

THE NATIONAL QUALITY FORUM

+ + + + +

MEETING OF THE HEALTHCARE ACQUIRED

CONDITIONS AND SERIOUS REPORTABLE EVENTS
IN HEALTHCARE STEERING COMMITTEE

+ + + + +

Thursday, November 19, 2009

+ + + + +

The Steering Committee convened at 8:00 a.m. in Salon A of the Park Ballroom of the Park Hyatt Washington, located at 1201 24th Street, N.W., Gregg Meyer and Sally Tyler, Co-Chairs, presiding.

PRESENT:

GREGG MEYER, MD, MSc, CO-CHAIR (via telephone)

SALLY TYLER, MPA, CO-CHAIR

LEAH BINDER, MEMBER
PATRICK BRENNAN, MD, MEMBER (via telephone)
TEJAL GANDHI, MD, MPH (via telephone)
CHRISTINE GOESCHEL, RN, MPA, MEMBER
CYNTHIA HOEN, ESQ., MPH, FACHE, MEMBER

HELEN LAU, RN, MHROD, BSN, BMus, MEMBER (via
telephone)
KATHRYN McDONAGH, PhD, MEMBER
JOHN MORLEY, MD, MEMBER
DEBORAH NADZAM, PhD, RN, FAAN, MEMBER
MARTHA RADFORD, MD, FACC, FAHA, MEMBER (via
telephone)

STANCEL RILEY, MD, MPA, MPH, MEMBER
DIANE RYDRYCH, MA, MEMBER
DORON SCHNEIDER, MD, MEMBER
PHILIP SCHNEIDER, FASHP, MS, MEMBER
ERIC TANGALOS, MD, FACP, AGSF, CMD, MEMBER
MICHAEL VICTOROFF, MD, MEMBER
PETER ANGOOD, MD, FACS, STAFF

HELEN BURSTIN, MD, STAFF
JENNIFER HURST, MHS, STAFF
LINDSEY TIGHE, STAFF

ALSO PRESENT:

EDDIE GARCIA, CMS

NOT PRESENT:

SUSAN GENTILLI, MBA, RHIA, CPHQ, MEMBER

A-G-E-N-D-A

SELECTING OTHER ENVIRONMENTS OF CARE:
EXPANSION BEYOND HOSPITALS6

Peter Angood, MD Senior Advisor
Patient Safety

ROLE OF TECHNICAL ADVISORY PANELS178

Peter Angood, MD Senior Advisor
Patient Safety

SREs/HACS: INPATIENT HOSPITAL FACILITIES

Greg Meyer, MD, MS
Sally Tyler, MPA

BREAK177

SREs/HACs: NURSING, REHABILITATION AND

LONG-TERM CARE FACILITIES

Gregg Meyer, MD, MSc
Sally Tyler, MPA

SREs/HACs: AMBULATORY CARE AND HOME HEALTH
SETTINGS

Gregg Meyer, MD, MSc
Sally Tyler, MPA

PUBLIC COMMENT176

SUMMATION AND NEXT STEPS238

Gregg Meyer, MD, MSc
Sally Tyler, MPA
Peter Angood, MD Senior Advisor

Patient Safety

ADJOURN

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

2 (8:08 a.m.)

3 CO-CHAIR TYLER: I'm just going to
4 ask folks here, just for the record to go
5 around and say who you are, just say your
6 name, so that everybody on the phone hears,
7 and then we'll go through and see who's on the
8 phone.

