track. You guys met our
15 expectations in that regard.

16 Secondly, I think I want to express
17 some concern that's already been expressed.
18 Ultimately what happens depends on whether CMS
19 looks at this report or puts it on a shelf. And
20 having seen some of the history that Sheila
21 referred to, the development -- the PQRS and the
22 work CMS has undertaken on the one hand, and

1 realizing that they have a fairly statutory
2 requirements on the other. I just -- I hope that
3 there is a transition for this that's sufficient
4 to keep that ramp well-constructed. I worry
5 about sometimes some of those things being out of
6 even CMS's control.

7 And finally, you know, one of the
8 reasons I'm glad Ira made the point about this
9 being an opportunity to be heard on this issue.
10 I think one of our standards of success for this
11 project was making sure that CMS heard from the
12 rural folks about the rural payment struggles.

13 You know, they've got a big job to do.
14 And you know, they have -- they first focus on
15 the urban areas. I understand that. They focus
16 on the big practices.

17 But time is ticking away and we don't
18 want to be left behind. We being rural
19 stakeholders and so forth. And if we can achieve
20 that with this report, we'll be quite happy. So,
21 thank you. It's been very good.

22 MS. JOHNSON: Thank you Curt. And I

1 think Marty is still on the phone. Marty, would
2 you like to say anything?

3 MR. RICE: Well thank you very much.
4 The only thing I can really say is wow. This
5 really turned out well. I agree with everything
6 Curt had to say. I also wanted to thank some
7 people that weren't mentioned that are kind of in
8 the sidelines, really helped us out in this
9 project.

10 One is Coretta Byrd from CMS, and she
11 is the Contract Officer Representative for this
12 contract. Jane Hammond with the Office of
13 Clinical Standards and Quality, and now I think
14 it's CCSQ. And Maria Durham.

15 They're the ones who approved this
16 project. And they saw worth in it. And we
17 really have to give a shout out to them too. And
18 everybody from HRSA.

19 Thank you all again. And thank you
20 for your time.

21 MS. JOHNSON: Thank you Marty. And I
22 guess it's my turn to say thank you to the

1 Committee. You guys have made this fun and very
2 much a learning experience for me as well.

3 As I told you before, it's dear to my
4 heart because that's you know, my roots are in
5 the rural area. So thank you for coming and for
6 being so friendly to me, the introvert of the
7 room. So, I do appreciate that very much.

8 So with that, I guess it's public
9 comment. So, Mitra I'll let you take that over.

10 MS. GHAZINOUR: Operator, would you
11 please open the lines for public comment.

12 OPERATOR: Yes ma'am. At this time if
13 you'd like to make a comment, please press star
14 then the number one.

15 There are no public comments at this
16 time.

17 MS. JOHNSON: Thank you so much. And
18 now we're going to end the day with Severa giving
19 us just a run through of what you can expect from
20 us from the next few days and months.

21 MS. CHAVEZ: Thanks Karen. So in
22 about two weeks NQF will put together a short

1 document of just a summary of the key themes from
2 the two-day meeting, along with the transcript,
3 the web recording link and the summary will be
4 posted on the NQF project page along their share
5 point page.

6 But we'll send you an email to let you
7 know that they are up there. Yes, a transcript,
8 word for word.

9 I hope you all have our March 19 web
10 meeting on your calendar. It's in the afternoon,
11 1:00 to 3:00 p.m. A few days before that we hope
12 to send you the draft report so you have time to
13 read it and we'll have a very robust discussion
14 of it during the call.

15 And then between March 19 and April 15
16 we'll be revising, tweaking the report based on
17 your comments. April 15 is when the draft is due
18 to HHS.

19 And sometime between June and July
20 we'll have the draft report open for public
21 comment. A 30-day period. And these comments
22 will be added to the final report that will be

1 submitted to HHS September 14. And again, of
2 course, you'll get a copy of that.

3 So thank you all for coming and safe
4 travels.

5 DR. BURSTIN: More a point to pick up
6 on Kelly's comments. When this goes out for
7 public comment, you should feel free to send it
8 to your networks as well.

9 Again, they may not be people who
10 would necessarily see it when we post it for
11 comment. So, we would welcome you sharing it
12 broadly and feel free to submit comments or have
13 others submit comments from that wider breadth.
14 Yes, Brock?

15 MR. SLABACH: A quick question on
16 that. After today's meeting, is it okay to like
17 blog or have a report on this in terms of public
18 reference?

19 DR. BURSTIN: Everything NQF does is
20 fully transparent, so absolutely. I mean, don't
21 attribute a recommendation obviously of this
22 group yet. I think you're still storming and

1 norming a bit. But you know, reflecting on it is
2 perfectly fine.

3 MS. JOHNSON: Thanks so much and bye.

4 (Whereupon, the above-entitled matter
5 went off the record at 1:13 p.m.)

A			
\$100.00 155:19 156:15	account 47:4 75:7	15:14 27:7 100:22	192:17 205:14
\$20 131:22	accountability 135:12	101:11 114:8 115:10	aligning 72:12 73:5
\$3,000.00 155:18	accountable 19:12	118:16 126:13 130:18	84:1,5
\$30 131:22	108:22	130:19 148:11 151:15	alignment 8:19 26:1
\$46 106:5	accrediting 84:2	184:4 201:14	45:11,12,17 53:8,15
\$8 106:22 107:20,21	accuracy 89:14 97:1	adjustments 118:12	71:6,11,18 73:11,16
\$8,000.00 156:17	achieve 48:9,13 215:19	124:14	74:1 78:9 84:13 87:8
a.m 1:10 4:2 113:18,18	achieved 137:3	administered 191:17	161:4 162:14,17
177:10	achieves 32:17	Administration 2:19,20	178:20 185:20 187:20
A1C 94:22	acknowledge 44:22	2:21	188:5 189:22 190:4,7
Aaron 1:18 39:17 45:6	acknowledges 149:9	administrative 11:21	191:10 192:10 194:12
130:15 133:7 197:6	ACO 2:6 46:19,22 47:17	209:3	194:13 195:2
ABDELLA 1:13 55:19	72:21 109:21 111:4	administrator 137:20	alignments 161:8
77:6 175:14	125:12 145:5 147:4	adopt 56:4	192:12
abilities 106:8,8	148:3 194:19 196:3	adopted 201:4	all-payer 112:8
ability 121:5 136:14	ACOs 46:18	adopting 120:13	allergy 40:2
205:11	acquired 124:5	advance 166:20	alleviate 183:14
able 34:9 40:11 48:2	acronym 69:12	advanced 12:21 22:17	Alliant 2:5
51:10 65:15,17 77:8	act 148:16	72:6 87:5	allow 57:9 65:16 108:14
79:15 105:17 112:11	acting 60:1	advantage 168:13	200:19
118:21 119:2 122:12	actionable 30:15	210:22	allowance 65:3
125:9 140:14 141:6	169:17	adverse 90:12	allowed 28:13
141:10 149:9 160:15	actions 169:10	advise 25:5	allowing 28:6
168:13,19 176:6	activities 64:5	advocating 17:1 175:19	allows 109:1
198:8	activity 64:19	Affairs 127:16	alluding 33:17
above-entitled 177:9	actual 126:12 127:7	affectionately 158:2	alternative 108:10
220:4	acute 84:20 101:22	afford 48:19 136:9	alternatives 91:12
absolute 188:15	add 5:2 31:16 34:5	African 126:4 127:19	Alzheimer's 90:4
absolutely 75:15 135:3	35:22 57:18 75:13	137:21	ambulatory 71:14
205:2 219:20	92:20 93:5 108:18	afternoon 4:11 16:1	American 2:7 137:22
abstracted 79:1	126:22 140:19 213:13	27:9 218:10	Americans 126:4
abstraction 79:7	add-on 13:10	age 140:22 146:21	AmeriHealth 1:15 84:3
ACA 192:6	added 127:17 143:9	agencies 159:12	amount 25:16 121:9
academic 76:19 144:3	147:10 218:22	agenda 4:18 5:9 6:1	190:6
academics 125:17	adding 31:17 124:18,22	aggregate 201:6	amplified 129:18
accept 148:20 163:13	127:12	aggregation 112:14	analogies 169:20
accepted 17:3 18:21	addition 83:5 163:6	ago 15:2 21:15 59:12	analogous 159:2
19:1 173:21 211:19	additional 3:5,9 4:17	76:21 95:17 127:17	analysis 28:1 160:15
accepting 118:10	52:3 108:4 113:10	128:21	analyst 2:14 160:14
access 20:18 22:18	144:9 191:22	agree 7:15 16:16 23:2	analytic 160:19
30:18 79:17 86:14,20	additive 127:12	24:4,4 33:7 38:8	anecdotal 109:11,13
91:11,17 105:4,8	address 11:7 29:22	46:20 52:10 67:18	Ann 1:13 46:17 53:19
107:6 108:14 109:6	30:6,16 34:3 112:12	103:17 151:10 180:21	55:18 77:5 89:19
110:20,22 111:16	113:3 130:8 198:3	182:5 183:16 187:19	109:5 175:13 177:18
112:22 122:21,22	addressed 13:6 199:18	201:19 216:5	196:4
136:7,15,19 137:14	adequacy 52:16 53:1	agreed 202:9,10	Ann's 83:7
139:2 143:21 144:15	adequate 54:20,20	agreement 25:4 27:13	annual 20:7 154:20
155:21 160:10,12,17	adherence 164:13	40:16	answer 14:18 47:16
170:13 178:16 182:21	Adjourn 3:20	Ah 7:18 66:19	48:2 66:16 74:13
182:21 185:1 193:4	adjudication 16:13	ahead 177:13 182:6	111:21 132:10 176:5
196:6 204:21 205:20	adjust 11:14,19 114:14	AHRQ 11:5 162:10,12	answers 15:19 200:10
208:2,7 209:4	114:14,22 118:4	aim 30:6 32:17	antibiotic 19:11,19 36:2
accomplish 30:14	123:9 129:22 140:13	Airport 157:12	54:19
77:14 105:22	adjusted 116:15,18	Alcohol 86:11	antibiotics 36:4
accomplished 39:14	118:15,22 119:1	ALEMU 2:18	anybody 9:5 42:22
174:8	130:1,5 140:18 141:5	align 161:5,22 162:3	98:10 124:20 142:8
accord 19:5	141:10 179:1	195:8	165:15,18
	adjustment 11:16,17	aligned 71:16 162:2	anymore 22:9 141:1

anyway 19:20 47:19
 129:8 151:20 196:8
apart 47:15
apologize 85:19
Appalachian 154:3
apparently 110:10
appeared 9:1
applicable 9:11,16 10:3
 175:2
application 17:14
 105:11 158:1
applications 138:1
apply 77:16 100:1,5,13
 184:20
applying 50:15 77:13
 213:19
appreciate 181:14
 183:12 185:10,14
 188:14 198:2 217:7
approach 22:21 37:21
 43:13,13 49:11,12
 57:7 179:19,20
 201:20
approaches 17:21
 49:17
appropriate 13:1,15,17
 16:12 33:20 36:4 44:2
 60:16 118:5,6 140:8
 144:8 158:16 160:4
appropriately 50:22
 60:4 149:14 168:21
 170:9
appropriateness 87:8
 89:12 112:15
approved 216:15
April 218:15,17
area 68:18 70:7 87:6
 91:21 98:2 109:2
 133:21 137:4 138:9
 143:20,22 159:3
 195:16 197:21 201:16
 201:21 211:13 217:5
areas 8:6 14:4 27:20
 30:16 81:17 90:3 91:3
 92:9,15 93:1,18 94:15
 96:3 97:19 99:13
 104:5 136:2 137:5
 161:19 182:19 187:13
 188:13,13 202:19
 203:10 215:15
arena 18:13 211:17
arguably 128:9
argue 125:11
argument 24:10
Arizona 107:9
arrogance 128:16
art 44:16 95:20
article 127:16

Asians 126:3
asked 16:9 145:8 152:3
 156:8 206:10 214:4
asking 79:20 166:6
 169:15
aspect 61:8 188:20
aspects 79:13 86:11
 184:10
assessed 149:14
assessment 18:3 20:5
assigned 123:20
assistance 51:10 57:19
 71:16 113:4 183:9
 202:21
Associate 1:16 2:8
associated 114:20
 161:18
association 2:11 24:17
 117:5
Association's 182:4
assume 71:20 98:5
 146:12 148:6
assuming 51:7,12
attend 63:2
attending 123:19
attention 82:13 133:15
attitude 149:12 156:1
attractive 200:18
attribute 219:21
attributed 102:22
audible 9:7 29:14 36:10
audience 181:13
augment 44:4
August 114:10
availability 30:7 55:22
 99:16 120:12 133:20
 154:2
available 11:20 25:8
 33:9 119:22 134:6,17
 143:3 169:8 197:22
average 131:13,15,21
avoid 31:20 72:10
 123:1
aware 22:16 63:3,7,8
 64:11 154:13 182:18
awareness 104:1
awfully 57:21

B

b 34:12 113:1 195:15
 199:15
babies 138:5,7
back 4:4 5:17 23:4 26:1
 28:3 39:11,12 42:19
 43:19 48:6,14 54:3,6
 60:8 62:20 67:10
 70:11,21 78:7 79:4
 83:7,22 91:14 102:12

113:9,12 116:1,10
 123:1,17 128:11
 136:12 137:15 147:1
 155:8 170:22 171:13
 177:6 181:5 198:11
 199:12 206:20
background 114:16
 129:2
backgrounds 142:16
backs 83:16
backwater 181:17
bad 47:21 62:3 99:3
 209:19,22
BAER 1:14 45:20 62:20
 63:13 64:11 83:22
 157:10 190:18
balance 32:14 33:2
balanced 32:7
ballpark 76:9
bandwagon 194:12
bar 37:14
Barbara 21:14 22:19
barrier 95:4,8
bars 162:6
BARTHOLOMEW 1:15
 20:11 25:13 70:8
 93:22 105:20 135:21
 185:4,9
base 44:2 65:14 187:6
based 15:10,15 30:5
 97:21 159:18 214:9
 218:16
basic 131:9
basically 21:15 64:4
 100:4 135:6 152:18
 200:13
basis 116:20
battling 48:18
becoming 31:5 189:3
bed 94:8
beginning 23:7 103:17
 152:12 162:19 174:17
behavior 130:3 203:21
behaviors 103:8
behold 55:9
behooves 184:18
belabor 177:6
believe 41:7 74:11
 77:22 78:11 101:12
 101:16 139:20 148:16
 148:17,18 149:13
 171:18 177:7 186:13
 189:1 199:19 201:15
 212:1
belly 208:11
belong 133:9
benchmarking 66:5
benefit 50:12 70:3

72:17
Benzik 21:22
best 72:12 197:2
 211:11
better 19:17,19 26:18
 26:19 55:1 72:18
 84:13 98:1,9,11 99:11
 100:9 125:10 128:18
 131:2 133:14 146:19
 153:14 162:1 203:21
beyond 9:11 38:6 54:7
 55:7 76:14 109:20
 211:18
big 29:8 83:15 117:20
 127:22 139:6 143:20
 144:3 164:9 165:11
 187:2 202:16 215:13
 215:16
bigger 52:22,22 53:16
 135:8 136:13 177:2
 182:16
biggest 83:9 107:13
bill 156:16
billing 199:8
Biostatistician 2:8
bit 4:7 5:1 7:16 16:16
 30:4 32:10 34:22 39:4
 39:22 41:15 57:3
 63:21 66:10 68:10
 70:2 72:1 80:20 82:10
 84:6 86:7 88:6 100:16
 108:7,8 112:13,18,21
 113:4 114:16 120:20
 156:21 157:21 171:4
 174:6 178:9 191:20
 198:16,20 200:17
 201:12 204:20 212:7
 220:1
BJC 121:22
blank 179:6
blanket 116:15
blew 129:6
blood 219:17
blog 9:22 32:19
bloodstream 28:22
 29:2
blowing 135:7
Blue 15:9 18:18
Blues 15:10
BlueWater 2:4
board 12:5 80:21 100:9
 117:22 118:5
boarded 122:17
boat 72:12
Bob 9:17 14:13 18:14
 21:5 30:21 31:22
 46:14 52:11 70:21
 71:21 83:3 91:21

95:10 97:14 106:14
 109:5 110:19 123:16
 124:8 142:21 144:19
 145:1 193:19 197:6
bodies 71:8 84:2
body 157:18
boil 22:18
bones 5:1 157:21
bonus 47:11 52:1 78:9
 78:13
bonuses 189:21
bouncing 123:1
box 206:5
Boy 193:1
brave 204:15
breadth 194:1 219:13
break 3:7 6:9 102:13
 113:12 129:19,20
 135:22 203:12
breaks 133:11
breast/cervical/colon
 19:6
bridge 132:14
brief 48:5
briefly 44:12 53:6
bring 20:5 52:13 66:15
 148:9 158:13 165:19
 170:19 181:11
bringing 81:13 204:13
broad 9:10 10:12 21:12
 21:20 32:21 115:21
broad-based 89:19
broaden 136:16
broader 8:7 9:15 27:8
 35:19 86:15 97:5
 134:13 170:16 179:4
broadly 9:16 10:3 89:1
 219:12
Brock 2:10 16:8 23:1
 24:14 25:14 36:13
 38:12 51:1 52:11
 57:19 59:6,10 73:15
 75:20 77:19 99:7
 101:13 104:19 105:20
 108:17 135:20 136:20
 138:16 148:6 151:9
 153:10 163:11 164:16
 167:10 168:11 181:20
 189:11 219:14
Brock's 80:16 159:4
broken 135:22 198:15
brought 11:4 26:6,15
 28:2 54:16 112:14
Bruce 2:1 17:9 18:11
 22:14 68:21 70:9
 71:20 97:15 99:7
 106:18 119:5 120:8
 142:21 148:6 198:14

Bruce's 83:22
BSE 2:9
BSN 2:2
bucket 77:11
buckets 194:11
budget 48:18 78:12,15
 189:14,15 191:21
build 20:6 58:11,19
 64:4 190:13
building 169:14
built 57:6 157:11
bullet 16:5 34:3 67:8
 74:1 91:7 95:12
bullets 30:1 75:2
bunch 65:20 150:16
 202:15 205:21
burden 39:11 84:18,21
 85:1,5,8,13 175:9
BURSTIN 2:13 13:10
 88:11 93:5 97:4,13
 114:3 117:9 121:8
 126:22 131:4 132:9
 135:3 140:6 141:17
 141:20 142:1,17
 146:14 157:17 163:21
 165:9 169:6 170:6
 213:13 219:5,19
busy 197:1 209:1
busywork 65:20
buy 49:1 123:4 143:22
buzz 7:11
bye 220:3
Byrd 216:10

C

cacophonous 161:6
CAH 52:4 69:7
CAH/non-CAH 69:5
CAHPS 26:10 108:10
 121:1
CAHs 28:14 43:8 50:7
 58:9 77:16 81:20 82:3
 150:7,7
calculated 79:3
calculations 196:6
calendar 218:10
California 107:8
call 55:11 59:11 62:3
 111:8 114:15 137:10
 145:19,20,20 147:13
 170:8 218:14
call-in 12:13
called 33:21 34:12
 115:16 116:20 120:4
 157:18 158:1 205:1
calling 64:2
cancer 19:5 20:21 90:9
 90:10 96:12

capability 66:8
capable 69:16 136:22
capacity 66:7
capture 19:21 50:12
 79:13 125:6
captured 5:20 79:3
 184:16
captures 15:14 20:15
capturing 21:2
card 22:8 45:7 107:6
 168:13
cardiology 87:16
cards 56:13
care 2:1 4:18 17:8
 19:17,18,21 20:15,18
 20:21,22 23:6 30:18
 38:3 54:18 56:15
 71:14 79:14,16 86:17
 86:20 87:15,18 89:4
 89:10 90:8,14 91:9,11
 94:2 96:13,14 97:18
 98:1 99:11,17 103:4
 104:21,22 105:4,15
 105:21 106:1,10
 107:7,18,22 108:22
 109:2,3,7,9,17,20
 116:5 127:7 128:15
 134:3,5,5 144:7
 147:15 152:19,21
 158:21 176:10 180:16
 188:16 190:22 191:2
 191:16 193:8,10
 198:6 203:22 205:6
 205:21 206:1 208:1
 209:1 210:3
careful 47:20 70:22
 128:5 184:10,19
carefully 5:19 26:12
 91:16 201:21 208:10
 208:13
caregivers 90:8
Caritas 1:15 84:4
CART 108:11
carve 191:15
case 27:22 37:12 109:9
 147:14
case-volume 8:9 9:9,14
 26:5 27:10
catch 181:11
category 12:22 55:15
 78:8
catheter 124:1,3,7
Caucasians 126:3
cause 40:2 124:1,6
 142:14,18 167:7
caused 72:20,22 195:1
causes 31:18
causing 195:10

caution 95:13
cautionary 181:2
cautious 55:16 103:11
caveats 118:4
cc 83:17
CCSQ 216:14
CDC 159:14 161:12
CDS 67:2
cells 141:21
census 122:13 135:5
 137:16
center 1:17,18 94:12
 132:12,17 144:3
 150:7 187:9
centered 17:18 174:22
centers 28:15 50:8 55:9
 195:17 199:8,9
central 10:8 15:22
 23:13 117:4 123:22
 132:8 154:2 206:11
CEO 121:22
CEOs 14:5
certain 16:22 37:1 44:7
 64:5 138:1 200:19
certainly 11:8 16:22
 33:22 42:19 68:11
 77:3 83:19 86:6,19
 90:21 121:10 139:11
 163:3 164:1,6 165:21
 169:20 178:7 201:10
 212:12
certification 21:8,12
 22:9 25:6
certified 16:21 25:17,20
 94:6
certify 22:5
certifying 17:21
cetera 30:3 71:8 92:22
 92:22 118:1 141:16
 159:14
chaired 128:13
Chairs 63:5
challenge 95:8 111:21
challenged 70:5,7
 137:11
challenges 3:5 8:7,7
 87:4 143:15 200:8
 207:13
chance 58:21 162:1
 165:2 177:14 210:22
 212:14
change 143:12 148:22
 155:20 174:4 203:20
 204:5
changed 6:1 73:3
changes 37:9 132:21
changing 155:9
characteristic 36:22

121:16
characteristics 135:1
charge 34:7 42:17
 198:22
chart 78:22 79:7 108:17
chart-abstraction-type
 79:11
Chautauqua 1:13
CHAVEZ 2:14 217:21
CHCs 43:8
cherry 145:7 148:4
Chief 2:4,13
choose 50:20 57:9 65:4
 65:18 184:19 201:11
choosing 87:8
chose 98:21
chronic 20:22 89:7
 101:18,20 102:9
circumstances 100:12
 124:6
circumvent 29:10
cities 202:16
City 136:10
claims 79:3 108:14
 109:19 111:11 121:10
 121:12 125:5,7
claims-based 199:10
clarification 79:10
clarify 10:6,11 77:6
clarifying 97:17
class 150:11
classification 186:15
classifications 120:14
clear 9:14 51:17 61:7
 66:9 78:10 103:19
clearly 19:4 45:18
 91:20 115:3 131:6
 200:2 201:10
clinic 1:16,19 14:3 47:2
 47:5,9,22 54:18 65:13
 70:16 94:7 106:20
 107:17 129:14 130:8
 153:13
clinic's 47:12
clinical 20:14 21:2
 23:13 47:1 85:3 94:18
 127:5 133:8 143:8
 180:13 192:22 193:7
 216:13
clinically 118:14 119:1
 125:1 140:18
clinician 28:4 158:20
 188:12
clinicians 118:1 127:3
 152:17 181:16
clinics 15:11 27:14
 28:14 50:7 72:16
 105:3,9 106:6 109:15

129:12 175:6 180:13
 183:6
close 40:6 52:19 110:4
 143:6 193:4
closed 52:21 138:4
closely 164:5,7
closer 109:16
closures 182:7
clump 131:17
clumping 203:11
CMMI 110:8
CMS 12:14 16:6 39:19
 42:19 46:6 49:6 58:7
 58:17 59:14,17,22
 60:9,11,14 61:2 62:22
 63:6 64:18 76:6 78:21
 79:14 81:9,20 83:6
 105:2 157:22 159:13
 159:19,20 162:11
 163:2,4,13 164:19
 165:17 166:21 169:21
 181:9 188:7,18
 190:13 194:3 195:3
 195:11,19 196:12
 198:10 199:2,12
 205:10 211:15 212:2
 212:8 214:5,18,22
 215:11 216:10
CMS's 215:6
CNM 2:7,7
Co-Chair 1:12,13 5:11
 6:3,7 7:5 8:5 9:8 10:9
 10:12 12:1,8 13:3
 14:13 15:21 16:4,8,15
 18:9 20:10 21:5 22:22
 23:14 24:2,14 25:12
 26:4 27:16,19 29:12
 29:15 31:22 33:4 34:2
 35:2,7,16 36:9,11
 37:18,19 38:11 39:2
 39:16 41:10 42:12
 43:3,6,16 45:6,16
 46:14 48:4 49:9 51:1
 52:9 53:18 55:18
 56:22 59:1 60:7,19,21
 60:22 61:12,16,18
 62:10,13 63:9,19
 64:17 65:22 67:17
 68:1,9,15,19,21 69:10
 69:16,20,22 70:6 71:4
 73:14,20 74:11,15,20
 75:15,22 76:12,16,20
 77:12 78:18 79:21
 81:1 82:2,6,9 83:1,19
 84:14,15 85:16 86:2,5
 87:22 88:4,9 90:20
 91:6,19 92:5 93:20
 95:9 96:9 97:14 98:14

99:6 101:13 102:11
 102:19 103:13 104:19
 105:19 106:13 108:3
 110:1,13 111:10,13
 112:10 123:15 124:8
 128:2 130:14 132:3
 132:16 133:3,16
 134:18 135:19 136:20
 138:15,16 139:5,9,12
 139:14 141:13,19,22
 142:13,20 144:11,18
 144:20 145:1 146:11
 146:22 148:5 149:15
 151:9 152:16 153:18
 154:16 156:4 157:6,8
 157:13 163:10,12
 164:16 167:5 168:22
 169:22 170:21 185:7
 197:13,16 207:5
 210:11
co-chairing 210:15
co-chairs 1:10 4:12
 114:12
co-production 128:15
coach 16:6 209:20
Coal 1:18
coauthor 114:11
codes 64:13 105:5
cognition 143:4
cohesiveness 98:8
cohorts 183:17,19
collaboration 72:3
 194:13
colleagues 143:1
 144:13 168:20 181:16
collect 27:3 30:8 39:5
 56:1 77:9 79:20 85:5
 106:12 203:3
collected 71:10 123:12
collecting 95:4 189:10
collection 12:7 39:7
 45:2 49:4 84:17 85:7
 85:13 108:11 137:2
 186:14,18
collects 133:10
College 2:7
colonoscopy 155:19,22
Colorado 136:10
combination 168:19
combine 37:17
come 27:13,17 28:3
 30:22 31:12 38:8 40:6
 43:18 44:1 56:20 80:6
 84:21 90:16 93:21
 94:20,21 96:19 113:9
 113:12 118:11 119:19
 121:7 133:19 136:1
 138:13 155:1,3 156:9

169:8 171:13 174:9
 174:21 177:6 188:14
 188:18,22 193:11
 194:6,9 197:22
 202:16
comes 39:13 48:10
 49:6 70:7 85:1 94:17
 110:2 173:2 198:10
comfort 13:18
comfortable 12:18
 60:15
comforting 176:1
coming 4:4 74:21 90:2
 91:14 95:3 124:3
 135:15 146:5 173:19
 206:10 217:5 219:3
comment 3:16 28:18
 30:12 44:12 62:21
 80:16 83:7 84:1 85:17
 99:9,19 101:14
 104:21 105:2 106:14
 117:8 119:5,6 121:6
 171:4 172:5 178:2
 185:15 209:8,10
 217:9,11,13 218:21
 219:7,11
comments 9:5 10:4
 16:3 27:10,11 28:16
 41:11 43:17 46:16
 48:6 54:6 66:18 71:4
 71:19 81:10 91:1
 93:22 102:16 103:14
 110:14 139:14 143:1
 150:6 153:19 157:9
 167:22 169:1 170:22
 208:21 214:7 217:15
 218:17,21 219:6,12
 219:13
commercial 44:14
 53:14 84:7 101:9
 111:14 191:3 210:8
Commission 2:9
 178:15
commitments 183:8
committee 1:4,9 4:5,12
 34:7 97:8 100:10
 119:9 128:21 160:2
 198:22 199:20 217:1
committees 208:20
common 91:12
communicating 212:12
 213:3
communities 14:19
 24:22 36:20 53:17
 64:4 71:2 73:1 89:4
 96:15 104:2 105:18
 122:4 132:13 135:16
 136:17 181:16 182:8

182:13 185:2 188:15
 188:17 194:20 202:22
community 1:18 10:15
 10:19 28:15 50:4,12
 50:19 65:19 73:7,12
 86:17,17 88:20 89:2
 98:8 101:19 102:6
 104:7 109:15 115:3
 119:21 120:5 121:17
 122:15,20 125:9
 134:12 136:3 146:10
 146:10 151:1,6 156:9
 169:18 182:9 184:15
 184:22 189:5 199:8
comorbidities 192:4
company 19:22 39:22
 191:1,2
comparability 30:13
comparable 138:2
comparator 144:8
 201:17
comparators 148:10
compare 32:15 37:10
 68:2 81:3 102:5 144:1
 156:13 188:21 190:1
compared 32:22 67:12
 69:9 70:13,14 107:21
 133:2 142:15 143:18
 146:1 148:19
comparing 118:13
 150:6 183:17
comparison 67:14 68:3
comparisons 66:5 67:9
 68:6 135:18
compete 72:9
competing 72:8
competition 52:20 72:3
 73:4
complain 195:7
complete 17:15 25:4
 34:9 106:4
completed 60:3
completely 5:5 23:2
 34:16 53:22 58:10
 92:19 151:11
complex 66:20
complexities 144:5
complexity 37:12
 140:21
compliance 129:1
 150:15
compliant 152:5
complicated 123:5
 126:11 203:6
complications 32:12
 48:10 123:22
comply 153:1 186:1
component 57:14

concept 32:6 45:21
 77:13 85:20 108:7
 128:15
concepts 77:16
conceptual 116:20
 117:6 166:5
conceptualize 8:2
 149:21
conceptually 123:8
concern 115:5,9 127:6
 179:18 188:1 214:17
concerned 156:11
 182:17 208:4
concerns 67:21 89:15
 89:17 102:19 158:17
 183:15 191:5
concomitant 182:8
concrete 113:5
condescending 195:21
condition 9:16 85:3
 89:8
condition-specific 9:12
 9:13
conditions 26:21 89:8
 101:18 102:10 161:18
conference 1:9 152:2
 181:6
confine 200:1
conflicting 126:10
confused 23:15 41:15
 80:15
consensus 5:17 9:2
consequence 96:1
consequences 13:19
 36:2,8 47:22 49:19
 52:8 72:21 96:8
 151:14 152:12 184:21
 195:20
consider 10:14,21 27:6
 33:10 70:21 87:7
 94:14 97:7 98:3
 100:21 115:9 163:5
 178:15,19
consideration 59:17
 62:5 85:9 88:6 158:12
 163:18 164:21 165:3
 165:16 166:12,18,22
 175:9
considerations 36:7
 60:12 132:13
considered 28:20 60:5
 62:8 91:18 105:12
 139:4 179:2
considering 179:6
consigning 181:15
constantly 48:8,18
constraints 24:11 59:4
construction 26:6

Consultant 2:6
contacting 22:2
CONTENTS 3:1
context 12:2,11 26:13
 28:1 33:8,16 34:6,19
 35:19 59:7 78:16
 109:21 137:17 207:16
 207:20
contingent 47:12
continually 187:10
continue 196:11 197:5
 205:5 207:17
continues 208:15
continuing 164:18
continuous 26:15
 73:17 186:14
contract 163:1,6 214:5
 216:11,12
contracted 146:5
contradictory 111:2
contrarian 31:2
contrast 178:14
contribute 104:7
contributes 103:5
control 10:1,1 20:2
 26:22 32:20 38:1,10
 54:7,13 55:8 103:10
 104:6,6 143:17 147:5
 151:3 152:22 215:6
controlled 96:6
controversial 142:4
convene 158:1
convening 119:9
conversation 12:12
 14:12 38:3 43:11 51:5
 51:20 53:22 57:21
 59:20 61:22 68:17
 77:21 92:2 101:17
 105:10 112:15 151:11
 174:15 186:12
conversations 12:15
 92:4 114:5 186:8
convince 107:12
 168:20
Conway 181:6,12 212:9
cooperation 72:15
 73:18
Cooperative 2:10
coordinating 160:1
coordination 38:4
 56:15 79:13 104:22
 105:5,16,21 106:2,10
 109:7
coordinator 107:7,18
 160:9
coordinators 147:15
copy 219:2
core 22:17 23:5,12

45:12 74:16 75:14,18
 80:7 82:15 85:21 92:3
 93:13 104:2 106:16
 166:19 190:10
Coretta 216:10
corporately 14:9
corpus 51:5
correct 31:4 48:11
 82:16 97:8 124:11
 164:19 166:15
correction 101:22
 125:19
correctly 5:20 16:7
 207:21
correlate 21:11 77:20
cost 32:12 67:5 86:21
 95:7 96:19 108:12
 109:8 112:22 117:21
 125:16,19
cost-based 52:3,4
costly 22:12
costs 90:1 94:17
 100:16
couch 28:3
council 162:12
count 99:14
counted 23:20 152:8
country 1:18 110:22
 133:22 139:13 154:3
 165:6 175:18 176:11
 206:14
county 1:14 104:13
 123:20 124:2 134:1
couple 7:15 29:4 51:6
 55:9 75:2 80:2 87:9
 108:4 114:5 140:11
 144:15 150:6 157:19
 161:17 165:9 168:1
 169:15 172:12,12
 174:19 175:14 186:11
 207:6 213:10
course 64:9 138:12
 194:7 219:2
Court 1:10,12 5:11 6:3
 6:7 16:4 35:2,7 37:19
 60:21 75:22 76:12,16
 84:15 91:6 98:14
 102:19 111:10,13
 138:16 139:12 144:20
 154:16 163:12 169:22
 185:7 207:5
cover 32:6 145:12
coverage 101:3 192:8
covering 187:3
CPT 64:13
crazy 32:4
create 40:1 74:4 108:5
 130:2,11 131:3,19

140:2
created 17:12 204:3
creates 85:5 96:7
 112:18
creating 40:9 63:1
creation 112:1
creative 122:18 209:11
credit 162:9
criteria 22:11 29:17
 35:8 39:21 42:6 51:8
 60:14
critical 105:3,8 139:2
 144:15 151:13 160:10
 160:11,17 170:12
 178:16 193:4 196:6
 196:17 204:21,22
 205:3,10,20 209:4
critically 105:16
criticisms 32:16
criticizing 21:15
cross 15:9 139:12
 175:7 181:10 202:10
 209:15
cross-cutting 209:16
 210:1
Crowley 128:20
crucial 190:5
crux 140:7
CTSA 120:15
cultural 15:15 91:13
 154:12
culture 11:5 74:6
cumbersome 22:12
 32:3,4
curiosity 154:1
curious 80:7 154:14
current 159:15,19
 199:2 208:19
currently 158:9,18
 160:11
Curt 2:19 7:19,21 214:1
 214:6 215:22 216:6
curve 56:19
cute 92:1
cycle 57:13

D

D.C 1:10
danger 36:7
data 2:4 11:20,21 12:6
 15:9 16:22 19:21
 27:14 30:7,7 38:16,19
 45:2 49:4,7 55:22,22
 56:6,19 71:9 79:15,20
 81:11 82:2 84:17 85:7
 85:13 98:10 103:3
 108:10,15,20 109:1
 109:19,20 110:8,9,20

111:1,17,18,20,22
 112:7 116:22 120:18
 121:9 122:13 123:10
 125:14,16 133:11,13
 137:2 143:2 144:5,9
 148:20 154:1,11
 184:3 186:14,16,18
 201:22 203:3
database 111:11
date 115:13
daughter 107:8
daunted 25:6
Dave 128:12
David 150:20
day 3:2 4:4 5:9 56:1
 104:8 112:12 113:9
 140:7,22 146:21
 149:3 172:12 205:4
 217:18
days 19:20 20:20 29:3
 51:6 89:20,21 114:5
 114:19 117:15 132:10
 157:19 169:15 172:12
 174:14 181:22 188:11
 207:12 213:12 217:20
 218:11
deal 33:22 34:13 56:11
 73:19 89:9 90:13
 138:10 162:13 186:7
dealing 66:3 189:4
 196:4
dear 217:3
dearth 102:3
death 99:1
debate 38:5 139:16
 140:7 147:9
debating 63:1
decade 58:15 211:5
decent 90:22
decide 47:3
decided 4:9 46:22
 50:18 118:2,5 140:10
 154:20
decision 92:16
decline 182:8
deductible 94:19 101:8
 155:16 156:17
deductibles 156:3
Deere's 155:10,11
default 33:15
deficit 105:8
define 71:3
defines 137:7
definitely 43:12 170:8
 178:6
definition 77:10 150:20
definitional 115:15
definitions 137:11

definitive 66:16
Delaware 187:4
deliberate 164:22
deliberation 153:21
deliberations 157:16
delivered 193:9
delivering 138:6 191:19
delivers 164:20
delivery 138:5 187:13
 192:1
demographic 11:17
 133:11
demographics 71:1
denominator 28:22
 29:2
denominators 29:8
 85:4
density 133:22
Denver 136:10
department 138:6,8
 152:13
dependent 23:19 24:13
 57:11 59:21
depends 214:18
deserve 181:17 208:3
deserved 206:14
design 40:6 57:4 58:8
 66:3
designation 136:21
 139:2
designations 137:6
desirable 11:13
despite 97:21 98:7,9
destructive 72:19
detail 198:17
determinants 27:6
 103:8 186:17
determination 116:14
develop 38:18 71:9
 198:7
developed 21:18 22:11
 88:19 93:7,11 165:5
 192:8 205:12
developing 18:1 64:13
 130:20 211:7,18
development 29:18
 166:2,12 214:21
develops 170:1
device 29:3
diabetes 10:1 193:8,8
diabetic 94:21
diabetics 85:14 152:20
diagnosis 97:7
diagnostic 89:14,15
 97:1,3
diagrams 206:5
dialogue 174:15 186:6
die 70:16 91:15

died 99:2
difference 127:22
 142:11 156:18 165:11
 192:20,22 193:12
differences 70:12 91:13
 118:13 119:3 120:1
 122:7 140:15 160:16
 180:2,14,17 183:12
 187:12 200:3
different 13:15 15:7
 19:15 33:16 34:20
 39:4 45:1,2 50:5 54:1
 68:4,10 71:2 76:7
 77:15 85:4,10 88:7
 91:16,18 92:19 94:3
 94:10 111:22 115:4
 130:19 132:19 134:21
 138:19 148:18 150:14
 150:15 151:12 158:13
 161:13 162:8 165:10
 167:17,18,20 174:13
 179:2 180:11,15
 181:2 183:18 184:4
 184:14 186:9 191:14
 193:16 203:10,13
 204:20 205:16 213:21
differential 69:5
differently 68:18 91:9
 169:3 199:7
difficult 12:5 24:8 26:8
 31:4 89:6 94:20 95:21
 111:18 112:3 148:20
 149:12 172:10 173:8
 173:15 185:17 198:21
 203:5
difficult-type 64:16
difficulties 11:14 113:1
difficulty 12:6 105:22
dig 156:12
digits 77:3,3
digression 48:5
dimensions 113:1
ding 19:22
direct 107:6 152:2
direction 24:15 25:1
 166:6 180:22
directions 54:1 126:5
directives 12:21 87:6
directly 135:10 164:11
 169:11
Director 1:13,14,18,20
 1:21 2:3,5,8,9,15
 160:8
disadvantage 143:20
disadvantaged 36:19
discharge 152:4
discharges 26:11
discuss 4:19 7:16 54:4