9 MEMBER GOESCHEL: Chris Goeschel.

10 MEMBER NADZAM: Debbie Nadzam.

11 MEMBER VICTOROFF: Michael
12 Victoroff.

13 MEMBER RYDRYCH: Diane Rydrych.

14 MEMBER HOEN: Cynthia Hoen.

15 MEMBER TANGALOS: Eric Tangalos.

16 MEMBER RADFORD: Martha Radford.

17 MEMBER RILEY: Stancel Riley.

18 MEMBER McDONAGH: Kathy McDonagh.

19 MEMBER DORON SCHNEIDER: Doron
20 Schneider.

21 MEMBER PHILIP SCHNEIDER: Phil
22 Schneider.

1 MEMBER MORLEY: John Morley.

2 DR. ANGOOD: Peter Angood, and we
3 have Lindsey Tighe, and Jennifer Hurst as NQF
4 Staff here.

5 DR. BURSTIN: And Helen Burstin.

6 CO-CHAIR TYLER: And Sally Tyler,
7 I'm here. And who do we have on the phone?

8 MEMBER LAU: Helen Lau.

9 CO-CHAIR TYLER: Okay, Helen, and
10 Gregg. Anybody else?

11 MEMBER BRENNAN: P. J. Brennan.

12 CO-CHAIR TYLER: P.J. Great.
13 Anybody else?

14 DR. GANDHI: Tejal Gandhi.

15 DR. ANGOOD: Gregg, are you on?

16 MR. GARCIA: There's also Eddie
17 Garcia here from CMS.

18 DR. ANGOOD: And Eddie, thank you.

19 MR. GARCIA: Sure.

20 CO-CHAIR TYLER: Anybody else on
21 the phone? Well, I wanted to thank you all on
22 the phone, especially those -- I know Tejal

1 and Helen, this is your second day with us on
2 the phone, and I know it's kind of a
3 challenging environment to do these meetings,
4 especially when they're day long meetings on
5 the phone, but we appreciate your hanging in
6 there with us, and look forward to see you in
7 person at the next Steering Meeting. So,
8 thank you.

9 MEMBER GANDHI: Sure, thank you.

10 MEMBER LAU: Definitely.

11 CO-CHAIR TYLER: And I think now
12 Peter and Helen are going to review what we
13 did yesterday, as far as updating the
14 definitions.

15 DR. ANGOOD: Yes, I will. And,
16 first off, just in terms of the day's agenda,
17 we're going to do this review just to make
18 sure we're still on the same page we thought
19 we were by the end of yesterday. Ideas do
20 change in 24 hours, as we know.

21 Then we'll jump back in to finish
22 reviewing the existing list of SREs. We'll do

1 a very collapsed discussion on what's supposed
2 to be part of Day 2 here regarding the
3 Environments of Care and the Role of Technical
4 Expert Panels, or Advisory Panels. And then
5 we'll see how well we can get into some of
6 these other environments. We probably won't
7 need to spend much time at all, on the
8 inpatient hospital setting, but certainly want
9 to at least begin the discussion on the
10 nursing, rehab, long-term care in the
11 ambulatory settings, get some discussion going
12 on those.

13 While we want to get as much work
14 done today as possible, I don't think we are
15 feeling like we have to get everything tied up
16 and wrapped into a nice little tight bow by
17 the end of the day. We have an ongoing
18 process here.

19 So, in terms of where we thought we
20 came out yesterday, we made that significant
21 change to the one word in this definition of
22 Serious Reportable Events. I've forgotten,

1 Donald, I forgot to mention to the operator,
2 we're formally open for the meeting. I forgot
3 that part. Thank you.

4 So, the significant change being
5 that the definition now says "defined as
6 preventable, serious, unambiguous, adverse
7 events that should not occur." Are we all
8 comfortable with that? Leah is not
9 comfortable, for the record. Yes? Not a
10 problem. Michael?

11 MEMBER VICTOROFF: I have
12 dismissible discomfort because I don't think
13 the last phrase is needed, because I can't
14 think of the other list we have of serious
15 reportable events that should occur.

16 DR. ANGOOD: I think, however,
17 though, to get back to some of Diane's point
18 yesterday, we have to be able to imprint a
19 sense of need or urgency on that. And that's
20 part of that purpose. Leah?

21 MEMBER BINDER: All right. So, let
22 me give you my two seconds on why I think the

1 word "never" is still appropriate. First of
2 all, not does not differentiate these events.
3 The word "not" does not differentiate these
4 events as special. The fact that we say they
5 should never occur does not mean that they, in
6 fact, never occur, any more than when we say
7 an airline crash is a never event.