112:13 113:7 132:5
180:3 204:15
discussed 7:9 20:16
29:16 59:3 69:19
86:15 102:9 132:7
167:12 214:13
discussing 8:21 16:16
71:12 99:22
discussion 3:4 6:10 7:6
8:12,17 9:1,9 10:16
10:22 11:6 15:22
16:19 27:8,21 28:6
42:3,13,14 45:17 49:3
57:1,8,17 66:3,10
70:2 74:15 78:13,17
87:5 90:19 112:11
116:4 120:7 132:8
135:5 157:15 183:13
188:10 194:5,7
218:13
discussions 47:11
114:4 149:2 186:16
201:13
disease 101:21 102:1,1
dish 176:12
disincentive 189:3
disincentives 140:3
189:21
disparities 115:6,10
116:6,6 125:18 126:1
140:2
Disparity 119:9
disproportionately
49:20
disseminate 83:20
distance 67:3 131:6,12
132:5,8,11 133:20
136:7 137:15 138:18
138:18 141:8 143:21
distinctions 137:1
distinguish 137:7,13
distribute 175:10
disturbing 127:2
ditto 207:6
diverse 129:2 204:14
213:17
diversity 65:11 207:8
divide 133:6
divides 68:17
doc 107:9
docs 154:22 176:16
209:1
doctor 145:21 154:4,5,9
156:16
doctors 14:6 122:10
document 218:1
documentation 107:14
dog 62:12 84:9

doing 12:6 17:8 18:6
31:11 37:2,4 39:7
41:4 44:8 49:17 50:14
52:15 60:11 65:20
69:17 74:6 78:21
82:18 112:16 115:12
130:13 134:14 140:12
143:15 144:14 146:16
148:11 151:15 171:15
176:16,18,19,22
177:1 200:5 203:19
207:18 211:4 212:6
212:20 213:14
dollars 84:12,12 191:22
191:22
domains 33:14
dominant 104:3
dominate 211:3
door 55:5,8 95:6 117:15
doors 117:17 205:4
dose 40:3
dovetail 106:15
download 25:8
downside 140:10
downstairs 160:5
DPH 17:22
DR 7:21 10:6,10 11:12
12:4 13:10 14:14
17:10 21:6 27:12,18
28:18 31:1 32:1 35:21
39:3,18 41:14 45:8,20
46:15 48:5 49:10
53:20 62:20 63:13
64:11 65:1 69:1,14,18
69:21 71:22 73:16
78:19 83:4,22 88:11
93:5 95:11 96:10 97:4
97:10,13,16 99:8
106:15 114:3 117:9
120:9 121:8 123:17
124:9 126:15,22
127:15 130:16 131:4
131:6 132:9 133:1,8
133:18 135:3 140:6
141:17,20 142:1,17
142:22 145:3 146:14
147:8 148:8 153:11
154:18 156:7 157:7
157:10,17 163:21
165:9 169:2,6 170:6
172:8 178:13 184:1
188:9 190:18 193:20
197:7,15,18 198:15
202:2 204:10 213:13
214:7 219:5,19
draft 34:10 218:12,17
218:20
drag 147:12

dramatically 75:6
draw 19:8
drive 136:9
driven 194:19 201:22
drives 196:12
driving 115:11
drool 110:19
drove 194:20
drug 40:1,1,5 86:12
90:12 96:2
drugs 124:3
dual 159:3 163:7 167:6
169:7 170:18
ducks 4:13
due 89:21 95:1,2
218:17
duel 166:15
duly 62:14
Durham 216:14
dying 91:13

E

earlier 30:12 37:20
54:15 83:7 112:14
123:18 140:17 167:2
195:14 212:1
early 140:20 161:19
166:4 167:1 171:10
171:11,11 178:9
easier 83:15 84:6
easily 56:7 115:17
206:5
easy 27:3 56:1 142:2
157:1 191:12 207:10
212:21
echo 137:18 189:11,22
190:18
economic 14:16 131:20
131:21 156:2 182:8
economics 155:15
edge 48:18 205:4
edit 57:18
editing 180:9
editorial 21:14
education 54:21 115:19
121:2 131:15 164:18
effect 127:12 145:4,7
196:8
effecting 135:10
effectiveness 90:6
effects 146:15
efficiency 189:16
efforts 18:12 64:20
73:12 199:17
EHRs 83:12
EHs 199:7
eight 210:18
either 17:18 43:22

59:16 61:7 68:3 112:1
148:10 204:5
electronic 14:21 56:2
56:14 79:6
elements 16:22 104:7
elephant 185:11
eligibility 159:4
eligible 166:15 170:19
eligibles 163:7 167:6
eliminated 189:5
Ellen 21:22
elusive 157:18
email 4:9 218:6
emergency 2:4 138:6,7
emerging 159:3 164:9
emphasize 20:12 172:4
emphasizes 21:13
emphasizing 65:3
empirical 116:21
201:21
employee 187:7
enable 183:9
encourage 28:10 73:18
encouraged 25:14
end-of 99:10
end-of-life 87:6 89:10
91:8 94:2 97:18 98:1
99:9
endorse 118:19
ends 98:9
energy 203:1
enjoy 177:7
enjoyed 177:13
enlarging 81:11
enlightening 197:8
enrollment 99:15
ensure 84:13 170:2
enter 56:7 156:5
enterprise 1:20 187:3
entire 51:5 75:21
156:16 161:12
entities 49:21 113:5
entity 50:17
entry 24:20 25:10
environment 10:14
16:6 65:9 91:5 135:2
153:8
environmental 131:2
environments 11:11
26:13,21 29:19,20
65:11 182:14 212:4
epidemic 96:2
equation 193:12
equivalent 183:17
ER 20:20 145:13,18,22
146:5 147:18,22
errors 89:15
especially 94:18 127:19

essential 50:4 184:15
essentially 46:16
 145:13
established 105:6
establishing 18:17
et 30:2 71:8 92:22,22
 118:1 141:15 159:14
ethical 130:7 152:14
ethnic 126:2
ethnicity 125:6,15
 133:12
evaluates 165:7
evaluation 190:12,14
evening 58:5
events 90:12
eventual 53:10
eventually 35:10 82:22
 209:17
everybody 4:4,10 5:13
 7:1 72:17 74:17 77:18
 88:11 156:21 157:2
 176:22 177:12 188:10
 195:6 198:9,16 207:6
 210:12,21 216:18
everybody's 139:19
everyone's 188:1
evidence 30:5 59:17
 74:5 109:11,13
 116:21
evident 19:4
evolved 23:4
evolving 174:3
exacerbations 102:1
exact 21:15 70:14
exactly 6:10 35:17
 57:22 63:10 68:16
 70:9 100:20 113:3
 157:15 198:21
example 10:7 11:4
 14:15 28:22 31:7 36:2
 52:3 54:15 55:1 72:4
 89:20,22 94:21 96:7
 117:3,3 122:1,15
 124:13 125:6,22
 142:3,5 155:17
 159:16 160:16 161:2
 161:9 165:13 166:15
 170:15 194:14
examples 18:12 26:15
 90:3 161:17
exams 19:14
excellent 198:5
exception 120:21
exceptions 164:6
excited 8:3 186:17
exclude 36:1 53:7
excluded 200:13
excluding 26:10 55:16

exclusions 26:8
excuse 37:19
Executive 1:13 2:9
exercise 76:19
exhaustive 93:17
existing 78:2 100:14
 169:16
expansion 192:5 207:1
expect 37:1 217:19
expectations 214:15
expected 189:8
experience 32:10 90:8
 217:2
experiences 186:9
expert 76:22 118:3
 119:16
expertise 170:20
 202:22
experts 158:19
explain 80:19
explained 126:12,13,19
 127:4
explaining 124:21
explains 185:7
explanation 124:12
 145:14
explanations 197:1
explanatory 127:13
explicit 35:4 68:6 75:17
explicitly 69:4,18 85:22
express 214:16
expressed 200:4
 214:17
extent 23:6 50:2 201:5
externally 30:10 35:14
extremely 137:22
 182:17
eye 19:14 128:1 190:19
eyes 31:18 60:21 76:15
 184:7

F

face 8:8 200:8
facets 173:6,6
FACHE 2:10
facile 176:8
facilitate 57:12 200:16
 207:11
facilities 28:12 66:8
 71:2 81:4 82:7 118:1
 134:3 182:19 183:20
facility 66:7 67:4 69:13
 117:15
facing 176:2,4
fact 23:20 99:22 101:6
 104:13 116:3,5 117:1
 118:21 121:18 123:3
 127:3,11 135:17

141:11 152:14 165:21
 196:20 198:2 206:17
factor 21:16 101:11
 118:15 127:5 141:9
factored 147:7
factors 11:17 14:17
 26:21 46:22 114:9
 115:3,6,9,14,21 116:4
 116:19 117:12 121:17
 122:14,15,19 124:5
 126:20 127:9 131:2
 140:19 141:7 142:10
fail 181:14 196:7
failing 83:9
failure 40:4 84:19 85:12
fair 35:19 67:14 68:3
 130:4 135:17 138:7
fairly 18:18 29:20 81:6
 143:7 187:2 215:1
fairness 140:9
fall 12:22 14:8 20:5,8
falls 39:11,12
familiar 163:15
family 90:17 94:9
 152:18 153:12 197:9
fan 21:7,8
far 11:17 132:15 199:22
 201:4
farmers 155:17
fashion 46:10
fast 57:21 147:19
faster 57:12
fatalistic 155:2,13
 156:1
father 154:5
favorite 128:13
fear 93:4 123:6
feasible 30:8 106:11
FEBRUARY 1:7
fed 79:3
federal 7:22 45:13 50:2
 50:17 58:15 62:8
 64:12 78:15 84:11,12
 137:12 158:6,9,13
 159:12,16 161:5,12
 161:13,15,21 162:8
 192:13 196:22 209:5
 211:12
Federally 50:7
feds 84:6
fee 17:15 106:10 191:16
feed 42:19
feedback 28:4 38:16
 56:10 194:10
feeding 25:14
feeds 199:11
feel 7:11 53:20 59:3
 82:11 168:6 172:2,5,6

187:7 212:8 219:7,12
feeling 97:20 128:10
feelings 177:22
fees 105:22 106:2
fellow 143:2
felt 69:14
field 24:10 93:9 211:4
 213:22
fifth 14:22 15:3 95:18
 95:22
fight 73:9 175:16
fighting 110:22 111:7
 175:16
fights 72:22
figure 61:4 107:1 131:1
 131:18 194:22 203:1
figured 55:10 105:2
figuring 198:21
fill 17:19 210:18
filled 17:13 123:3
final 18:10 27:10
 114:10 157:8 159:21
 160:1 163:17 169:1
 171:14,19 177:20
 218:22
finally 27:5 190:8 196:1
 201:13 212:3 215:7
financial 48:20 114:20
financially 48:17 205:5
find 29:8 40:9 64:15
 73:11 105:14 108:1
 109:18 123:10 176:6
finding 148:10
fine 33:2 47:17 119:7
 172:7 220:2
finite 92:3,12
fire 208:11
first 15:5,5 31:8 49:10
 54:20 55:2 59:13 69:3
 74:1 75:2 89:5 91:2
 94:1 95:7 100:17
 108:17 114:2 138:16
 172:8 174:18 185:4
 188:9 193:21 194:11
 198:20 202:3 207:6
 215:14
fit 55:15 59:5 111:4
 157:16 168:9 196:14
fitness 125:15
fits 105:4 196:13
 205:15
five 21:14 39:10 84:19
 84:19,20,20 85:8
 174:5
fix 194:22
fixed 83:10,12,14
 196:19
flaw 196:5,9,17

flexibility 65:2,17
flexible 65:4 74:18
 176:8 190:11 205:14
floor 1:9 57:16
flu 73:10
focus 9:2 10:21 13:6
 23:12,16 30:11 31:6
 31:19 34:4 42:17
 53:16 87:14 91:1
 116:6 117:20 119:15
 133:14 161:4,19
 215:14,15
focused 28:14 73:7,22
 89:8
focuses 151:12
focusing 31:3 53:1
fold 181:11
folks 72:5 87:13 92:6
 102:12 139:18 149:19
 170:12,14 184:12,13
 192:16 195:19 212:3
 215:12
follow 62:14 160:20
 169:21 180:21 183:7
following 129:3 198:22
follows 9:10
for-performance 37:8
 40:14,21 41:19 42:7
 45:15 47:9 51:4,22
for-reporting 41:17
force 178:18 190:14
forced 56:18
forces 115:11
forget 31:13 41:11
 62:21 64:3
forgot 39:1
form 58:9
former 39:9
forth 26:11,12 39:6,10
 42:21,21 75:5 174:21
 181:6 212:15 215:19
forum 1:1,9 63:14
forward 8:4,10 16:14,17
 25:3 35:18 41:2 61:7
 90:18 135:15 139:7
 165:19 166:8,13
 183:21 188:7 204:4
 207:19 213:3
found 82:17 122:14
 147:19
four 8:6 38:7 85:8
 127:16 136:10,10
 152:20 153:7 196:18
FQHC 133:10
FQHCs 180:6
fracture 49:2
frankly 17:7 47:4
 140:14 176:1 194:20

195:9
free 7:11 125:15,19
 219:7,12
freely 25:8
frequently 23:18 24:12
 33:14 67:12
fresh 123:4
FRIDAY 1:6
friend 128:12
friendly 217:6
friends 172:20 177:15
frontier 52:17 68:18
 70:4 137:10,11
 185:12 204:18 205:22
fruits 123:4
frustrated 121:4
frustrating 137:22
full 160:14
full-time 107:18
fully 115:1 219:20
fun 217:1
function 50:19 101:2
fund 49:8 107:18
funded 157:22 214:5
funding 104:12
further 7:16 92:11
 112:11,13
future 3:14 6:22 40:18
 45:22 157:16 163:5
 176:9 186:19

G

gained 176:7
gal 21:21
GALE 1:16 23:2 36:14
 85:18 86:4 179:16
gamut 44:7
gap 102:8,17 129:21,22
 130:10,11 140:16
 151:5
gaps 8:13,15 86:9,21
 87:22 88:15 93:19
 159:7 166:19
GARMAN 1:18 45:8
 133:8 197:7,15,18
garner 196:11
gee 168:2
gender 126:1 154:16
 156:14
general 67:12 108:7
 117:10 121:4 123:20
 131:8 139:16 173:5
 174:2 187:13 210:2
generalist 175:3
generally 18:21,22
 19:16 160:22
generate 169:10
generation 14:22 15:4

15:6
gentlemen 176:15
geographically 70:5,7
 137:10
German 15:1,3
getting 55:5,6 60:4 70:1
 70:1 72:18 81:12
 90:12 107:4 109:17
 135:17 136:8 143:17
 146:4 166:2 172:15
 207:1 208:20
HAZINOUR 2:14
 171:6 217:10
gigantic 149:4
GIRMA 2:18
give 7:1 19:18 22:7 24:9
 36:4 49:7 55:1 93:17
 113:20 122:20 126:16
 133:14 164:8 171:19
 177:20 185:15 200:17
 204:20 205:6,6
 216:17
give-and-take 28:8
given 12:6 54:15,20
 85:10 88:20 108:12
 114:18 140:21 169:18
 173:7
gives 32:21 59:17
 161:22 198:11
giving 56:12 58:17 82:3
 152:2 189:21,21
 201:1 217:18
glad 5:12 62:18 116:7
 130:12 215:8
glaze 31:18 76:15
glide 53:9,10
gliding 18:1
go 4:15 7:12 11:21
 17:17 30:1,21 41:9
 43:18 47:8 54:3 57:1
 62:18 63:20 70:20
 78:7 94:11,12 102:12
 108:17 114:6 125:18
 126:18 128:11 134:10
 146:3 149:11 156:15
 158:14 159:20 166:6
 172:2,8 177:12 178:2
 178:8 184:2 189:8
 198:17 207:5,19
goal 53:10 161:20
goes 19:17,20 45:3
 78:12 83:22 94:8
 178:9 190:7 204:4
 205:22 209:15 219:6
going 4:15,20 5:9,15,16
 6:9,12,20 7:5 10:16
 13:3 14:8,14 15:22
 16:13 23:19 24:7 25:3

25:7 26:1,2 27:16
 31:1 36:15 39:1,3,7
 40:11 41:2 42:10,14
 46:3,7 47:1,8,20 48:6
 48:14,19 49:1,3,6
 50:11 52:4,7,20,21
 53:12 54:3 57:3 60:9
 61:9 62:20,22 63:6
 65:16 66:15 70:8,11
 71:3 74:6 75:3 80:8
 80:11 82:9 83:7 86:19
 92:11,12,16 93:3
 96:16,21 99:7,14,19
 100:5,19 101:2
 102:13 104:17 105:1
 105:13 106:11,15
 107:3 108:6 110:3
 111:2 113:7 121:7
 123:5,7,9,17 124:13
 125:8 126:7 129:21
 130:11,22 132:4
 134:13 136:12 137:15
 138:11 140:2 141:17
 141:20 142:1 146:17
 147:11,21 149:12,18
 150:12 151:7 152:5
 153:3 154:4 156:5
 168:21 174:3,12
 176:6,13 177:17,19
 178:4,11 183:2,6
 184:11 194:12 198:9
 198:17 199:14 202:8
 203:2,3,6 204:1,7,10
 207:15 209:2,2 210:4
 210:16,17,19 211:19
 212:9,13,22 213:5
 217:18
gold 22:7 107:6
good 4:3 5:11 9:18,20
 10:15,19 13:11 18:12
 19:2,2,7 21:1 23:13
 27:1 31:7 32:14,17
 37:20 39:15 40:15
 57:1 58:1 61:15,22
 62:14,22 73:7 76:1,5
 83:1 90:5 92:14 95:5
 99:15 103:3 105:1
 112:15 116:11 120:12
 120:22 144:5 148:10
 153:6,8 162:15 164:9
 171:19 175:16 179:8
 181:9 192:14 194:15
 195:10 201:7 203:12
 203:19 204:11 208:2
 209:15,18,19,20,21
 215:21
Goodrich 162:10,11
gotten 139:5 161:14

214:9
governing 71:8
government 45:13
 50:17 161:12,22
 192:13
granular 125:21
great 6:3 8:17 21:14
 40:10 46:9 52:17
 59:20 62:10 89:9
 90:13 95:13 138:21
 148:11 162:13,21
 176:11 177:5 186:7
 187:18 213:1,6,12,15
greater 13:18 18:17
Greg 30:21 39:10 48:4
 52:11 55:21 62:19
 64:22 74:20 95:9
 123:15 136:1 137:9
 153:9,10 157:6,10
 194:2 204:9 213:19
Greg's 70:11
GREGORY 1:19
grew 155:6
group 7:20 13:9 39:12
 40:15,22 50:16 63:16
 65:6 66:18 77:17
 84:22 87:12 90:19
 98:16 102:22 103:1
 108:5 119:3,14,17
 130:17 131:19 147:7
 147:17 163:3 166:10
 166:15,20 167:15
 168:3 169:5 170:18
 170:19 173:7 178:14
 178:14 179:4,13
 194:1 202:4 207:7,8
 210:21 213:7,16
 219:22
group's 169:9
grouping 28:7
groups 30:14 64:3 66:4
 66:9,13 67:1,6 68:4
 69:3 85:1,7 110:21
 130:20 131:3,17
 143:17,18 144:9
 158:14 160:2 166:14
 167:9,17 168:16
 180:10,10 189:20
 201:17 203:9
growth 58:13
guess 16:10 20:11
 27:22 32:1 33:1 34:16
 34:17 39:18 46:15
 54:4 58:3 59:12,15
 66:22 67:9,10 82:12
 98:12 99:20 108:19
 132:11 144:4 149:19
 152:20 155:20 165:5

168:7 172:1 174:6
 181:22 185:18 192:18
 198:19 212:13 216:22
 217:8
guessed 8:16
guest 7:18
guidance 102:3 202:6
guideline 21:4
gut 97:20 134:20
guy 2:3 27:11 28:2
 35:20 36:9 39:16
 41:12 42:5 95:10 96:9
 128:3 130:14 156:6
 187:11 202:1
Guy's 41:11 48:6
guys 8:4 14:18 80:8
 126:11 154:14 162:3
 171:19 185:5 188:7
 201:6 202:11 214:14
 217:1

H

half 125:12,12 210:17
half-step 14:10
Hammond 216:12
hand 5:9 199:5 214:22
handed 145:16
handoff 145:13
handoffs 86:10 146:17
hands 61:14 187:15
handwashing 9:22 10:7
 10:11
happen 19:13 27:4
 51:11 73:2 78:6
 105:18 106:17 117:11
 212:22
happened 55:2
happening 31:16 45:22
 63:17 80:4
happens 19:16 62:9
 91:9 94:7 117:16
 158:11 173:19 176:11
 214:18
happy 46:19 163:3
 169:20 198:10 215:20
hard 31:4 33:3 48:11
 71:3 146:20 147:19
 155:14 199:21 214:8
harder 141:18 212:7
harm 195:1,10,10,11
Harvard 2:1 144:13
 194:3 213:9
hat 39:4,9
hate 171:21
he'll 19:19 197:22
head 39:19 89:20
 105:21 160:7
header 24:1

health 1:4,14,17,18 2:1
 2:5,7,10,11,18,19,20
 4:5 8:1 10:18 24:18
 24:21 25:11 27:6
 28:14,15 29:4 50:7,8
 64:6 86:19 87:1 101:8
 102:20 103:2,3,5,11
 104:11,13 105:3,9
 107:22 115:7 117:22
 121:3,22 127:16
 128:11 134:1,16
 136:11 137:3 150:18
 150:20,21 164:2
 175:2,6 182:9 184:22
 192:15 195:17 199:8
 199:9 214:4
healthcare 115:7
 133:20 158:19 174:2
 185:1,12,13,16
 197:11 198:4,5
hear 9:6 14:4 92:8 93:3
 110:19 117:9 164:10
 174:14 184:7 194:6
 213:22
heard 7:7 8:6 60:8 80:8
 102:2 142:7 149:2,3
 168:5 195:14 199:1
 200:6 203:10 215:9
 215:11
hearing 63:11 64:21
 92:6 186:8,8 194:8
 195:6
hears 181:9
heart 84:19 85:12 153:2
 217:4
heavily 44:4
heck 213:5
held 14:5
Helen 2:13 6:12 27:9
 67:2 88:1 108:6
 113:19 132:4 149:16
 153:19 163:12 168:5
 169:1 170:1
Helen's 212:6
hell 206:21
help 25:2 37:10 73:6
 83:18 91:14 96:13
 113:22 119:10,14,22
 141:12 183:14,18
 189:9 194:17
helped 98:17 204:20
 216:8
helpful 32:15,21 33:1
 79:18 83:16 89:1
 96:22 105:16 170:13
 195:9 198:12 212:9
helping 128:17
helps 72:18 73:13

heretofore 182:2
heroin 124:4
hesitant 12:16 54:9
heterogeneity 149:4
 176:3 188:14
Hey 61:19
HHS 71:8,17 75:5 84:1
 158:4 162:13 192:14
 218:18 219:1
Hi 88:11
HIE 106:9
high 17:14 29:9 81:7
 88:17 94:19 101:7
 122:4,16 127:20
 155:16,16 156:3
 164:4 189:16,17
 211:14
higher 28:5 67:4 98:19
 101:7 114:20 147:22
 147:22
highest 93:12 126:21
highlight 94:15
highlights 186:12
highly 22:1
Highmark 1:21 18:18
 187:7
highway 138:20
hills 139:10
hire 49:4 94:4
Hispanics 15:4,6 126:4
historically 41:22
history 214:20
hit 58:4
hitchhike 55:20
HIV/AIDS 161:18
HMO 128:21
hodgepodge 58:13
hog 140:12
hold 19:12
hole 81:22
holidays 114:13
home 11:1 17:3,8 21:7
 52:12 55:3 91:13 94:9
 94:11 109:16 134:1
 134:15 164:2 175:5
 209:3
homeless 152:22
homes 16:19 17:6,18
 17:22 26:11 164:3
hometown 97:22
homogeneous 176:3
 207:8
honest 87:10 165:13
honestly 47:15 140:15
 194:7 211:9
hood 176:20
hook 14:2
hope 4:8 63:21 141:12

174:20 177:13,14
 185:5 197:4 198:10
 215:2 218:9,11
hopefully 60:1 93:12
 113:21 118:18 168:21
 203:9 204:20 205:17
 211:17
hoping 56:3 121:5
Hopkins 194:3
hopper 62:7
horrible 96:7
hospice 91:11 94:5,12
 99:15,17 134:15
hospital 14:3,5 42:1
 46:4 65:13 70:17
 71:13 81:3 91:14 94:8
 94:13 99:2 117:4,11
 121:12 122:6 123:2
 123:21 124:2,5 130:8
 131:7,13,22 132:21
 132:22 134:8 137:20
 145:9,12 147:17
 158:20 163:15 164:2
 168:14 170:15 178:22
 182:7 188:21 190:1,2
 193:4 194:15 205:2
 205:22 209:2,4,18,19
 209:22
hospitalist 147:5
hospitalists 146:4
hospitals 28:12 36:3
 43:9 48:16 49:13
 67:21 68:2 72:7,16
 76:2 77:7 78:21 79:4
 87:2 98:19 104:6
 105:4,8 108:12
 109:15 117:19 122:3
 122:5 144:2,16
 160:10,12,17 170:13
 178:16,20 180:6
 183:5 184:2 186:1
 194:21 196:6 204:22
 205:20 206:4
hot 153:16
hour 16:1
hours 17:15 29:6
 136:10,11 210:18
HPSA 137:3
HRRP 142:5
HRS 143:2,4
HRSA 52:15 137:6
 159:14 163:4 175:20
 216:18
huge 21:6 46:1 95:4,8
 106:19 127:18 145:4
hundred 25:7 205:13
 205:13
hundredth 65:2

hung 104:4
hurt 49:19
husband 94:8
HVBP 188:22
hypertension 161:11
hypertensives 85:15
hypothesis 150:15

I

i.e 28:13 30:7 61:9
 99:12
IA 2:2
ICD-10 46:2,7
Idaho 206:11
Idaho's 206:13
idea 43:13 62:22 81:20
 142:19 158:3 161:5
 171:12 172:1 203:12
ideal 33:12 39:21 40:1,1
 40:5
ideals 198:4
ideas 60:4 133:14
identified 88:15,22
 214:12
identify 3:9 17:4 50:3
 92:15
illness 11:19 89:21
 126:20
imaging 20:20 87:4
immigrants 15:1,4
impact 46:1 95:5 152:2
 152:10 184:22 211:13
implement 119:10
implementation 39:8
 39:13 46:2
implemented 175:11
implications 27:7 129:8
implicit 75:13
implicitly 35:5
implied 55:21 203:16
importance 103:19
 211:21
important 7:3 30:2,21
 33:19 38:20 40:9
 45:18 51:19 52:8 53:8
 58:3,20 59:2,7 61:8
 77:17 78:16 86:20
 87:7 88:22 91:4,20
 92:8,16 93:1,19 94:14
 101:15 119:11 122:14
 128:9,11 129:9
 130:22 131:1,11
 137:19 146:15 154:13
 162:4 167:14,16
 173:9,11,12,13 176:9
 180:18 181:8,18
 182:6,10 183:20
 188:6,19 191:10

193:10 200:6,21
 201:15 202:13 203:7
 204:2,6 208:7,17
 210:3 211:10
importantly 56:8
 143:13
impressed 212:5
impression 14:2
impressive 202:4
improve 73:12 76:18
 109:7,20 143:11
 151:6
improved 81:6
improvement 30:9,17
 38:18 56:12 57:15
 66:4 71:15 81:8
 151:13
improvements 37:16
inappropriate 89:11
incentive 62:8 189:1
incentives 195:16
 201:1
include 6:11 25:21 26:7
 50:11,21 57:14 67:3
 77:7 118:16
included 49:2 77:11
 150:5 160:22
includes 49:3 125:14
 158:7,8,18 159:11
 160:11
including 86:11 90:8,9
 123:13 143:3 204:13
including-the-kitche...
 22:21
inclusion 115:14
income 115:19 120:14
 131:7,8,13,21
inconsistency 35:12
incorporating 201:18
increase 55:12
increasing 79:2 109:14
increasingly 13:12
 165:21 181:15
incredible 174:14
 175:22
incredibly 108:21
 109:22 137:19 181:8
 181:8 205:15 213:21
incubator 49:1
independent 17:21
 154:4 155:17
Indian 192:15
indicators 10:18 60:2
individual 32:16 39:12
 40:16 41:3 81:2
 115:21 116:13 118:1
 121:15 149:13
individually 126:8

infections 29:1,2 117:4
infinite 74:4
influence 104:5 115:3
 116:19 151:6
influenced 101:4
influencing 38:6
infomercial 52:14
informal 28:7
information 75:8 109:6
 110:12 173:2
informative 79:18
informing 12:14
infrastructure 49:16,20
 106:7
infrastructures 25:19
inherent 53:9
inhomogeneous 65:7
initial 37:21 38:9
initially 4:8 44:22 150:4
Initiatives 1:21
injecting 124:3
innovative 205:7
inpatient 82:18
input 1:3 158:4,15
 159:22 160:2 162:4
 165:5 196:11 212:4
 212:15
insert 105:1
insertions 165:3
inside 117:11
instability 112:18
instance 17:22 84:18
 143:19 199:6
instances 199:1
Institute 24:19 103:2,16
 104:11
institutions 50:16
insurance 19:22 101:3
 108:19 131:14 156:3
 199:15
insurer 187:2
insurers 53:14 84:11
 210:8
integrate 92:4
integrated 14:9 176:17
integration 14:3 181:1
intend 78:10
intended 13:13,21 97:5
intense 147:9
intensive 99:12
intentionally 213:16,17
interact 141:14 167:18
interchange 197:4
interest 43:17 63:15,16
 89:10 90:13 128:6
 139:11 162:14 163:2
 179:18
interested 61:3

interesting 8:14 20:17
97:11 113:21 121:19
142:3,19 146:12
156:7 160:19 162:18
166:3,10 178:13
204:14
Interestingly 160:5
interests 179:22
interface 182:11
interject 5:3 43:5
internally 30:8 35:13
147:9 161:22
International 157:12
interoperability 83:10
interpretation 67:2
interrupted 123:18
interstate 138:19
intimate 60:18
introduce 7:19
introduced 10:5
introvert 217:6
inventive 206:7
inventiveness 206:2,3
invitation 186:21
inviting 190:16
involved 17:11 22:1
62:2 166:1 202:18
involvement 63:11
IOM 80:6 97:8 128:11
Iowa 1:20 55:4
IPPS/LTCH 142:5
Ira 1:10,13 5:12 43:12
59:11 61:17,19 76:1
82:16 129:19 167:3,3
207:3 213:14 215:8
Ira's 34:17
IRVINE 1:19 31:1 48:5
65:1 95:11 123:17
153:11 157:7 204:10
isolated 134:12
issue 8:8,19 12:12
15:20 17:10 23:18
24:3,8 26:6 29:11
30:7 31:20 52:13,22
53:8 61:3 66:19 71:6
71:18 77:15 80:15
86:21 96:13 99:9
110:2 121:9 123:6
128:6 130:21 132:5
134:20 136:19 141:14
144:8 146:15 149:4
153:19 155:22 156:2
156:11 178:21 187:21
190:1 195:13 199:12
200:12 215:9
issues 5:17 18:8 22:3
26:20 29:16 37:12
49:15,16 52:17 66:2

86:13,14 99:21 100:1
106:16 112:14 114:1
119:11 120:10 121:19
130:9 153:9 164:9
170:16 172:16 176:3
195:12,15 204:15
214:10,13
items 48:19

J

jam 44:14
JAMA 114:12
Jane 216:12
January 118:9
Jason 1:20,21 18:14
37:19 39:17 43:19
53:18 54:15 146:22
177:18 186:22 190:20
job 21:1 96:10 100:10
120:22 125:12 200:15
203:19,21 209:13
213:1,15 215:13
John 1:16 23:1 36:12
36:12,13 77:19 83:21
85:16 155:10,10
179:10 180:21
Johns 194:3
Johnson 2:15 4:3 5:22
6:5 34:15 43:2,5,7
63:20 80:1 81:19 82:5
82:8 87:21 88:1,5
104:12 113:19 153:22
171:2,8 174:11
175:12 177:5,12
179:9 180:19 181:20
183:22 185:3 186:3
186:22 188:8 190:17
193:19 197:6 198:14
202:1 204:9 207:3
215:22 216:21 217:17
220:3
join 145:8
joined 72:22
joint 2:9 64:20 178:15
Jonathan 2:2 186:3
judging 130:3
judgment 112:2
July 218:19
jump 5:6 76:1 79:22
165:22 189:7 194:12
jumping 42:9
June 218:19

K

Karen 2:15 5:11 6:12
13:4 18:11 38:2 79:21
104:16 171:1 210:13
212:16,18 217:21

Kay 162:10,11
keep 5:7 31:15 42:14
46:12 48:11,19 56:8
56:14,17 81:11 82:15
149:22 178:7 192:14
204:2 205:4 215:4
keeping 85:20
keeps 90:2
Kelly 1:10,12 4:15 5:10
6:2 16:3 36:12,13
37:18 83:3,21 84:14
91:5 94:1,10 102:18
103:17 138:15 163:10
207:3 210:13 213:14
Kelly's 219:6
kept 202:11
KESSLER 1:20 53:20
172:8
Kevin 160:6
key 21:13 90:2 192:10
218:1
kick 113:22
kid 19:16 54:16
Kim 51:20 151:10
183:22
Kimberly 2:4 49:9
52:11 77:19 78:18
86:16 133:16 136:12
148:5,7
kind 5:6,13 6:20 7:1
11:15 20:9 21:3 22:7
22:9 23:3 29:10 32:1
39:9 42:10 44:6,17
45:3 46:15 51:7 53:14
54:3,4 58:13 64:7
67:20 71:22 79:7 83:8
90:16 97:16 105:7,9
118:15 121:18 122:17
128:1 142:10 150:21
154:12 155:7 156:5
159:3 164:3 169:13
171:13 173:3 174:6
185:11 187:5 191:17
192:8 199:21 216:7
Kindig 128:13 150:21
kindness 153:2
kinds 139:17
kings 206:3
knew 63:17 116:10
213:20
knife 48:17
know 4:7 6:17 7:11 14:7
16:18,20 18:7 19:3
21:19 22:10 23:3 32:6
36:22 38:3,4,7 39:8
39:14 40:4 42:17 44:8
44:20 46:3,5,8,11
48:1,12 53:5,10,11,11

53:22 54:16 58:2,10
59:18 60:5,13,17 61:1
61:1 63:15 64:9,12,13
67:4,5 69:2,6 72:19
73:10 74:13 76:17
77:9 80:3,5,5,11 84:5
84:8,8 85:22 87:14,19
93:19 94:17 97:19
99:10,15 100:2,3,8,17
103:9 106:2,6,10,17
107:9,10,22 109:4,4,5
109:12 110:18 111:16
111:17,20,21 118:4
120:13 122:3,9,16
126:11 128:17,22
129:3,15 131:1,7,19
131:20,21 133:5,5,9
134:10 135:6,9,14,21
136:1,14 137:9
138:11 139:1,22
140:1,8,9,16,18,20
141:21 142:4,6,15
143:14,19 144:1,18
144:20 147:21 148:1
149:19,21 150:1,4,6,9
152:17,19 153:4,5,15
154:14 155:4,5 156:7
156:17 160:10 162:16
163:16,18,22 168:1,2
170:17 171:9,20
172:11,20 173:1,8,14
173:20 174:16,19
175:3,4,6,10,17 176:1
176:14,17 181:4
184:6 187:20 190:1
191:3,5,11,15 192:15
192:20 193:2,3,8,13
194:15 195:22 196:3
198:20 199:6,11,12
199:13,16 200:2,7,10
200:11,13 201:5,9
202:9,16 203:1,1
208:8,15,22 210:7,9
210:12,14 212:20
213:8,15 215:7,13,14
217:4 218:7 220:1
Knowledge 2:3
knows 146:6

L

labs 20:19 95:2
lack 87:3 97:21 98:9,20
120:11 122:21,22
144:5 179:17
lacking 202:21
ladder 189:8
lag 93:8 110:7,11
Lake 136:9

LANDERS 1:21 18:16
43:21 147:2 148:2
187:1
LONDON 2:1 17:10
69:1,14,18,21 99:8
120:9 142:22 198:15
language 75:12
large 78:22 191:3
largely 112:6
larger 199:12
Larson 160:7
lastly 183:11
lately 72:5
Laughter 43:1 128:7
139:8 144:17,22
151:21 154:15,17
launched 118:9
laundry 106:3
law 46:6
laws 199:20
lay 61:5 129:6
leaders 119:18 158:19
leadership 104:3 187:6
202:7
leading 96:1 175:16
leads 169:7
learn 44:18 46:5 58:18
58:19 118:18 127:10
176:22 186:18
learned 44:17 45:5 65:5
186:7 188:11 207:9
213:11
learning 5:14 7:8 28:10
56:6,19 217:2
leave 31:13 61:14
117:16 144:16 171:10
171:14 177:19 178:5
181:7 206:20
leaves 19:20 117:15
leaving 172:9
led 162:12 186:13 194:5
left 81:8 82:19 105:9
124:17 215:18
lens 89:4
let's 7:10 19:18 30:1
42:14 43:16 58:21
60:10 91:1 102:11
177:6,12 208:12,12
level 28:1,5 40:16 41:3
41:21 46:19,21 47:1,2
47:9,17,21,22 50:2
82:7 88:17 104:14
117:6 119:21 120:5
121:16,17 122:20
125:9,10 126:1,2
131:15,21 134:8,9
154:11 166:5 181:1
191:18 192:14 211:12

levels 28:5 104:17
112:16
Lexington 14:20 15:12
124:14
libertarian 206:13
life 74:8 90:7 91:17
98:11 99:11
lifetime 61:10
light 173:16
like-to-like 66:5 67:9
68:5
liked 32:6
limb 63:21
limit 79:12
limitations 186:15
limited 76:17 121:9
173:8
limiting 115:18
limits 139:3
Lincoln 98:3
line 10:8 32:2 33:2
57:10 100:6 117:4
129:4 164:7
lines 66:6 123:22 163:7
175:7 217:11
link 218:3
linkage 71:13
lip 60:18 196:15
list 29:21 30:19 34:1,6
34:20 35:3 39:21 45:9
60:14 62:4 86:9 88:2
88:14 91:20 92:19
93:3,13,14 96:11,20
99:20,20 102:7,12,17
106:4 113:8 115:22
116:2 159:15 161:16
164:20 165:20 166:17
166:19,21 206:20
listed 161:16
listen 15:18 195:20
196:14,17 212:2,3
listener 128:5
listening 61:21 151:16
202:6
lists 40:8
Literacy 128:12
literal 138:3
literally 154:7 155:21
162:7 196:4
little 4:7 5:1 23:15 30:4
32:10 34:22 38:2 39:4
39:22 41:14 45:1,2
53:21 57:3 63:21
66:10 70:2 72:1 80:7
80:15,20 82:10 84:5,6
86:7 88:6 100:15
108:6,8 114:16
120:20 127:4 156:21

157:20 169:3 171:4
174:6,13 176:7,12
178:8 181:5 191:20
198:16,20 200:17
201:12 204:20 205:2
206:4,17
live 67:11 205:3
lived 33:11
living 67:10
lo 55:8
load 83:15 145:18
local 30:18 42:11 46:21
67:15 157:5 181:1
locally 33:22 176:17
location 138:3
locations 109:3
locked 112:6
logical 35:11 116:18
168:3
logically 146:18
long 45:7 106:3 116:2
134:3 158:21 174:17
189:7
long-winded 197:1
longer 78:3
longitudinally 112:19
look 8:3 20:17 21:4
23:3,9 29:5 39:5
45:14 70:22 80:11
81:2 85:11,14 89:6
103:3 112:19 114:22
116:22 119:13 126:8
127:1,14 130:9,10
133:13 139:6 140:22
141:2,6 142:3 153:6,7
153:14 166:10,20
167:7 170:17 173:22
174:2,16 180:5 182:6
212:14,19 213:3
looked 85:8 92:10
106:3 120:2 143:5
206:17
looking 5:16 8:4 20:12
25:18 37:7,13,15 52:1
60:9 67:13,15 80:20
84:3 100:8 111:5,19
122:2 126:17 130:6
142:8 143:2 166:17
178:20 179:4,5,6
210:16
looks 69:7,8 177:7
179:10 214:19
loop 38:16 56:11
lore 157:5
lose 58:6 176:19 196:8
losers 150:4
lost 89:18 96:20 180:4
lot 4:19 8:16 9:1 11:13

12:13 15:19 17:16,20
21:17 22:2,14 23:17
25:15 27:12 34:4 38:5
41:20 55:12 58:10
61:1 63:16 64:12
65:12 68:17 74:7
87:14 89:12,14 90:15
96:3 97:12 98:1,4
99:11 100:3 110:18
111:9 113:2 115:4
117:16 118:18 119:11
121:11 123:7 125:18
126:6 127:6 133:11
135:4,8 143:14
156:20 157:17 159:6
159:17 162:9 165:19
169:9 172:14,21
174:8,8 176:21 185:8
187:14,16 188:11
189:9 192:19 195:16
199:1 200:8,10,14
201:16 203:17 207:1
207:8 213:11
lots 115:1 122:16
190:21 200:6
Louis 122:1
love 9:5 117:9
low 8:8 9:9,14 26:5
27:10,22 33:13 49:20
77:3 98:19 141:14
142:14 145:6,15,19
146:1 152:19,21
153:9 180:3 184:13
low-volume 1:4 23:18
24:8 30:6 36:19 100:4
100:13
Luke's 1:19
lump 194:11
lumper 194:10
lunch 3:11 6:19 59:16
125:16,19 171:1,2,12
171:18,21 177:7,8,14

M

ma'am 217:12
macro 135:6
magnitude 75:17
main 8:6 27:20 34:12
99:21,22 145:14
185:19 187:5
Maine 1:16,17 156:21
156:22 157:1
maintaining 32:20
major 93:18 102:8
104:11 111:8 112:6
130:11 172:16
making 4:20 6:21 42:5
65:4 86:4 95:21