8 We know it actually does occur,
9 sometimes. It's just something that is such
10 an awful outcome that we set a very high
11 standard for how much we want to prevent it,
12 which means we say never, never, never. And
13 except that, unfortunately, it might happen.
14 So, setting the standard at never has captured
15 the imagination of the public. I mean, there
16 is nothing that I can -- I've said it before
17 yesterday. It is something that people really
18 respond to, and understand, that the
19 healthcare community is setting a very high
20 standard around certain events that are so
21 catastrophic, and so awful to families and
22 patients that they're really going to make

1 sure there's zero tolerance.

2 "Never" is the word that has
3 captured the imagination. "Not" does not
4 differentiate these SREs from anything else,
5 and it shies away from a high standard that we
6 had already set. So, in doing so, it will,
7 itself, be newsworthy to no longer really put
8 that word "never" on the table.

9 DR. ANGOOD: Thank you, Leah. Any
10 comments?

11 CO-CHAIR MEYER: This is Gregg. I
12 guess my counter to that would be that
13 although it has captured the imagination, it's
14 also created equal anxiety on the other side,
15 and confusion. And I think, in the end, my
16 sense is, is that these are differentiated,
17 because the National Quality Forum, and
18 through its authority through the National
19 Technology Transfer and Advancement Act, is
20 telling states that these ought to be reported
21 publicly. And I think that that's incredibly
22 powerful. And, at the end of the day, whether

1 or not we say "not" or "never", doesn't matter
2 a whole lot.

3 I think the downside of the
4 confusion of "never" makes me think that
5 abandoning it is the right thing to do at this
6 point in time. Yet, the overall importance of
7 this, and the public imagination is that
8 they're going to see this information, and
9 that this body is recommending that it be
10 publicly reported by states. And, to me,
11 there is no stronger statement of urgency and
12 importance than that.

13 DR. ANGOOD: Thanks, Gregg.

14 CO-CHAIR TYLER: I think Leah
15 wanted to follow-up.

16 MEMBER BINDER: Just one more
17 statement about that. Most people in the
18 public do not know that it is not a reportable
19 event in some places for some of the wrong
20 side surgery, and so that is not going to gain
21 us a huge amount of enthusiasm from
22 purchasers, or from the public, if we say oh,

1 the big drama is that it's now going to be
2 reportable. I think for them, of course, it's
3 reportable. Most people can't imagine why it
4 wouldn't be, so that's not capturing anybody's
5 imagination, to be quite frank.

6 The word "never" did, and the word
7 "never" set the kind of standard I think that
8 we should all set as a healthcare system. I
9 don't think it's confusing. I think it says
10 we think these events are so bad that we're
11 going to put the word "never" to them. And
12 understand that mistakes happen, and maybe it
13 isn't going to be never, just like an airline
14 crash, just like any other catastrophic event,
15 but we do see them at that level.

16 DR. ANGOOD: Martha.

17 MEMBER RADFORD: I took away from
18 the discussion yesterday, and please correct
19 me if I'm wrong, that part of the role of this
20 group is to, in a sense, broaden the scope of
21 reportable events to get beyond the serious
22 catastrophes, and into near misses and things

1 like that, that do occur, and we know they
2 occur. And that, in fact, reporting near
3 misses can prevent the serious catastrophe.
4 So, I think that it's accurate, and there is
5 something to be said for accuracy, to say
6 these things, to use "not" instead of "never".

7 DR. ANGOOD: Diane, you had a
8 comment?

9 MEMBER RYDRYCH: Yes, I just wanted
10 to say, you know, I was one of the people who
11 didn't want to take out the phrase entirely,
12 because I was worried that we would lose some
13 of that sense of urgency, if we got rid of
14 "never". The reason that we, as a group, came
15 up with "not" as a compromise, and maybe it's
16 not the right word, and maybe there are others
17 that are better, is because I think we all
18 would have felt more comfortable with "never",
19 if the list didn't include things like
20 pressure ulcers, and falls, that are kind of
21 in a different class of events in some ways,
22 than some of the others.

1 In my state, when we talk about
2 these, we don't usually use the term "never
3 events." For some, we do, because wrong side
4 surgery shouldn't ever happen, and some of
5 these other events are definitely in that
6 category. But we felt uncomfortable saying
7 even one of these events is too many when it
8 came to things like pressure ulcers, so that
9 was just kind of what was behind some of the
10 discussion, and the decision to move it to
11 "not" yesterday. I don't know if "not" is the
12 absolutely right word to use, but we were
13 trying to acknowledge that there are some of
14 these that are a little bit different than
15 some of the others.

16 DR. GANDHI: This is Tejal Gandhi.
17 I just wanted to confer with that. I think
18 that's definitely where my level of concern
19 comes from around "never", as well, is around
20 the falls and pressure ulcers, because it
21 would lead to the most discussion for us, as
22 well. I just wanted to agree with that

1 comment.

2 DR. ANGOOD: Thanks, Tejal. John,
3 and then Leah.

4 MEMBER MORLEY: I certainly do
5 appreciate the emotion attached to that
6 "never" term, but that emotion is something
7 that can be used in a positive mechanism for
8 drawing additional resources, additional
9 attention, additional focus, all sorts of very
10 positive things.

11 On the other side, unfortunately,
12 in the area that we live, and the time that we
13 live today, that "never events" also brings
14 with it the concept that if it never should
15 happen, then somebody, obviously, didn't
16 create a human error, they did something that
17 was either malicious, or demonstrated total
18 incompetence. And I think we can accept that
19 those can certainly lead to those events we
20 have on our list, but there are many other
21 mechanisms by which those things can occur,
22 that don't, necessarily, imply incompetence,

1 or maliciousness.

2 DR. ANGOOD: And Leah, again.

3 MEMBER BINDER: Well, we've been
4 using the term "never events" at Leapfrog, and
5 have the policy, and it's been wildly
6 replicated. We've never ever accused anyone
7 of incompetence, nor has it been interpreted
8 that way, frankly. I don't think that has
9 ever been the consequence of the term "never",
10 and why "never" matters.

11 And in terms of your point about
12 pressure ulcers, absolutely, pressure ulcers
13 are not never events, but I don't think that
14 we've defined, at least in the policies that
15 I've seen in NQF before this, we haven't
16 defined it as all pressure ulcers. We've
17 isolated the specific kinds of pressure ulcers
18 that really should never occur. I don't think
19 a Stage Four pressure ulcer -- I mean, we
20 should set that as a standard that that should
21 never occur. We should be able to prevent
22 that.

1 The word "never" does have some
2 emotional resonance, but, frankly, we're
3 talking about things that are emotional to
4 people, that wrong side surgery, removing the
5 wrong limb, I'm sorry, that's a catastrophic
6 event. That's a very emotional event, and I
7 think that the healthcare system by responding
8 and saying yes, it is a catastrophic event.
9 There is emotion attached to that. It's
10 important to us, too. The word "never" gets
11 to that point the way nothing else can, or
12 maybe there's another word, but "never" has,
13 in my mind, been very effective as a strategy,
14 at least from a purchaser's point of view, it
15 has been a very effective way to describe what
16 these events really are. And to address them,
17 I think, in very effective ways.

18 DR. ANGOOD: Michael, and then
19 Cynthia.

20 MEMBER VICTOROFF: Just to
21 interject the dilemma of the malpractice
22 defense, because we live in a litigious

1 environment, as well. And what our experience
2 is beginning to be, as this list gets
3 propagated and understood by plaintiffs, is
4 that this is a kind of get into jail free card
5 for a plaintiff, that the phrase, which I
6 object to for logical reasons, not because it
7 doesn't emotionally emphasize how horrified we
8 are about things, but because it emotionally
9 trivializes how horrified we ought to be.