136:22 182:12 183:7
183:11 207:19 210:1
215:11
male 127:20
man 17:15
manage 151:4 197:19
203:2
managed 190:22 191:2
191:16
management 90:14
95:13,14,16,19
101:21
manager 2:14 39:9
managing 96:14 213:15
mandate 16:21 48:16
mandated 11:3
mandatory 8:22 9:2
57:5 76:4 168:16
190:10 191:15
manner 56:20 86:18
MAP 6:13 16:11 77:22
88:2,16 108:5 113:15
153:20 157:15,19
158:3,11 159:20
160:1 161:3 163:14
163:18 164:4 166:1
167:10 170:1 202:12
202:14 211:17
MAPs 108:7 153:20
167:22 168:9
march 41:2 218:9,15
Marcia 2:15 63:21
Maria 216:14
marital 127:18
mark 31:9
market 67:11,20
marketplace 53:5
markets 68:10
marks 30:11 87:9
marry 177:1
MARTIN 2:20
Marty 8:2 61:18 62:17
83:2 216:1,1,21
Mary 21:22 162:20
mask 115:10
Massachusetts 17:22
masters 60:18 196:15
match 164:5
materials 25:8
math 66:11
matter 40:3,4 110:10
126:9 129:17 133:1
147:8 173:18 177:9
220:4
mature 21:19
maximize 23:11
MBA 1:12,21 2:1,2,9,15
MBQIP 82:17,20

McCall 1:19
McCook 14:19
MD 1:14,18,19,20 2:1,3
2:4,5,6,13,18
meal 125:16,19
mean 17:1 33:6,11 35:6
51:17,18 56:10 59:18
59:19 60:17 66:20
67:10 68:13,17 74:3,7
74:10 75:3,11 76:8
77:1 81:9 93:6 96:13
96:14 97:5 98:21
99:17 103:11,16
104:10 107:11 109:19
110:18 112:4 120:14
126:18 127:20 129:13
129:16 131:8 132:20
137:18 140:15 141:8
142:13 145:18 146:16
147:6 150:3,9 154:7
155:7 156:14 157:4
163:14 164:8 180:21
195:3 202:17 203:4,5
209:9,21 214:2
219:20
meaning 92:1 116:21
meaningful 8:10 23:7
25:21 29:17 69:5 83:9
83:15 99:5 104:15
112:9 125:5 160:7,8
160:12 195:4,18
meaningless 65:20
means 108:14 206:1,2
meant 93:16 113:3
202:13
measure 13:17 23:11
26:5,7 28:19 33:9,10
34:18 37:8 39:21
40:10 42:6 50:20,22
54:9 55:16 81:15 85:6
90:11 98:17,22
100:14 101:1 112:17
116:14,14,15 118:19
126:17 142:18 147:2
159:7,7 163:19
165:16,18,19 194:14
204:5 209:21
measured 71:7 118:7
measurement 1:3 2:16
29:18 49:17 50:21
71:7 74:8 75:4 86:13
88:14 94:18 100:12
101:9,12 102:9
104:22 130:18 146:16
148:3 149:7 162:12
172:17 173:4 184:3,8
184:11,17 187:12
199:10

measures 8:11,13 9:11
9:13,15,18 10:3,13,14
10:19,22 11:2,4,8,10
11:12,15,18 13:12,14
17:2 18:21 19:1,5
20:14,21,22 21:3 23:7
23:19,21 24:6 26:2,14
26:16 27:3 28:19,20
29:4,7,22 30:16 32:16
33:12 36:1,15,16,18
36:21 37:3,7,14,16,22
38:6,9 39:5,11 40:11
41:8 42:18 44:1,3,5
45:12 48:15 50:11
51:9 54:5,7 55:14
57:9,12 62:3,5,7 65:4
65:18 71:11 72:14,20
73:11 74:3,5 76:4,4
76:13 77:1,21 78:2,3
78:20 79:1,2,6,11
80:7,17 81:3,4,16
82:13,18 84:16,19,20
84:20,21,22 85:2,8,12
85:12,21 86:10,19,21
86:22 87:3,6,8,17
89:6,14,17 90:6,9
92:3 93:3,13 94:18
95:5 96:20 97:1,6
98:5 99:4,12 100:9,14
102:3,20 103:12
112:2,18 114:19,21
114:22 117:13,21
118:10 120:12 121:1
121:7,11 123:7 125:4
127:2 135:11,15
138:1 140:12,17
142:4,6,9 158:1,5,12
158:16,17 159:8,19
159:20,21 160:3,16
160:18 161:11,15
162:7,17 164:12,21
165:3,4,8 166:2,4,11
166:17,21 167:11,21
169:4,11,16 173:9
174:21 178:15,19,22
179:7 184:19 190:4,9
198:8 202:17 203:2
203:18,20 204:3
205:11 206:8 208:20
209:16 210:2,9 211:8
211:8,19
measuring 127:9 200:8
211:21
meat 5:1 15:2,12
157:20
mechanism 50:6
mechanisms 108:11
med 37:3 44:1 73:10

194:16
media 209:14,20
Medicaid 1:20 84:4
100:18 101:9,10
111:14 120:19 131:14
157:1,3 170:18 191:2
191:6,14 206:22
210:7
medical 1:14,16,18,20
2:1,3,5 11:1,22 14:21
16:19 17:3,6,8,21
21:7 55:3 56:2 111:6
131:12 132:18,19
133:2 144:3 160:7
175:5 180:12 187:9
medicalized 150:19
medically 137:4,5
Medicare 32:13 47:11
53:12 79:15 84:5
100:18,20 101:9,10
105:22 108:14,19
109:8,19 110:18,20
111:1,14,20 112:7
191:3,13 210:7
medication 10:1 72:13
129:4
medicine 2:1 19:2
23:13 40:6 95:20
151:17 172:17 200:5
205:22
meet 60:15 152:6
meeting 4:5 12:13
57:15 113:17 160:6
171:7 192:19 205:12
210:15,17 214:8
218:2,10 219:16
meetings 48:22 63:2,3
63:6 64:12 88:12
165:1
member 64:10
members 25:5 55:6
64:1,1,10 121:21
membership 64:5,8
167:18
mental 29:4 136:11
mention 91:4
mentioned 9:21 19:10
53:6 81:2 86:12 89:9
100:15 112:20 120:2
129:19 132:7 133:10
149:17 160:13 162:2
216:7
mentioning 99:16
160:9
menu 57:9 65:3 93:1
205:17
merge 125:8
MERRELL 2:2 186:4

mess 195:15
message 182:22
 204:21 206:12
messages 206:19
met 1:9 178:14 214:14
method 51:14
methodologic 148:12
metric 12:17 130:1,1,10
 194:19
metrics 12:12 33:20
 53:6,11 67:13 103:19
 103:22 104:18 129:22
 151:1
MI 84:20
mic 117:8
Michael 1:14 45:19
 62:19 83:3,21 193:19
Michigan 22:15 123:20
Michigan's 21:20
middle 150:11
migrate 67:16
miles 70:17 132:1
 138:18,19,22 139:3
mind 34:16 46:13
 149:22 155:1 156:1
 204:2 211:1
mine 48:17 128:12
minimum 5:7
Minnesota 16:20
 139:10
minute 113:12
minutes 113:14
mirrors 57:22
misheard 40:22
missed 85:19,20 89:20
 89:21 172:3 179:14
 214:8
missing 34:1 81:22
mission 60:3 184:14
Mississippi 137:20
mistake 204:17
mistakes 31:15 58:18
misunderstanding 67:8
Mitra 2:14 114:2 165:22
 166:16 217:9
mix 32:7,20 36:14 37:12
mixed 35:1
model 20:13,15,17
 24:22 117:1 118:22
 118:22 127:5 141:7,9
 143:2,8 144:10 156:6
 176:10
models 115:14 118:15
 127:1
moderate 206:15
modified 4:17 169:16
modifier 189:13
modules 74:18 190:11

mom 19:16 54:16
moment 39:4 54:4 58:3
 58:7 158:15
money 47:13 73:3,8
 94:3 205:19 207:1
month 59:12 104:16
 106:22
month-to-month 48:20
months 55:9 94:22
 108:1 127:17 217:20
morning 4:3,20 5:12,16
 54:15 88:13,17
 101:18 116:1 145:22
 212:20,22
mortality 91:15 98:16
 98:18
Moscovice 1:10,13 7:5
 8:5 9:8 10:9,12 12:1,8
 13:3 14:13 15:21 16:8
 16:15 18:9 20:10 21:5
 22:22 23:14 24:2,14
 25:12 26:4 27:16,19
 29:12,15 31:22 33:4
 34:2 35:16 36:9,11
 37:18 38:11 39:2,16
 41:10 42:12 43:3,6,16
 45:6,16 46:14 48:4
 49:9 51:1 52:9 53:18
 55:18 56:22 59:1 60:7
 60:19,22 61:12,16,18
 62:10,13 63:9,19
 64:17 65:22 67:17
 68:1,9,15,19,21 69:10
 69:16,20,22 70:6 71:4
 73:14,20 74:11,15,20
 75:15 76:20 77:12
 78:18 79:21 81:1 82:2
 82:6,9 83:1,19 84:14
 85:16 86:2,5 87:22
 88:4,9 90:20 91:19
 92:5 93:20 95:9 96:9
 97:14 99:6 101:13
 102:11 103:13 104:19
 105:19 106:13 108:3
 110:1,13 112:10
 123:15 124:8 128:2
 130:14 132:3,16
 133:3,16 134:18
 135:19 136:20 138:15
 139:5,9,14 141:13,19
 141:22 142:13,20
 144:11,18 145:1
 146:11,22 148:5
 149:15 151:9 152:16
 153:18 156:4 157:6,8
 157:13 163:10 164:16
 167:5 168:22 170:21
 197:13,16 210:11

motivate 148:20,21
mountain 138:20
mountains 139:6
mouthpieces 175:18
move 8:10 10:17 13:20
 15:2 16:17 40:20
 41:21 42:2 51:13 66:1
 86:18 99:7 101:21
 153:20 156:22 157:9
 157:14 166:7,13
 183:21 186:13 211:17
moved 9:9 15:5 22:6
 157:2 190:2
movement 17:4
moving 37:6 61:7 79:5
 101:20
MPH 2:5,6,8,10,13,18
MSc 2:1
MSN 2:7
MSSP 159:17
MUC 62:4 164:20
 165:20
muck 208:15
Mueller 2:19 7:19,21,22
 214:7
multi-cultural 152:1
multiple 23:10 89:7
 101:18 118:20 175:2
 195:7
multiracial 152:1
multistakeholder 1:3
 158:4,14 208:10

N

n 97:21
N.W 1:10
name 7:21 21:22 64:3
names 5:14 144:19,21
Nancy 162:10,11
narcotics 96:6
narrow 200:1
nation 197:10
national 1:1,9 2:11
 41:21 88:18 93:18
 119:18 160:9
nationally 18:7
NCQA 17:12 18:8,8
 21:8,12 22:12,20 23:3
 23:6 25:4,6,15,17
 32:4
near 45:22
nearby 70:12
neatly 111:4
Nebraska 14:20 22:10
 155:22
necessarily 25:20 27:3
 28:21 41:8 44:20
 69:12 70:14 84:21

147:13 166:21 167:19
 201:17 203:18 219:10
necessary 26:9
necessity 188:16
need 4:19 5:1,4 7:16
 8:10 9:15,15 11:19
 26:12 27:20 28:4
 35:16,22,22 37:22
 38:4,6,9 43:10 45:21
 46:12 49:7 50:8,20
 57:7 61:4,12 64:21
 65:15 66:16 67:12
 68:6 71:7,11 74:8
 75:16 78:2 82:10
 84:16 87:17 92:6,10
 95:13 99:3 111:16
 112:13 122:22 163:2
 167:13 171:10,14
 172:9 177:6 180:18
 181:10 182:13,18
 183:1,4 184:9,15
 189:9,16 190:5,10
 192:16 196:17 199:14
 202:17,19 205:6,13
 205:14 207:15,18
 208:5 209:10,10,15
 210:8 211:6
needed 66:9 67:1
needless 156:6
needs 35:4 38:15 42:20
 50:18 56:4,5 57:6
 78:10 86:13 91:18
 92:21 138:21 191:21
 206:7
negotiate 53:13
neighborhood 135:5
neighbors 177:15
net 52:6 188:16 208:16
network 1:14,14 52:16
 53:1 64:2 176:16
networks 52:21 219:8
neutral 28:10 78:12
 189:14,15 191:21
never 40:2 48:9,12,13
 151:2 190:2 210:12
 210:14
new 4:16 7:18 39:10
 46:6 77:10 81:13,14
 94:19 100:14 105:5
 112:18 119:9 147:17
 173:4
nice 21:4 159:10 168:19
 169:19 187:14
night 8:15 106:18
 206:18 212:18
nimble 206:6
nirvana 23:17 84:2
nod 24:9

nominees 170:8
non 193:13
non-adjusted 130:1
non-CAH 69:8
non-clinical 20:14 21:2
non-hospice 99:17
non-palliative 89:11
non-rural 170:3 192:21
noncompliant 153:15
noon 6:19 171:18
norming 220:1
note 101:16 133:9
 181:3
noted 7:16 120:10
 128:5
notes 8:14
noticed 185:11
notion 8:21 10:18 26:22
 43:22 52:6 75:7 78:16
 86:15 137:16 149:17
notwithstanding 181:1
NQF 2:12 61:2 64:1
 92:8 128:9 140:4
 157:22 158:12 164:20
 165:7 170:1 172:21
 175:20 201:20 204:13
 205:10 210:14 211:15
 212:2,7,17 217:22
 218:4 219:19
NQF's 113:20
NRHA 181:6
NUKI 2:3 27:12,18
 39:18 96:10 97:10
 130:16 131:6 133:1
 156:7 169:2 202:2
number 11:18 29:1,5
 37:15 74:4 76:5,6
 77:21 78:19,22 79:2
 84:22 85:1 90:22 92:3
 92:12 107:7 111:3
 124:1,6 138:7 162:7
 165:4,4 175:15
 206:10,19 217:14
numbers 107:15 130:19
 153:14
numerator 28:21 29:1,9
nurse 39:9,9 49:4
Nurse-Midwives 2:7
nurses 31:10
nursing 26:11 39:12
 164:2 209:3

O

OB 138:4
obesity 125:15 161:19
objectify 95:14,21 96:4
objective 99:11
obligation 163:13

obvious 55:20
obviously 29:19 36:15
 40:10 68:5 81:9 97:11
 100:8 124:22 129:13
 146:15 195:3 219:21
occasion 5:3,6
occupation 115:19
Occupational 1:15
occur 64:15
occurred 54:22 58:14
oddly 34:1
offer 58:4 102:18
 108:10 214:1
office 7:22 95:2 160:8
 214:12 216:12
Officer 2:4,13 214:4
 216:11
oftentimes 127:2
oh 61:18 62:20 86:4
 97:13 105:12 110:15
 113:13 146:22 179:11
 195:21 196:1 210:17
oil 155:9,20
okay 6:8 7:21 8:5 9:8
 16:3 18:9 20:6,10
 21:5 22:22 23:14
 24:13 26:4 27:11,18
 27:19 29:12,15 36:11
 38:11 39:3 41:1 45:6
 46:14 51:1 56:22
 63:19,22 64:17 65:22
 66:19 68:15 69:20,22
 71:5,20 73:14 76:20
 77:4 79:21 81:19 82:5
 82:8,8 86:4,6,7 88:4
 99:6 101:13 102:11
 104:19 105:19 106:13
 108:3 110:13,15
 112:10 113:15 114:2
 119:6 120:20 133:7
 135:19 136:4,20
 140:1 141:19 153:10
 154:18 164:16 168:22
 169:1 171:8,16
 177:12 179:11 207:3
 219:16
old 40:3
ONC 83:6,17,20 160:14
once 22:6 58:21 110:8
 134:21 173:2 212:14
oncologist 96:16
oncology 87:16
one's 87:11
one-quarter 23:22
one-third 15:3,4
one-year 110:2
one/five 210:5
ones 9:20 19:1 37:22
 38:9 75:7 88:21 89:1
 92:17 93:11 118:15
 173:10,11,12,14
 175:4 203:13 216:15
ongoing 78:5 173:18
 189:6 192:3
onset 54:21
OP/PT 87:4
open 48:20 57:16 60:12
 61:4 63:5 64:14 82:19
 149:22 165:15 205:5
 217:11 218:20
opener 190:19
opening 128:1
openly 186:6
opens 14:11
operating 31:8
operation 31:13 152:15
operationalize 146:19
Operator 217:10,12
opinion 191:8
opinions 167:20
opportunities 28:11
 30:17 79:14 90:7
opportunity 3:16 6:21
 7:2,8 58:6,8,17 116:7
 116:11 130:12 144:12
 145:16 151:6 162:15
 175:22 177:3 178:2
 181:5 185:14 196:21
 209:6 211:11 214:2
 215:9
opposed 72:3 117:13
 130:20 159:8 201:1
opposite 34:16 126:4
opt 28:13
opted 206:22
optic 116:6
optimal 26:17
optimistic 212:11
option 64:6 201:8,11
 205:21
optional 85:21
options 134:16 192:9
order 50:19 75:17 78:14
 106:4 182:14 189:19
 190:9
organization 190:22
organizations 108:22
 205:10
organized 175:17
ORHP 64:18
oriented 142:10
originally 13:7
orthogonal 99:21
orthopedic 213:5,18
Orthopedics 1:19
orthopod 204:16

other's 73:8
OTR 1:15
ought 36:21 37:2 50:1
 111:7
outcome 11:8,12,15,18
 23:21,22 24:6 32:18
 33:9,15 37:7,15 40:10
 90:9 98:8 126:17
 135:11
outcomes 10:21 22:6,7
 23:16 24:12 30:11
 31:3,20 37:8 40:12
 48:7 115:4 116:20
 139:21
output 135:2
outs 191:15
outside 20:8 58:10
 109:19 165:2 176:20
over-utilization 97:2
overall 32:17 39:15
 109:8 126:1 180:22
 210:3,9
overcome 140:3
overlap 23:7 88:7 90:22
 91:1 170:14
overlaps 29:20
overutilization 20:19
overview 6:13

P

P-R-O-C-E-E-D-I-N-G-S
 4:1
p.m 177:11 218:11
 220:5
P4P 33:20 34:4,19 43:8
package 107:3
packing 15:2,13
page 205:8 218:4,5
paid 106:1 199:7
pain 90:13 95:12,14,15
 95:16,18,18,22 96:6
panel 76:22 118:3
 119:17 121:22 153:7
 194:4 204:14,16,19
panels 24:18
paper 114:11 123:21
parallel 78:20
paralyzed 31:5
parameters 42:10
paramount 100:2
parsimonious 93:13
part 12:17,19 18:17
 28:21 43:15 45:18
 47:12 56:18 59:7
 63:14 69:3 81:14
 103:18 104:1,3 112:7
 113:1 114:16 117:20
 118:16 121:14 122:12

127:10 128:13 132:8
134:11,21 141:3
146:13,14 147:3
161:2,3 164:7 166:5
169:8 173:3 191:1
195:15 199:15,15
202:5 209:13 214:5
participate 168:14
186:2
participating 108:22
200:20 201:2
participation 8:22 9:3
26:3 57:4,6
particular 50:3,18,19
88:20 89:2,3 90:17
112:16 119:6 120:4
121:13 142:15 164:12
particularly 10:17
26:20 112:8 114:18
114:19 117:20 121:19
122:20 143:16 184:12
184:19 199:4 213:14
partly 98:19,20 145:7
partners 2:4 209:7
partnership 64:18 78:1
158:2
parts 34:8 192:13
pass 138:20 144:11
passed 153:17 173:21
passionate 18:19
path 18:1 53:9,10
pathways 115:4
patience 4:6 211:6
patient 17:17 29:6
31:10 32:10 39:15
44:9 72:13 90:1,10,16
94:9,16 96:5,19 98:21
99:2 100:16 106:21
107:4,20 115:2,2,22
117:5 119:21 121:16
125:10 129:3,15
135:1 156:1 174:22
192:21,21 193:2,9,10
patient's 174:22
patient-centered 11:1
16:19 17:3,6,7 21:7
55:3 90:14 175:5
patients 44:9 48:9 55:5
56:15 70:15 89:7
94:20,21 95:6,17
96:12 107:12,17
109:1,8,9,16 124:1
131:14 136:8 147:4
152:4,9 153:12
193:13,14 203:22
204:6 208:3 209:1
Patrick 181:6 212:9
pay 37:7 40:13,20 41:16