10 Because I really can't come up with the
11 alternative list of the errors that should
12 happen, or that ought to happen in your
13 institution at a certain rate, or that you
14 should encourage people to commit.

15 So, in a way, no matter how minor
16 an error is, it shouldn't occur. "Never" is
17 the goal for errors, but when we get into
18 court, it's a whole other discussion. It's
19 not rhetoric, at all. There is a legal
20 mousetrap here that we're experiencing, and is
21 causing consternation among people who have to
22 make logical arguments in front of juries,

1 that if some authoritative body published a
2 list that simply said the following items are
3 indefensible under any condition, which is how
4 it's been presented, that it puts us in a very
5 difficult position when, actually, there is a
6 defense.

7 So, for that reason, there's a very
8 strong sentiment among the people that have to
9 deal with administrative accountability, and
10 litigation that this is a terribly prejudicial
11 term. They could live with "not", but the
12 folks I work with couldn't live with "never"
13 any longer.

14 MEMBER HOEN: I would agree with
15 Michael, and we have, in fact, seen a
16 significant increase in the number of lawsuits
17 associated with pressure ulcers, which were
18 not preventable, because the family believed
19 based upon the wording in these particular
20 guidelines that they were never events.

21 We just recently tried one twice,
22 both to defense verdicts, but to a tune of

1 probably a million dollars in attorneys fees.
2 And we've had many others arise in those
3 events, which should not have occurred, and it
4 was unfortunate the expectations of the
5 families and the patients were furthered by
6 the "never" concept. And, thus, became very
7 angry, and uncontrollable.

8 I agree that we don't want these
9 things to happen, but some of them are not
10 preventable, and "not", therefore, is a little
11 bit of a softer and less accusatory term in
12 those instances.

13 CO-CHAIR TYLER: Philip.

14 MEMBER PHILIP SCHNEIDER: I'm
15 wondering when we get to the discussion of
16 alternate healthcare settings, where the
17 control over the healthcare that's delivered
18 is less rigorous, whether we would be hemmed
19 in by having a term like "never", because in
20 a home care environment, for example, there
21 may be some things that are egregious, and
22 should not happen, but maybe less easy to

1 assure that they never happen, because the
2 care is less carefully overseen than it is in
3 a hospital setting. So, this definition may
4 well have made sense in a highly organized
5 healthcare delivery setting, like a hospital,
6 that may be less easy to conceive of in other
7 healthcare settings.

8 CO-CHAIR TYLER: Eric.

9 MEMBER TANGALOS: I'm actually
10 worried about the extended environment, as
11 well, not so much -- we've already heard about
12 the threat of the "never" piece, but on the
13 opposite side, if we just blow it off, because
14 "never" makes no sense, then we lost the
15 middle ground, where we really want to do
16 something about it. And one of the biggest
17 abuses we have right now with pressure sores,
18 which are bad, and should not occur in almost
19 all situations, is you get a free pass when
20 you convert the patient to hospice. So,
21 you've thrown in the towel, so to speak, and
22 I don't want to see that part happening,

1 either.

2 CO-CHAIR TYLER: Leah.

3 MEMBER BINDER: I can't speak to
4 the legal ramifications, except that, as you
5 all know, there are studies that show that if
6 you apologize to the patient, you will reduce
7 the rate of -- the likelihood of malpractice
8 by whatever it is, 55 percent I think was the
9 latest.

10 That's the extent of my knowledge
11 on that, so I defer to your knowledge that
12 there's -- that "never" is somehow triggering
13 lawsuits. But, again, I think saying
14 something should never occur does not
15 prescribe that this thing -- who is at fault,
16 or why. There can be reasons why it still
17 does occur, or it doesn't occur, but it
18 doesn't prescribe who's at fault. It simply
19 says that this is the standard we've set for
20 this particular condition that we name, and
21 that's why it's considered an extreme case, a
22 serious reportable event. So, "never" says

1 that like other things don't.