41:18 42:6 45:14 46:8
47:8 51:3,21 82:12
94:4 95:3 139:18
156:15,16 158:7,8
pay-for 13:6 46:11
51:13,18 58:13
102:20 182:11
pay-for-performance
12:14,17 14:11 35:10
40:17,19 41:4,17,22
42:2,9,18 46:18 47:20
48:14 50:10,11 53:17
70:18 102:21 112:2
188:20 205:18
pay-for-reporting 40:20
42:7 46:11 50:10
102:21 190:3
payer 75:4 111:11
187:22 190:20
payers 71:8 76:14 84:2
162:1 190:22
paying 41:7 106:22
payment 13:20 28:5,7
34:21 50:2 66:8,22
72:6 105:10,16 181:2
189:13 210:6 215:12
payments 105:11
pays 107:14
PCMH 17:10 20:13,17
23:4 24:16,22 25:22
44:17
PCMHs 18:18
PCP 134:12
PCPs 77:11 133:21,22
pediatric 49:2
peer 30:14 66:4,9,13,18
66:22 67:6 68:4 69:2
130:17,20 131:3
147:7 203:8
peers 32:22 146:1
147:3
peeves 184:1
penalties 53:7
penalties 142:12 201:1
penalty 52:1,5
Pennsylvania 1:15
151:19,20 187:2,3
190:21 191:1
people 10:3 18:2 19:8
25:15 28:3 42:16 47:5
47:13 55:11 57:18
67:15 71:19 72:11
73:7 79:15 80:12 87:2
94:11 98:2,5 101:7
106:2 122:17 123:8
128:18 132:18 139:22
140:3 145:8 146:5
147:20 148:16,17,18

152:21 153:7,16
156:21,22 157:2
168:1 170:2,3,4 171:9
181:13 187:15 188:16
188:21 200:4 201:11
202:15,18 203:19,20
209:9 212:14 216:7
219:9
people's 31:18 44:15
peppered 114:4
perceive 209:17 210:4
percent 80:21 81:5
87:10 103:5 124:16
124:16,19 126:18,18
131:13,14 137:21,21
196:13
percentage 154:20
perception 34:17
perfectly 220:2
perform 50:19 52:2
performance 1:3 13:7
37:9,17 38:17 41:8
46:12 47:13 51:14,19
57:13 58:14 80:20
158:8 182:12 184:3,8
200:9 211:22
performing 37:5
perinatal 161:18
period 82:21 118:8
127:11 218:21
periodic 19:15
periodically 157:18
periods 189:7
person 129:6 169:7
209:4 211:3
personal 182:4 191:8
personality 65:13,14,15
personally 41:7
perspective 34:17 53:3
58:4 89:16 120:6
123:14 131:5 135:7
136:16 148:9 150:18
170:5 174:6 185:15
185:19 196:12 204:21
214:9
perspectives 186:9
213:20,22
pet 184:1
Peter 10:7
Petri 176:12
PFP 49:6
pharmaceutical 39:22
phase 185:21
phased 37:21 43:13
45:20 49:17 57:7
phasing 25:18 49:11,12
56:5
PhD 1:13 2:4,8,15,19

Philadelphia 157:12
phone 55:10 62:17
107:7 216:1
physician 19:18 28:12
42:1 46:21 47:2,21
130:3,3 152:6 165:12
165:14 180:14 189:13
194:15 209:18
physicians 41:7 145:9
152:18 184:2
pick 55:10 173:8 219:5
picked 205:17 213:16
213:17
picking 51:20 134:11
145:7 148:4
picture 177:2 182:16
pie 73:9
piece 73:9 75:21 119:8
133:18 137:19 160:19
pilot 176:13
piloting 63:22 64:2
Pittsburgh 151:18,18
151:19 187:6,9
place 26:2 38:14,15
43:22 48:20 50:3
105:1 156:20 199:9
places 17:16 50:15
67:20 68:11 70:12
106:12 112:1 122:17
154:22
planned 4:8 42:20
planning 90:14 99:9
plans 94:19 101:8
111:15 117:22 171:22
plant 15:2,13
Platte 1:16
play 64:8 110:2 180:17
player 112:6
plays 150:1
plea 65:2
please 70:10 159:9
185:20,20 217:11,13
pleased 202:5 214:12
pleasure 187:18 193:18
210:13
plumber 197:9,21
plumbing 197:17
Plus 131:22 179:3
pneumonia 36:3 81:16
84:19 85:11
pocket 90:1 94:17 95:7
96:19 100:16 106:22
155:19
point 7:7 10:20 13:2,11
14:10 16:5 24:20
25:10 26:8 31:2 33:6
35:19 36:15 37:20
42:4 54:19 55:13 59:2

60:8 62:11,14 70:9,11 75:1,20 76:1 83:2 91:7 95:12 102:18 108:13,19 133:13 138:17,17 146:12 148:9 149:16 162:20 176:14 180:18 182:4 182:5 183:3 199:13 209:12 210:6 215:8 218:5 219:5 pointed 57:5 87:2 169:9 points 11:1 21:13 49:10 67:19 80:2 185:18 policy 2:1 8:1 24:19 111:2,8 115:13 119:10 137:12 199:2 214:4 poll 206:17 pool 27:14 poorly 37:5 popping 88:12 populated 170:10 population 10:18 24:18 24:21 25:11 52:19 65:14 86:18,22 102:20 103:2,4,6,11 104:11 129:2,15 130:9 131:12 137:22 150:14,18,19,21 152:9 169:12 173:7 192:4,6 populations 85:10 137:6 183:18 portion 177:17 positive 205:19 possible 24:11 25:3 65:5 72:2,9 78:11 124:12 136:21 possibles 143:12 possibly 14:5 138:2 178:8 183:14 206:16 post 219:10 post-acute 79:17 158:21 posted 218:4 postulate 52:18 potato 153:16 potential 3:4 48:10 64:20 100:14 134:5 140:9 182:11 potentially 46:1 47:8 106:19 135:11 159:2 162:16 199:16 200:18 powerful 151:8 PPS 76:2 77:7 PQRS 159:17 165:13 189:1 214:21 practice 14:21 36:19	44:18 134:13 136:13 145:4 146:2,9 147:10 152:4,8,15 153:12 180:13,13 197:9 200:9 209:18 practices 28:13 37:1,11 37:11 43:9 44:8 186:1 215:16 practitioner 134:9 209:19 practitioner's 187:22 praying 56:3 precedent 104:9 189:18 preconceived 149:17 predicated 51:4 predicates 51:12 predictors 143:8 prefer 70:4,5 preferable 24:7 preference 144:6 premature 170:7 preparation 179:17 prescribed 129:5 prescription 96:2 prescriptions 123:3 present 1:11 2:17,22 35:17 116:9 148:21 presentation 39:19 presentations 24:16 25:5 presented 122:1 presents 182:9 preserves 52:5 President 2:2,11,15 presiding 1:10 press 217:13 pressure 10:1 32:19 41:20 pretty 31:10 32:14 40:15 87:5 93:8 118:7 121:4,12 122:3,7 131:9 142:4 143:6 146:20 150:11 154:12 164:8 165:11 166:4 167:1 170:7 176:8 201:10 202:5,10 214:14 prevalence 101:7 prevalent 155:13 preventative 20:21 previous 47:10 86:3 primary 17:8 19:17,18 23:5 71:14 87:14 180:10,16 primer 113:20 principle 35:22 principles 34:18 prior 67:8 89:9	prioritize 92:6 priority 211:15 private 159:11 161:7 162:1 192:8 privilege 185:10 probably 8:15 21:9 30:3 36:16 44:21 47:4,5 61:8 80:15 84:6 95:19 96:19 99:13 102:8 104:14 107:16 114:6 117:4,12 125:7 133:3 139:3 147:21 154:6,8 154:10,12 156:13,17 159:5 170:11 180:5,8 187:15,19 188:5 189:2,17 199:14 204:16 206:13,15 212:12 problem 21:11 30:6 32:3 37:5 70:15 83:20 107:13 125:4 152:3 179:3 196:2 problematic 184:12 problems 112:5 147:16 172:19 procedures 87:3 process 6:14 16:12 17:11 21:8,21 23:3,19 23:20,22 24:13 25:9 31:6,6,17,17,21 32:4 32:18 33:10,12,16 36:16,21 37:14 44:17 44:21 48:6 51:8 56:5 63:10 71:9 72:6 73:17 78:5 118:12 149:8,8 152:14 161:4 165:7 165:17 166:1 167:2 168:15,17 172:5,13 173:3,15,18 174:7 179:19 180:9 183:9 184:11,17 190:7,14 190:15 202:12 204:4 208:10 212:10 processes 21:18 48:11 62:1,6 212:5 produced 108:20 product 198:11 production 110:7 productivity 89:18 96:20 Products 2:3 professional 130:7 137:4 186:6 professor 2:1 151:17 profound 2:3 152:10 profoundly 151:16 program 32:13 55:3 57:4 63:1 66:2 82:17	82:21 100:18,18 108:20 138:4 160:11 164:18 165:13 189:1 189:2,3,14,15,19 191:4,6,8,13,17,19 192:7 196:4 199:16 programs 42:1 50:3 57:4,14 58:11,15,19 62:8 102:4,5 158:6,9 158:13 159:16 161:1 161:5,13,15 162:8 163:16 164:2,3 165:12,12,14 168:18 189:6 191:14 progress 174:10,17 199:17 prohibited 115:13 project 2:14,14 62:4 190:14 214:3 215:11 216:9,16 218:4 projects 104:15 prominent 53:12 promise 102:14 promote 72:3,15 73:11 proposal 12:16 proposed 163:16 protected 184:16 proud 94:15 prove 198:6,8 provide 102:3 105:17 107:11 158:3 198:5 212:15 provided 103:4 127:8 210:3 provider 1:21 19:12 38:1,17 54:8,18,20 99:3 101:5 102:22 134:6 150:13,22 153:13,14 167:9,17 181:16 204:18 provider-specific 103:22 providers 1:4 8:11 26:9 28:7,11 30:9 35:13 37:2 42:11 43:15 46:3 49:14 50:4,5 51:9 54:12,14 55:5,6 56:4 76:17 77:14 79:19,20 101:20 103:4,9 104:2 108:6,21 109:4,4 111:18 122:11 128:16 135:12 149:5,13 163:8 167:8 175:3 179:22 180:4,7,15 183:5 184:9,15 189:5 189:17 200:13 208:9 208:22 211:9 provides 51:9 158:11
--	---	---	---

providing 89:4
Provonost 10:8
proxy 121:2
psychiatrist 136:4
 185:6
psychiatrist-less 213:9
pubic 30:10
public 3:16 12:19 13:17
 14:11 34:21 35:14
 41:16 63:2,14 64:15
 104:4 111:2 129:12
 171:3 178:2 181:5
 190:3 208:21 209:8
 217:8,11,15 218:20
 219:7,17
public's 76:15
publically 148:15
pull 47:14 125:4,13,15
pulled 90:3 210:5
pulling 23:9 84:7 208:6
punishing 201:2
purchaser 89:16
purchasing 98:15
 159:18
purpose 55:17 59:21
 93:2 199:20 203:17
 203:19 211:2
purposes 30:9 103:20
 148:12
pursue 25:6
push 73:3 188:6
pushed 191:18 192:1
put 35:18 36:13 39:3,6
 39:9,10 42:10 72:11
 90:18 102:17 104:12
 116:22 131:3 157:20
 166:21 170:18,19
 172:11 176:12 193:15
 199:14 202:14 204:2
 204:16 206:5 217:22
puts 159:20 167:15
 173:4 214:19
putting 134:19 144:9

Q

QI 67:8 148:9
qualified 50:8 187:8
qualifies 120:19
qualify 193:16
quality 1:1,9 2:16 18:18
 30:9,17 56:12 66:4,13
 67:13 79:19 86:12,22
 88:18 90:7 93:18
 98:17,22 111:19
 112:22 172:17 182:19
 182:21,22 185:1
 189:17 198:6 206:2,8
 216:13

quandary 137:1
quantum 46:10
quarters 23:22
queens 206:3
question 12:11 14:17
 18:20 30:11 34:15,20
 74:2 80:14 87:9 91:6
 91:22 97:17 98:13
 114:14 121:2,11
 123:6 124:9,10
 132:11 135:10 140:7
 140:16 153:22 162:5
 163:12 169:22 197:14
 219:15
questions 4:22 15:18
 15:19 151:5 162:22
 163:8 168:9
quick 13:10 85:19
 110:17 153:11,22
 171:9 206:6 219:15
quicker 26:17
quickly 27:2 41:21 43:7
quite 9:21 11:10 17:6
 30:20 82:7 115:17,18
 132:2 161:6 164:5,7
 210:14 215:20

R

R 143:11
R-squares 127:1
race 125:6 133:12
racial 116:6 120:14
 125:18
RACs 58:9 180:6
radar 104:18
rage 95:17
raise 90:19
raised 140:17 168:13
 187:15 214:10
raising 15:18
ramp 215:4
random 146:5
randomness 129:14
range 115:21 126:16
Rankings 104:13
rapidly 109:6
rare 193:22
RASK 2:4 49:10 78:19
 133:18 148:8 184:1
ratchet 77:8
ratchets 45:3
rate 104:8 122:16
 145:15 155:15,16
rates 55:12 91:15 98:18
 122:8 141:11 142:11
 145:6,22 146:18
 147:22 150:15 164:4
rating 210:5

ratio 28:20
rationale 116:18
RAUNER 2:5 10:6,10
 14:14 21:6 32:1 46:15
 71:22 83:4 97:16
 106:15 124:9 127:15
 145:3 147:8 154:18
 193:20
raw 151:7
reach 26:9
reaching 25:1 123:11
reaction 134:20
reactions 28:17 41:10
 41:12
read 21:10 171:9
 196:22 218:13
readily 27:4
reading 59:22 209:4
readmission 117:21
 122:8 142:6,15 145:6
 145:15 147:22 194:14
readmissions 20:20
 79:17 117:14 127:19
 143:3
ready 113:20
real 14:1 43:7 44:16
 49:5 58:6 62:4 110:4
 110:4 138:3 139:16
 153:11 176:9 208:16
 212:9
reality 33:13 92:11
 104:1 128:19 138:10
 138:14
realize 54:13 62:17
 127:22 195:4
realized 12:13
realizing 215:1
really 5:16 7:9,12 8:11
 11:9,13,18 12:2 13:5
 13:11,13 14:9 20:1,9
 20:12 21:1,6,22 22:17
 22:19 23:4 32:14,17
 32:21 33:1 34:3 37:20
 38:5 44:7 45:10 47:19
 49:18 50:9 53:1 54:8
 58:20 59:2 61:21,22
 64:18 66:12 70:19
 73:17 74:16 75:5,6,10
 77:17 87:15,17 88:22
 89:6,13,17 90:4,11
 91:4,16 92:10 96:22
 97:6,19 102:7 103:2
 104:18 107:4 110:13
 111:17 114:17 115:2
 115:18,20 116:3,7,8
 116:13,17,17 117:5
 117:21 118:6,12,14
 118:18 119:22 120:3

120:4 127:21 129:9,9
 129:10,17 130:12,12
 130:21 132:20 134:7
 135:1 136:15 138:13
 144:5 145:22 146:1
 146:15 148:19 149:13
 150:11,12 151:16
 155:14,16 159:6
 161:3,4 162:4,13
 166:9 167:14,14,16
 168:9 170:19 172:1,9
 172:15 173:7,22
 174:7,14 177:16
 178:18 179:1 181:18
 184:9 185:9,9 187:14
 188:10,14 189:16
 192:11 196:7,16
 197:16 198:2 199:3
 199:10 200:3,21,21
 201:15 202:19 203:6
 204:6 207:7,13
 209:15 210:9,22
 211:16,17 212:17
 213:1,11,12 216:4,5,8
 216:17
reason 27:1 50:6 54:10
 54:11 121:14 141:3
 194:9 214:3
reasonable 76:5,6,7
 82:15 166:6 198:8,11
reasonably 17:14
 120:12,22
reasons 33:21 34:12
 72:10 111:3 115:6
 144:1 145:5 148:11
 150:2 215:8
reasserting 23:5
reassured 54:17
rec 44:1 73:10 194:16
recap 6:8
receives 207:14
receiving 109:3,10
recipients 183:2
recognition 17:11
recognize 115:1 186:15
recognized 18:8
recollect 13:4
recommend 22:1,13
 62:7 168:16 174:4,5
recommendation 24:20
 59:13 61:6 79:9 85:21
 163:22 219:21
recommendations 3:2
 3:9,13 6:16,22 59:18
 108:4 117:18 119:16
 163:14 164:4,14
 173:20,22 179:20
 185:19 186:13 200:16

200:21 207:19
recommended 163:19
recommending 6:18
 59:14
reconciliation 10:2
 37:3 72:14
reconvene 177:13
record 11:22 14:21 56:2
 113:18 135:22 172:3
 177:10,22 198:16
 220:5
recording 218:3
recruiting 185:22
reduce 75:6 84:17
 109:8
redundant 83:9
refer 158:2
reference 33:19 67:1
 219:18
referral 131:7 132:12
 132:17 134:5
referred 70:4 134:15
 214:21
refers 97:3
reflect 6:22 10:15 89:18
 99:4 210:9
reflecting 13:20 181:22
 220:1
reflection 124:10
 178:10 179:12 210:2
reflections 3:13 125:3
 171:20 214:2,6
refreshing 213:11
regard 214:15
regarding 95:12 133:9
 172:17
region 131:8 134:1
 154:3
regional 2:3 148:3
regionalize 70:10
regionalizing 70:18
regions 136:18 205:1
Register 196:22 209:5
Registered 1:15
registries 56:14 83:11
 95:1
regulars 213:10
regulations 199:21
reimbursement 52:3
 58:16 105:5
reimbursing 50:5
reiterate 16:10 69:1
 94:1
relate 79:18 89:7
related 8:12 35:6
 100:12 115:6 156:13
 201:14 208:20
relates 30:12 59:10

79:19
relating 81:9
relationship 86:20 92:1
 112:22 117:2
relative 39:14 51:21
 120:11 168:9
relatively 29:9 100:19
 120:16 129:1
Relax 108:9
released 80:9,10
relevance 211:20
relevancy 8:12 16:10
 54:5
relevant 10:13 11:10
 16:5 29:17 30:8,10,13
 35:13,13 38:17 42:4
 42:18 45:10 51:8 78:3
 81:15,17 92:18 93:15
 117:13 128:14 129:10
 143:16 167:12 168:18
 169:11
relying 121:12
remarkable 160:21
 162:9
remember 45:21
remembered 206:8
remind 188:21 206:18
remote 67:4 137:13
remove 124:12,15
renal 40:3
repeat 162:5 182:1
replacing 92:13
reply 196:21
report 5:4 6:11 9:19
 11:3,8 13:21 16:22
 17:5 18:10 44:18
 45:13 56:7,13 59:7,22
 61:5 66:14 82:12 83:5
 83:20 114:10 116:1,9
 116:12 118:3 128:12
 128:14 167:15 179:20
 195:3,8 207:14
 212:15 214:19 215:20
 218:12,16,20,22
 219:17
reported 71:10 90:11
 95:16 103:22 148:15
reporting 12:19 13:18
 14:11 25:22 28:4
 30:10 34:21,22 35:9
 35:14 38:16 41:9,16
 44:16 46:8 58:7,14
 74:17 75:7 81:20 82:4
 83:11 95:4 104:5
 129:12 137:3 149:8
 152:6 158:7 163:15
 168:16 185:21 189:10
 190:2,3

represent 185:12
representative 23:10
 193:22 216:11
represented 180:1
reputation 206:14
require 11:15 165:17
required 18:2 94:5
 106:1,9 118:20
requirements 25:21,22
 26:1 108:9 152:6
 183:3 215:2
requiring 79:7
research 1:16,17 24:19
 92:21
researched 109:13
 142:7
researchers 165:6
residual 124:17
resourcefulness 98:7
resources 2:18,19,20
 17:19 71:15 76:17
 91:17 97:20,22 98:10
 99:12 105:17 122:21
 132:21 133:21 182:13
respect 87:17
respectful 59:17 207:9
respectfully 60:5
respond 4:14
responded 140:5
Responding 208:21
response 9:7 14:7
 29:14 31:16 36:10
 97:17 142:22
responsibilities 113:10
 130:7
responsible 14:6 151:3
rest 124:20 177:16
 212:7
result 141:4,5 152:8
 205:12
results 126:10 146:8
resumed 113:18 177:11
retinal 19:14
retire 78:3 82:22 85:11
retired 84:16
retirement 112:17
retiring 81:12 82:19
 92:13
return 104:8
revenue 32:11 205:18
review 3:2 159:19 180:9
revised 119:10
revising 218:16
reward 189:16 203:18
rewarding 37:13
rewrite 199:20
RICE 2:20 61:17,19
 62:12 82:16 216:3

rich 9:1 29:21 86:9 87:5
 188:10
rid 124:19 153:6 208:8
rides 138:8
right 6:4,4 7:9,13 10:9
 12:8 19:19 41:18
 43:10,22 58:22 59:6
 60:12 61:11 71:20
 73:17 74:7 81:22 96:5
 97:9 101:1 106:16
 113:7 114:13 129:20
 142:17,20 145:1
 147:9 148:4 156:6
 157:13 172:9 175:14
 178:12 182:10 192:2
 200:12 208:13
rise 14:8 89:3
risk 11:14,15,17 14:16
 15:10,12,14 20:5 27:7
 30:16 31:5 49:18
 55:19 114:7 115:9,14
 117:1 118:15,21,22
 124:13,15 126:13
 130:18 148:11 161:17
 163:20 184:4
RN 2:2,20
road 51:15 92:17
Robert 2:5 104:12
robin 6:21 171:13,15,20
 177:17
robust 218:13
role 166:10 176:9
roll 115:17
rolling 41:18 184:7
ROMAN 2:6 39:3 41:14
 188:9
room 1:9 31:8 81:8
 185:11 186:5,10
 187:14 210:21 217:7
roots 217:4
rosa 58:9
rough 34:10
round 6:20 171:13,15
 171:20 177:17
Round-Robin 3:13
row 4:13
RPRI 24:18,18
rule 162:16
rules 159:21 163:17
run 49:18 52:12 95:1
 107:15 163:20 217:19
running 86:7
runway 200:17 201:12
rural 1:3,4,16 2:9,11 4:5
 7:22 8:11 9:14 10:13
 11:10 12:1,6,12 14:4
 14:4 16:5,9 24:19,21
 26:9,13,21 28:14

29:18 36:5,19 37:11
 38:1 42:11 49:14 50:7
 52:17,18 53:3,17 56:3
 60:12 61:3 64:5 65:9
 65:10 67:11 69:7,8
 75:21 77:7,10,11
 79:19,20 80:15,18,22
 81:15 88:20 89:2,4
 91:5,9,16 92:10 94:2
 94:15 96:3,13,15
 97:19 98:4,12,18
 100:12 101:5,19
 102:6 104:2 105:3,9
 105:18 106:6,11
 108:5 109:15 111:4,4
 112:6 114:1 116:4
 120:5 123:14 129:10
 129:16 130:21 131:5
 132:13 134:12,22
 135:12 136:2,3,17,17
 136:18 137:17,20
 143:20 144:2 150:7
 152:17 153:8 154:21
 163:8,20 166:10
 167:8,12 168:17
 170:1,2,4 172:17
 173:13 175:2,5 176:8
 180:3 181:10 182:7
 184:9,22 185:1,13,16
 185:16 187:12 188:13
 188:15 192:20 193:3
 193:13,14 194:2
 195:16,17 197:9,11
 198:4,5 199:8 200:13
 202:19,22 203:10
 207:13 208:1,9,22
 209:7 211:20 212:4
 214:4 215:12,12,18
 217:5
ruralist 194:2
rurally 142:10 196:12
rurals 81:5
rush 2:7 5:21
rushing 36:3

S

safe 219:3
safer 31:14
safety 11:5 39:15 52:6
 175:1 188:16 208:16
sake 60:10
sale 106:21 107:2,20
Salt 136:9
sample 29:11 119:12
 179:3
SAS 121:3
sat 5:13 167:3,10
satisfy 168:20

saturated 143:7
SAUNDERS 2:7 174:12
Savings 32:13 108:20
 109:20
saw 72:8 216:16
saying 5:6 13:14 22:14
 24:5 28:3 35:5 41:1
 55:7 67:18 92:20 93:2
 94:10 118:4 136:13
 139:20,22 140:1
 141:3 159:8 164:1
 166:18 176:15 186:5
 193:21
says 19:18 39:10 62:12
 69:11 103:3 145:21
 165:18 188:2 190:20
scale 82:15
scare 185:5
scares 70:19
scattered 4:10
scheduled 171:4,17
scheme 57:11
SCHMALTZ 2:8 11:12
 12:4 28:18 35:21
 73:16 126:15 178:13
school 2:2 89:21
 125:13
science 19:2,7 66:11
scientific 2:13 148:13
scope 20:8 38:1 43:15
 134:13 136:13
score 15:10,12 124:15
 131:19 151:4,7
scorecard 32:7
scores 57:11 95:15
scoring 55:4 152:18
scratch 179:5
screening 19:15 32:18
 86:12
screenings 20:22
SDS 6:10 15:22 66:10
 112:21 113:15,20
 114:1,2 115:16
 116:16 118:16,22
 129:2,8 130:4,20
 140:13 141:5 151:15
 153:19 156:5 157:9
 183:14 193:15 201:14
seasonality 139:10
seatbelts 155:5
seclusion 29:5
second 4:16 8:10 15:6
 16:4 33:18 54:21
 80:13 91:7 94:16
 100:21 138:17 189:19
 195:13
Secondly 49:22 51:18
 183:4 214:16

section 178:10 181:10
sector 8:20 71:13
 159:11 161:7
sectors 8:20 71:12 75:9
see 8:3 20:17 38:20
 39:20 44:13 45:9
 48:15 55:11 89:19
 90:15,18 95:4 96:2,10
 102:7 109:1 117:1
 118:21 119:2 120:3
 125:22 126:2,3 127:3
 132:7 140:14 141:10
 142:6 145:21 148:17
 150:22 153:4,12
 160:15 161:8 163:4
 166:3 176:13 179:4
 182:6,16 186:17
 190:12 192:21 194:3
 211:12 214:13 219:10
seeing 13:19 96:1
 139:7 142:9 170:21
seen 55:6 126:19 191:8
 191:9 214:20
segmented 111:22
select 37:15 159:9
selected 158:5 168:18
selection 34:18 51:7,8
self-employed 155:17
self-insured 111:15
selves 56:13
send 83:6 147:4 183:1
 218:6,12 219:7
sending 83:5
sends 25:1
Senior 2:8,10,15,15
sense 24:4 34:3 44:7,10
 58:12 60:11 65:18
 66:14 75:19 88:19
 89:1,5 93:10,17
 117:12 122:20 123:8
 124:20 126:14 129:7
 130:2 131:4 138:3
 141:1 146:18 148:3
 164:9 169:17 188:1,3
sensitive 183:5
sent 70:16 206:12,16
 206:19
separate 165:7
separately 180:6
separating 179:21
sepsis 124:2,7
September 219:1
serious 91:22
seriously 74:9
SERPA 2:5
serve 138:12 184:13
served 128:20 137:5
service 57:10 60:18

66:6 109:2 191:16
 192:15 196:16
services 2:19,19,21
 79:17 89:11 100:4
 136:9,11,15 137:14
 191:19 193:2,5
serving 86:16
SES 115:17,18
set 4:13 9:10,15 10:13
 23:9 25:1 37:13 38:19
 45:12 49:2 57:10 71:7
 74:16 75:4,14,18 80:7
 81:11 82:15 104:8
 119:20 123:13 125:14
 136:18 155:1 156:2
 159:8 173:8 190:10
 211:18
sets 11:9 23:11 94:8
 108:20
setting 19:13 36:6 52:4
 91:9,10 94:2 136:17
 173:12,13,14 208:1
settings 42:11 100:13
 136:18 179:7 200:9
seven 189:2
Severa 2:14 165:22
 166:16 178:3 217:18
severely 192:3
severity 11:19 126:20
shaking 89:19
share 218:4
shared 32:13 109:20
 212:18
sharing 172:6,7 186:6
 219:11
shed 173:16
Sheila 2:6 44:12 188:8
 190:17 214:20
shelf 214:19
shift 13:16
shingles 154:7
shoot 48:9
short 82:21 115:22
 217:22
Shortage 137:4
shorten 38:20
shortly 158:10
shot 73:19
shots 73:10
shout 216:17
show 21:10 33:15 153:3
 158:10
showing 193:12
shows 197:10
shy 210:21
side 15:8 32:5 38:2
 43:12,18,19 44:14
 66:13 79:10 87:15

93:21 124:10 134:20
135:4 139:15,19,21
152:17 180:13 187:22
187:22
sidelines 216:8
sides 187:21
sidetracked 170:3
sign 95:18,22 107:12
107:17
significant 93:8 119:4
122:7 125:1,1 141:6,9
silent 34:11
similar 14:20,20 46:16
69:8 85:7,13 108:11
110:21 137:16
Similarly 161:16
simple 18:5 56:17
simply 33:15 93:2
134:16 140:22 144:12
sincere 56:16 212:6
single 199:15
sink 205:20
sit 48:22 159:12 170:14
sites 79:16 134:5
sits 94:9 159:13
six 94:22 108:1 127:16
132:18
sixth 14:22
size 2:9 12:10 14:1,20
23:15 24:9 29:11 33:6
34:8 35:4,11 52:10
59:9 60:17 61:11,14
66:20 67:22 68:8,13
68:16,20 73:21 74:13
74:19 75:12,16 76:10
76:14 91:22 103:15
110:17 111:12 112:4
128:4,8 131:11,12
132:17 150:3 180:20
205:15 207:7
sizes 119:12
ski 139:13
skill 45:4
skip 84:20
SLABACH 2:10 16:9
24:15 38:13 51:3
57:20 70:3 77:20
101:15 104:20 108:18
110:6 136:21 151:10
151:22 164:17 168:12
181:21 219:15
slate 179:6
sleeper 52:17
slide 6:4 9:5 16:11
27:22 28:16 39:21
42:13,15 57:2 66:1
85:17 86:3 87:19 88:3
88:10 89:9 90:21

106:14 110:14,15
112:11 119:7 161:2
slides 4:16,17 5:8 8:9
13:5 86:1 212:19
slightly 33:16
slogging 211:6
small 10:16 16:12 29:11
43:9 48:16 49:14,20
69:6,7 106:11 141:21
144:2 149:5 150:10
153:15 179:3 180:6
186:1 189:20 200:9
SMALL-PRACTICE 1:3
smaller 28:12 92:3
129:12,13 141:21
158:22
smiling 159:4
snowboarding 107:10
social 11:16 27:6 94:4
103:7 143:4 184:14
186:16
socially 14:16
society 111:6
sociodemographic
15:8 114:9 118:11
119:20 198:3
sociodemographics
117:6
socioeconomic 70:22
114:8 124:5 156:14
socioeconomics
124:18 125:17
solid 21:19 98:10
solution 176:5
solutions 2:5 3:4 208:8
solved 172:18
Somali 15:7
somebody 57:20 78:13
78:14 80:19 117:15
188:2
someone's 101:3
someplace 151:20
somewhat 4:18 50:4
83:4 85:13 97:4
100:19 115:8 133:8
179:1
soon 5:8 31:10 86:8
sore 54:17
sorry 5:22 6:1 61:20
88:11 93:6 110:17
123:17 162:11
sort 11:7 14:17 18:1,5
22:10 23:5 46:9 59:4
81:11 90:18 99:17,18
99:20 100:1,11 114:4
119:18 120:13 135:6
140:4 143:8,17 144:5
159:2,2 180:8 200:1

200:11,18,22 211:1
214:10,12
sound 135:21 198:15
sounded 41:6
sounds 6:14 17:12
52:14 61:21 62:4
63:15 132:10
sources 109:2
south 107:10
Southern 1:17
sparked 105:20
sparse 96:16
speak 174:18 211:7
speaking 25:15 49:13
special 100:11
specialists 143:21
175:4 180:15
specialties 87:16
specialty 87:18
specific 17:2 18:20
87:3 92:9 101:16
116:4 150:22 166:7
specifically 21:20 50:6
59:10 119:15 158:4
specifications 26:7
118:20
specifics 114:1
spend 5:16 7:13 26:19
207:18
spending 31:10,11
107:21 207:2
spent 18:16 100:3
sphere 77:2
spin 173:4
split 43:11 113:13
spoke 33:8
spot 5:13 134:19
square 143:11
St 1:19 121:22
staff 2:12 18:11 94:5
131:12 132:18,19
133:2 210:14 212:17
stage-specific 90:10
stakeholders 164:10
206:11 208:6 215:19
stakes 114:20
standard 100:19 119:19
123:13 152:7
standardized 71:9
standards 25:2 45:1
53:1 215:10 216:13
standby 67:5
Standing 119:9
standpoint 192:22
193:7
star 210:5 217:13
Starfield 21:14 22:19
start 7:6 30:21 35:9

37:15 40:18 43:19
46:9 91:5 129:17
131:16 135:14 145:8
150:22 151:4 162:19
177:18 178:11 193:21
200:20 205:19
started 4:7 22:4,5 52:21
73:22 128:21 129:11
188:22
starting 56:4 86:9
104:16 133:12 146:3
162:19 179:5 198:3
state 16:20,21 18:12
22:14 25:16 111:3,6
112:5 136:3 150:5
185:6,16 190:21
191:18 192:2 206:13
stated 45:10 86:1 201:9
statement 54:14 75:20
states 17:20 18:6 21:17
22:14 110:21 136:3
136:17 149:6 156:20
192:7,9 211:8
stating 55:19
statistically 31:4 48:13
124:22
statisticians 124:11
statistics 149:20
stats 66:11 126:11
status 22:8 114:8 121:3
127:18 156:14
statutory 215:1
stay 67:15 205:5
staying 109:16
stays 85:13
steeped 19:2
step 167:15 168:3,10
174:18 211:16
step-like 46:10
step-step-step 44:21
Stephen 2:8 178:12
186:13
steps 3:18 7:3 168:7
178:3
Steve 11:11 28:17
35:20
Steven 33:5 73:15
stole 138:16
stop 9:4 31:19 39:1,6
138:4 201:22
storming 219:22
story 185:15
strata 119:13
Strategic 1:21
strategy 61:5 88:18
93:18
stratification 119:2
141:15

stratified 141:4 169:16
stratify 119:12
streak 154:4
streamline 195:5
Street 1:9
stress 202:20 203:8
stressed 192:3
strictly 84:4
strongly 52:10 168:6
struck 151:15
structural 11:3 196:5,9
structure 73:2
structured 56:6
structures 53:13
struggle 48:21 152:13 205:4
struggled 192:19
struggles 215:12
struggling 15:20 46:3,4 46:5,7 129:16 147:20 150:12 154:19
studied 91:8,15 146:7
studies 21:10 128:22
study 22:13,17 129:7 140:11 150:2 164:13
studying 25:9
stuff 50:15 59:20 64:14 66:20 98:6 104:13 106:9 121:3 124:11 136:7 143:3 148:15 150:16 176:12 193:1
stupid 111:9
style 145:4 146:2,9
sub-county 104:17
subgroups 167:8
subject 183:6
subjected 76:3
submission 79:6
submit 165:16 219:12 219:13
submitted 127:1 160:17 219:1
suboptimal 199:3
subpopulation 167:7
subsample 170:11
subset 85:22
substantially 81:6
suburban 129:16
success 60:2 148:2 215:10
successful 19:4 59:19 102:4 111:6 185:22
sudden 41:3 212:19
sufficient 119:12 123:1 215:3
suggested 9:18 13:8
suggesting 34:5 69:11
suggestions 113:5

166:7 201:5
sum 174:16
summarization 172:11
summarized 9:10
summary 7:6 214:11 218:1,3
supply 134:20
support 30:5,18 50:18 51:3 123:1 157:10 197:10 205:9
supporting 50:13
supports 143:4
suppose 183:12
supposed 80:9 176:19
sure 4:20 5:4,19 6:17 6:21 7:2 15:14 16:6 23:9 38:13 43:6 62:9 63:10 83:17 86:4,6 87:10 97:13 99:4 108:13 110:6 113:2 123:2,3 132:2 133:4 135:14,17 142:7 147:11 170:9 171:11 177:21 179:15 182:12 183:7,11 184:16 207:4,19 209:7 210:1 210:8 211:16 215:11
surgeon 204:19 213:5 213:18
surgery 48:8
surgical 123:22
surprise 99:10 210:20 210:20
surprised 127:21
survey 11:6 120:22
surveys 108:10
survival 90:10
survive 205:11
Susan 2:7 38:12 39:2 55:21 174:11 175:12 177:18
sustainability 106:19
Swedish 15:1,3
symptom 90:13 97:7
synthesizing 172:22
system 75:21 112:8 121:22 122:2 125:13 185:21 187:13 203:4
system-oriented 40:19
systematic 90:11
systems 27:15 46:4 73:12 109:17 122:10 192:2

T

TA 57:5
table 159:13,13 164:11 169:5 170:20 171:9

179:15 180:1
tabula 58:9
take 4:18 6:19 35:12 40:2 44:15,19 45:4 46:9,9 73:8 74:8 75:6 78:20 93:14 102:13 113:11 114:21 144:7 152:19,21 161:7 163:17 168:12 170:11 176:9 185:18 200:22 217:9
takeaways 68:14
taken 42:2 61:2 78:14
takes 17:15 25:17
talk 6:9,12 7:11 13:5,9 22:2 42:22 48:22 54:2 57:3 78:8,9 87:11 108:6 110:19 113:22 116:8 139:9 141:15 157:21 163:3 171:1 177:14 178:16 184:8 191:9 192:12 203:17 204:11 209:14
talked 6:8 11:16 18:11 27:12 30:13 58:1 72:4 86:22 89:12 112:17 129:20 130:17 139:1 141:14 151:14 157:17 159:17 183:13 195:13
talking 12:20 14:16 19:14 20:13 23:16 41:15,18 42:5,6,8 49:15 52:6 53:14 70:17 75:18 77:2,2,13 79:11 88:16 97:2 101:8 104:4 106:7,18 110:4 112:21 134:22 135:22 136:5,6,8,14 142:14 150:19 160:6 168:7 191:20 195:22 202:11
talks 128:14
tangential 83:4
task 178:18 190:14
tasks 199:4
teaching 56:13
team 14:8
tease 13:1
teasing 180:8
technical 11:13 51:9 57:18 71:16 113:4 183:8 202:21
technology 56:17 106:8
teleconference 2:22
Telehealth 86:12
telemedicine 136:6
tell 48:8 150:3 178:3 188:1 199:22 206:20

211:5
telling 153:9
ten 17:5 44:9 76:9,13 92:18 124:19
tenants 17:17
tend 29:7 44:14
tended 77:22
tends 126:21
term 134:3 137:10 158:21 181:13
terms 8:6 9:2 10:2 11:6 11:8 12:21 24:17 26:5 27:9 31:2 34:4 49:11 51:20 58:7 60:3 64:19 68:5 78:19 79:9 86:8 86:14 90:5 92:9,21 102:3 104:17 105:4 112:17 113:9 114:7 115:18 137:14 138:14 139:16,18 143:20 144:13 148:10 152:7 152:19 172:15,21 173:1,19 182:7,9 183:8 184:14 194:13 195:2 200:22 211:18 211:20,21 219:17
terrified 202:14
terrifying 169:3
tertiary 144:3
testing 97:3
thank 4:4,5 80:1 138:17 174:11 175:12,15,20 179:9 180:19 183:21 186:3,5,22 188:7,8,9 190:17,18 193:17,19 197:5,6,7 198:13,14 198:16 202:1,3 204:8 204:12 207:10 210:12 212:16 213:19 215:21 215:22 216:3,6,19,19 216:21,22 217:5,17 219:3
thanks 5:11 177:3 186:20,21 190:16 193:21 202:6 204:9 213:2,13 217:21 220:3
theme 149:3
themes 57:17 218:1
theory 116:19
therapies 90:5
Therapist 1:16
thing 6:4 18:8 33:18 40:5,14 44:13 49:22 52:12 53:15,21 64:8 64:16 65:10,19 68:16 80:13 94:16 99:18 100:22 102:7 106:19

120:17 148:14 149:16
 150:17,21 154:12,16
 159:10 167:6 169:3
 174:3 179:8 192:18
 196:3,10 198:20
 201:7 202:20 203:15
 207:22 216:4
things 4:14,18,21 7:14
 15:16,17 17:5 19:3,3
 19:6,9,10,11,22 20:1
 20:2,4,8,9 22:17,18
 22:19 23:12 32:2 37:1
 40:8 41:2 44:1,7,14
 45:8 47:4 55:4 59:9
 60:22 61:20 72:2,19
 73:5 81:21 83:14 88:7
 96:11,18 100:1 103:8
 106:4 107:11 108:12
 108:16 112:19 113:6
 117:10 119:13 120:15
 125:8,22 126:9
 129:17 130:16 131:9
 132:4,6 134:4,14
 143:16 144:6 145:16
 152:11 154:20 174:19
 176:2,4,18 178:4
 188:6,19 192:11
 194:7,17,18 195:5,8
 196:13 198:19 199:3
 200:6,14,19 202:8,10
 203:9 204:5 207:6,17
 208:3,4,19 210:4
 215:5
think 4:19,20 5:17 6:3
 9:1,17 11:7 12:5,11
 13:5,12,13,20 14:1,10
 14:15 15:17,21 16:1
 16:11 18:10 20:16
 21:3,11,17 22:16 23:8
 24:3,3,9,22 25:13,15
 25:18 26:2,12,18
 29:10 31:16 32:2,5,10
 32:20 33:17,18 34:10
 35:2,7,17,21 36:5
 37:13,19,21 38:5,7,8
 38:19 39:5,6 40:13,14
 41:20 42:3,4,16,19
 43:11 45:9,10,14,21
 46:8,12,20 47:3,18,19
 49:5,11,17,22 50:1,8
 50:9 51:4,13,16,19,22
 52:5,8,16 55:20 56:5
 57:22 58:4,12,17,20
 59:1,5,6 60:16 61:1,3
 62:13 63:10 64:1,18
 65:7,10 66:14 67:1,3
 67:17,19 68:9 69:4
 70:20 71:3,22 72:1,13

73:10,13,17 75:11,16
 75:19,22 76:2,4,10,11
 76:14 77:12,15,20
 78:7,9,16,20 79:8
 80:9 83:18 84:5,16
 85:9 86:1,2,16 87:13
 89:18 91:4,7 92:5,8
 92:10,14,15,21 93:1
 94:13,14 95:13,21
 96:4,10,18,21 97:10
 98:14 99:3 100:7,10
 100:11 101:15 102:6
 103:10 105:15 107:13
 109:21 110:7,8 111:4
 111:7,16 112:21
 113:8 116:10 117:19
 119:14,19 120:21
 121:6,18 122:8,19
 123:6 126:7,15 127:8
 127:10,15 128:8,10
 128:14 129:9,21
 130:3,22 131:11,11
 131:15 133:5,18
 134:7,7 135:3,9,13
 136:15 138:13 140:21
 143:14,15 144:18
 145:4,6,14 146:7
 147:6 149:15 150:17
 151:7,13 156:8,9,10
 156:19 157:4,14
 158:16 160:3 161:1,9
 161:10,14 162:16,20
 162:21 164:15 166:19
 167:13,13,14 168:15
 168:18 169:4,13,19
 170:17 171:3,21
 172:14,18,20 173:5
 173:16,17,18,22
 174:1,15 175:8 176:4
 176:7,8,14,21 178:18
 178:21 179:8,21
 180:2,7,16,17 181:8,9
 181:13,14,18 182:3
 182:15,18,21,22
 183:4,13 184:8,18
 185:7,22 186:11,12
 187:19 188:5,6,13,18
 189:4,11,14 190:4,5,8
 190:13 191:10,12,20
 191:21 192:9,13
 193:6,7,14 194:5,8
 195:6,10 197:9 198:4
 198:7,9,18 199:1
 200:2,11,12,15,20
 201:3,9,13,15,19
 202:2,14,17 203:9,16
 203:19 204:1 207:9
 207:18,22 208:9,18

208:18,21 209:14
 210:3 211:10 212:2,8
 212:9,11 214:16
 215:10 216:1,13
 219:22
thinking 5:5 31:19
 34:18 36:14,17,20
 37:6 49:14 73:22
 74:17 77:8 80:12
 103:18 115:20 117:22
 121:15,17 123:12
 135:14 149:1 169:10
thinks 53:2 81:21
 156:22
third 15:6 95:11 108:18
 196:10
thirds 214:8
thought 23:16 44:6,11
 54:1 69:3,9 88:21
 90:17 97:22 105:21
 107:15 114:6 120:6
 140:21 143:10 157:2
 157:11,20 159:5
 160:19 175:9 181:7
thoughtful 50:9
thoughtfully 5:19
thoughts 10:4 11:11
 12:9 27:10 28:8,16
 29:13 30:2,20 66:18
 71:19 162:22 163:9
 166:11 167:4 172:11
 172:16,22 175:15
 177:20 180:20 212:18
thousand 131:22
 203:13
threatened 31:12
three 5:20 18:17 23:21
 76:21 77:3 88:12
 108:16 126:18 137:6
 147:14,15 153:7
 171:16 194:11 196:18
 214:7
threshold 36:22 37:14
 57:15
thrive 182:14
throat 44:15 54:17
throats 56:18
throw 6:6 24:6 54:9
 76:8 131:16 155:8
throwing 96:6
ticking 215:17
tie 182:15
tied 136:7
tiered 210:6
Tim 2:9 12:9 13:11 23:1
 23:14 33:4 36:12,12
 36:12 51:2 52:9 59:8
 66:19 71:21 73:15,20

75:22 91:21 110:16
 123:16 128:2 145:2
 148:6 150:2 180:19
Tim's 30:12 60:21 62:20
 70:3
time 4:11 7:12,13 13:16
 17:19 25:17 26:18
 29:5 31:11,11 35:9
 37:9 38:21 44:15,19
 45:4 46:6 54:4 57:13
 71:10 75:10 76:3 81:6
 82:10,21 100:3
 109:12 110:4,5,7,11
 114:21 125:12,13
 138:22,22 141:2,8
 149:9 154:8 155:2,3
 155:10,11 157:14
 160:14 171:19 172:18
 177:16 179:11 182:17
 189:7 196:22 197:3
 202:22 207:18 215:17
 216:20 217:12,16
 218:12
timeline 110:3
timeliness 86:11,14
 110:1
timely 38:16 56:19
 86:18
timeout 31:7,9,12,13
timeouts 31:9
times 187:16 189:12
 198:21 205:13
timing 26:16 27:3 36:3
 61:8
to-the-last 95:12
today 5:15 6:20 7:17
 8:4 43:15 61:20 96:11
 120:7 164:19 173:17
 214:10
today's 219:16
told 147:14 217:3
tomorrow 145:21
tone 200:22 201:3
tongue 115:17
Tonya 1:15 16:22 17:13
 18:15 20:10 25:12
 68:22 70:6 91:21
 93:20 99:16 105:19
 133:17 134:11 135:20
 185:3 194:2
tool 108:11 165:15
tools 18:3 56:14
top 89:3 155:14 189:8
topics 113:14 165:6
topped 78:4 80:16,18
 80:22 81:21
total 32:12 147:5
totally 37:22 111:1

195:17
touched 72:1
tough 133:6 211:6
town 14:22 15:10
 153:15
towns 150:10
track 20:18,19 56:8
 79:15 135:5 214:14
tracking 37:16
tracks 137:16
tractor 155:9,12,20
trade-off 81:18 82:14
trading 81:12
traditional 150:20
transcript 218:2,7
transferred 153:13
TransforMED 18:4
transition 13:21 41:16
 42:8,20 51:10 176:10
 215:3
transitional 51:7,14,18
 188:20
transitioning 24:17
transitions 25:3 86:10
 104:21
translate 152:11 164:11
 191:11,12
translates 110:9
transmit 75:8
transparency 118:17
 141:11
transparent 219:20
travel 138:22 171:22
travels 219:4
tread 201:20
treatment 102:10
tremendous 177:4
 197:10
trending 182:7
trial 118:8 127:11
tricky 141:22
tried 200:11
triple 30:6 93:3
trivial 156:5
trouble 139:13
true 65:8
truly 20:15 99:5
try 5:2,7 13:1 18:4
 44:14 48:11 110:22
 112:1 130:8 140:3
 144:7 153:4 161:3
 167:16 172:10 200:15
 202:8 211:12
trying 8:2 13:12 17:17
 20:12 37:10 39:18
 40:1 46:5 56:11 73:8
 95:14 96:4 101:21
 107:1 114:17 127:10

194:22 196:19 203:13
turn 53:21 83:15 138:11
 170:22 216:22
turnaround 38:20
turned 109:17 127:17
 216:5
turns 119:3 149:10
tweaking 218:16
two 14:19 19:19 31:9
 32:8,8 41:11 49:10
 55:9 56:20 59:9 60:22
 71:2 77:3 83:14 90:3
 92:4 93:22 113:14
 132:10 147:16 152:22
 161:14 165:4 167:17
 171:10 174:14 180:10
 180:20 181:22 185:18
 185:18 188:11 193:1
 195:18 196:1 207:12
 209:1 213:12 214:8
 217:22
two-day 218:2
two-lane 138:20
two-year 118:8
type 11:20 28:19,19
 29:7 51:21 66:7 69:11
 126:17 186:18 200:5
types 10:22 105:11
 150:13 175:2 179:7,7
 179:21 180:15 181:2
 201:14
typing 57:21

U

U.S 17:4 146:20
UDS 133:10,10
ultimate 98:17 196:15
ultimately 115:16
 116:12 118:2,5
 135:16 140:10 161:14
 214:18
unaccepted 19:9
unadjusted 151:3
unclear 66:22
uncomfortable 103:21
uncommon 154:10
under-served 137:5
 188:12
underestimate 54:12
undergo 152:15
underlie 29:17
underline 188:4
underlying 44:1,3
understand 4:21 5:5
 24:1 25:16 98:18
 100:8 114:17 119:22
 155:7 167:16 168:15
 170:4,16 177:22

190:6 195:19 207:13
 207:15 208:5 215:15
understanding 6:15
 118:13 143:7 203:4
understood 207:20
undertaken 118:8
 206:9 214:22
unfairly 148:19
unfortunate 209:13
unfortunately 72:22
 146:3 194:19
unfunded 48:16
uniform 71:7
uniformity 74:2
uninsurance 155:15
unintended 13:19 36:1
 36:8 47:22 49:19 52:7
 72:21 95:22 96:7
 151:14 152:11 184:21
 195:1
unique 47:3 65:11,13
 65:14,15 120:5 130:9
 130:21 136:2
uniquely 187:7
uniqueness 46:22 72:5
 126:7
University 1:17 123:19
 151:17,18,19 187:8
unpopular 54:14
unsatisfying 120:16,20
Up/Next 3:18
uploading 4:16
upstream 101:21
urban 37:10 65:8 67:12
 80:18 81:4 91:10 98:2
 98:3,12 109:17 116:5
 122:4 132:6,7 134:22
 135:4,7 138:9 143:22
 173:14 187:13 188:13
 215:15
urban-rural 121:18
urgent 19:21 54:18
urging 200:22
usage 19:11
use 10:11 13:13,21
 14:15 23:7 24:18
 25:21 29:18 36:18
 56:7,13,17,19 57:13
 60:16 66:5 67:8 79:14
 79:17 82:20 83:10,15
 95:13 99:12 107:8
 108:9 109:18 111:18
 112:1 122:13 123:11
 125:5 132:17 154:20
 160:7,8,12 161:15
 162:7 165:18 186:19
 195:4,18 211:8
useful 9:21 10:19 11:9

13:22 17:9 18:11
 114:6 120:6 123:14
 198:12 204:7
uses 13:15 35:15
 114:20 137:6
usual 213:21
usually 11:20 71:1
 118:14 124:4 140:18
utilization 32:11 145:18
 148:1

V

VA 192:15
vacancies 122:16
vaccination 72:14
vaccinations 9:22 41:5
 194:16
valid 32:11
validity 148:13
Valley 1:16
valuable 108:21 109:22
 110:11
value 11:5 93:12 159:17
 167:20 168:10
value-based 189:13
values 23:5
variability 150:9
variable 124:16
variables 116:2,22
 119:20 120:5 121:20
 123:10,13 127:12
 139:17
variation 127:13 213:7
varies 126:16 146:9
various 10:22 75:9
 165:6
vast 190:6
VBP 163:15 190:3
VBPM 189:19
vegetables 123:4
vehicle 75:8
vendor 110:9
vendors 108:9
verbally 212:14
version 34:10 143:6
versus 8:22 14:11
 23:20 29:5 34:21 48:7
 68:20 91:14 98:12
 118:15 129:16 138:22
 140:9,18 143:21
 155:19 167:21 180:15
viable 205:5
Vice 2:10,15
view 31:2 32:22 75:20
 88:18 89:19 134:20
 182:4,5
viewpoint 114:13 200:7
Virginia 1:22 187:3,5,11

visit 20:7 54:21 95:2

154:21

visitors 124:2**vital** 95:18,22**voice** 90:16 206:15

208:19 209:8

volume 26:10 28:1

96:21 98:20 109:14

141:14 142:14 149:5

152:21 153:9 180:3,7

184:13

volumes 16:12 33:14**voluntary** 8:22 28:10**vulnerability** 122:21**W****wag** 84:9**wait** 56:20**waiting** 57:11**waiver** 192:7**walk** 174:20**walking** 33:1**walks** 55:8**walls** 38:7 117:11**want** 5:18 6:10,17 7:12

10:14 13:9 20:18,19

30:3 34:5 35:17 40:18

42:22 50:9 52:13

55:20 58:6 61:9 63:11

64:3 65:19 68:1 70:13

72:8,9 73:1,4 78:7

79:12,12 81:10 82:14

94:11,11,12 107:5

108:17 131:16 135:13

140:14 144:1 148:16

149:16 152:7 153:6

165:18 171:8 172:4,4

177:21 179:15 182:1

184:6 197:7 204:11

204:12 206:11,12,19

207:22 208:1,2,7

210:11 213:1 214:1

214:16 215:18

wanted 51:17 54:2

55:13 79:22 104:20

116:10 119:15 120:9

167:7 178:18 181:7

194:8 202:20 203:8

212:16 216:6

wanting 56:2,16**wants** 19:16 195:3**warehouses** 38:19**Washington** 1:10 157:2

157:3,3 202:16

206:12

wasn't 6:4 36:4 73:22

98:22 99:8 169:7

water 103:9 129:7**wave** 15:5**way** 9:10 16:13,17 18:5

19:15 23:4 31:14

36:20 37:7 39:20 41:8

46:9 50:18 58:12 64:9

65:16 78:5 84:9,13

107:3 109:18 114:18

118:7 123:18 128:20

131:3 137:7 143:13

143:17 153:5 164:14

167:8 174:1 179:17

180:10 184:20 187:6

188:3 190:12,15

193:7,16 197:2 199:1

199:2,6,7 200:16

201:22 208:14,19

210:17 212:8

Wayne 123:20**ways** 36:22 65:12 90:12

105:14 122:19 165:10

we'll 5:2 6:11,19 7:3,4

8:9,17,20 27:7 28:2

30:21 38:15 42:14

43:17,18 62:18 66:9

86:5,8 87:11 88:16

91:5 93:21 107:22

108:1 112:11,20

113:12,13 118:17,18

118:21 119:8,13

168:7 178:2,5,6

205:20 207:16 212:11

215:20 218:6,13,16

218:20

we're 4:16 5:15,16 6:9

6:17,20 7:5 13:12

15:20,22 23:9 27:16

34:9 36:15 41:2,4,15

41:18 46:3,18 47:1,18

48:12,17,18,19 49:1,3

52:6,7,22 53:14 56:2

56:11,16 57:3 59:19

59:20 60:15 62:17

63:11 64:1,2 65:11

67:13 69:22 70:1 74:6

75:3,18 77:2,2,12

86:7 89:8 92:20 93:2

96:1,14 99:7 100:8

101:8 104:4 105:1

106:7 107:1,2 113:6

115:20 123:9 127:9

127:10 128:17 130:2

130:6 134:22 136:2,5

136:6,8 140:1,2,12

147:11 151:12 159:22

171:15 176:4,6,11,22

177:1 178:4 184:4

187:2 194:22 197:1

207:2 210:16 212:20

212:21 217:18

we've 4:17 7:15 13:6

22:10 39:6 47:9 49:15

50:15 51:5 57:8 59:19

60:5 71:12 74:5 85:22

91:8,15 104:8,15

111:5 112:16 114:17

118:7 129:11 139:1

142:17 147:10 149:1

154:18 157:17 159:17

169:14 172:3,14,18

173:16 174:8 177:17

196:20 200:5 206:22

207:17 210:18 211:11

wear 155:4**weather** 26:20**web** 218:3,9**webinar** 52:15**webinars** 64:20**website** 25:9 114:11**wedge** 194:19,20**weeks** 52:15 147:16

217:22

weigh 50:21**weighted** 44:3**welcome** 219:11**well-constructed** 215:4**wellness** 154:21**went** 8:14 17:13 48:3

54:17 113:17 115:22

124:14 154:6 177:10

214:4 220:5

weren't 152:5 179:1

202:9 210:20 216:7

West 1:21 187:3,5,11

206:11

whatnot 48:12 99:13

100:9 143:4,9

wheel 102:14**WHIO** 111:5,10 112:5**white** 162:6**WHNP-BC** 2:7**whoa** 6:7**widely** 126:16**wider** 219:13**wife** 127:20**willing** 212:2**Wilson** 2:15 162:10,11**win** 196:8**winds** 170:12**winners** 150:4**winnow** 30:3**wins** 155:20**Wisconsin** 2:10 53:5

91:8 103:1 129:11

139:1,6

wise 49:12,18**wisely** 87:9**wish** 33:11**wonder** 29:21 213:4

214:6

wondering 10:2 140:4

171:17 212:22

Wood 104:12**word** 24:3 64:21 148:4

169:2 179:12 187:20

188:4 218:8,8

wording 33:19**words** 65:3 78:4 174:13**work** 3:14 7:1 8:1 18:21

25:17 34:9 35:6 39:7

39:11 53:13 65:7

66:17 68:20 72:18

76:21 78:15 80:4,8

84:4 89:21 97:11,12

98:14 101:19 105:14

106:20 108:2 110:3

113:15,20 120:11

122:1 125:13 128:9

129:9,11 130:13

137:19 144:14 145:10

145:12 149:18 150:10

159:6 162:1 169:14

172:21 173:1 174:9

174:17 175:10 176:13

181:9,15,19 182:6

183:10 184:2 187:16

190:6,9 194:18 199:4

199:22 201:6 202:15

202:19 205:8 208:21

209:7 211:4,15

214:22

worked 65:8 156:19**worker** 94:4**workgroup** 78:1 108:5

158:20,20,21 159:4

163:7,8 164:22

168:14 169:7 170:15

workgroups 158:22

160:1

working 80:6 97:9

173:1 210:13 211:8

works 6:15 190:13**world** 33:11 46:17

174:2 204:22

worried 41:1 47:7,14

144:4

worry 22:8 215:4**worse** 97:19 98:5,11

99:13

worst 156:10**worth** 42:3 75:9 96:17

106:21 107:20 194:6

216:16

worthwhile 74:21**wouldn't** 67:6 99:10

117:5 131:9,10 138:2
 147:2 195:20
wow 196:1 216:4
wrap 3:18 6:20 214:11
wrap-up 7:3
write 196:22
writing 5:4
written 47:10 195:18
wrong 69:21 149:11
 164:19 166:16 199:9
wrote 123:21
Wyoming 136:4 213:9

X

Y

yards 25:7
yeah 6:5,5 14:13,14
 45:20
year 47:7 48:2 80:10
 189:19
years 13:18 15:2 18:17
 21:15 42:2 56:21
 76:21 92:18 95:17
 115:12 128:20,21
 140:11 144:15 154:5
 154:8 174:5 189:2,17
 195:19 196:1,18
yes/no 164:12
yesterday 4:10,22 5:18
 7:10 8:4 9:18 12:21
 17:1 19:11 20:14
 23:17 26:16 28:9
 29:16 34:4 40:15 41:6
 45:11 53:6 58:5 65:6
 69:4,19 70:11 74:16
 80:14,17 83:8 84:1
 87:5 89:13 99:22
 100:3 101:17 102:13
 130:17 162:2 168:4
 173:17 214:11
yesterday's 6:1

Z

zap 128:18
ZCTSA 120:15
zero 48:9,10,13 124:13

0

0.9 15:11

1

1 3:2 97:21 118:9
1.2 15:11
1.7 15:13 124:15
1:00 218:11
1:13 220:5
1:30 171:15

10 32:9 79:12
10:29 113:11,18
10:30 102:14
10:51 113:18
100 32:9 76:3 87:10
 107:16,16 124:13
1030 1:9
11:50 177:10
114 3:9
12:28 177:11
12:30 171:15 177:6
14 219:1
15 76:9,13 79:12 103:5
 113:12 114:10 126:18
 132:20 212:19 218:15
 218:17
150 158:18
15th 1:9
177 3:14
19 218:9,15

2

2 4:4 5:9
2:00 7:4 178:7
20 77:1 124:16 132:20
 158:9,13
2003 138:4 188:22
2010 188:22
2015 1:7
20ish 32:9
217 3:16,18
25 15:2 154:5

3

3:00 218:11
30 20:20 104:7 117:14
 138:18,19 161:10
30-day 218:21
350 75:14

4

40 70:17 161:10
46 79:1

5

50 131:10 149:5 154:8
 191:14

6

6 1:7 3:2
60 132:1 137:21

7

70 137:21,21
700 181:13

8

8 3:5

8:00 145:21
8:37 1:10 4:2
80 107:16,16 113:13
 124:15
80s 81:7

9

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