2 Now, having said that, I'm not -
3 I'm very strongly, as you know, in favor of
4 keeping "never" in there, but if the
5 alternative that this group is going to vote
6 on is not occur, I particularly don't like
7 that, because that implies that there's some -
8 - in that Venn diagram that we did, that
9 there's some other things that maybe should
10 occur. I mean, the opposite is true, or
11 something. I think it would be better just to
12 leave it at serious, ambiguous adverse events,
13 period. That would be my second choice, but
14 I'm just -- but I'm extremely strongly in
15 favor of keeping "never".

16 MEMBER TANGALOS: Well, if you were
17 here yesterday for that vote, I think it
18 occurred beforehand, that was almost a split
19 vote yesterday. That piece was very close to
20 leaving it all out, versus putting "not" in.

21 CO-CHAIR TYLER: Philip.

22 MEMBER PHILIP SCHNEIDER: On the

1 other side, I'm kind of going back and forth
2 on this in my own mind. I'm concerned about
3 hemming ourselves in for the alternate care
4 settings, but I also -- I'd be interested in
5 the opinions of the rest of the group as to
6 whether or not it's important to either
7 retain, or recommit ourselves to a sense of
8 urgency when it comes to the safety agenda.

9 It's my feeling that it's not as
10 urgent as it has been, when To Err Is Human
11 was published. And I think that the momentum
12 is, I don't want to say lost, but I just get
13 a sense that in setting standards for patient
14 safety we do need to be, I don't know if the
15 term "dramatic" is the right word, but we need
16 to be forceful. And I -- Leah's comments are
17 really striking a responsive chord with me.

18 I know when we talked about this at
19 an international meeting, and one of my
20 colleagues talked about never events, it
21 really got people's attention, that in the
22 U.S. we're talking about things that we really

1 shouldn't allow to happen in the healthcare
2 system. And that really raised a lot of
3 eyebrows, and that kind of sound byte really
4 was powerful in our discussion. And I'm
5 resonant to the idea of maintaining a sense of
6 urgency, or recommitting. Maybe that's the
7 way I'd say it. And I'd be interested in
8 whether other people feel that that's true, or
9 not. Maybe I'm being too pessimistic.

10 CO-CHAIR TYLER: Stan, I think was
11 next.

12 MEMBER RILEY: I guess the word
13 "never", to me, means that there's a solution,
14 that we have a way to make these things be
15 okay. So, if you say "never", that means --
16 that implies that you have the fix for
17 whatever it is, wrong side surgery, for any of
18 those other things.

19 I think the thing that would really
20 help the sense of urgency is to come up with
21 a fix, say this is what works for this. That
22 would make a headline, I think, just as well

1 as saying "never".

2 DR. ANGOOD: And that's probably
3 where in the opening comments trying to weave
4 the SREs, practices, and measures all sort of
5 together over time, because they have their
6 individual purposes, but we need to get them
7 closer together to help reinforce one another
8 along the point you were just making.

9 CO-CHAIR MEYER: This is Gregg. I
10 can I just make a comment along those lines.

11 CO-CHAIR TYLER: I'm sorry. Is
12 someone on the line?

13 CO-CHAIR MEYER: Yes, it's Gregg.
14 I agree with this need to re-establish
15 urgency. I disagree that the right way to do
16 that is to keep the word "never". I think
17 that the way to do that has to do with I think
18 the way that the Quality Forum is trying to
19 repackage, and reinvigorate its safety
20 portfolio. And, in particular, I think that
21 when this new list of SREs, along with the
22 next version of Safe Practices comes out, I

1 think that there's a great opportunity for the
2 Quality Forum to really take the bully pulpit
3 and push very hard to say we took a fragmented
4 approach in the past, we're trying to pull
5 these things together to the extent they make
6 sense to pull together, and doesn't -- a
7 completely tight coupling. But that will be,
8 I think, very, very powerful.

9 And, in the end, you know, my
10 vision is, is that we ought to have the
11 accountability out there with a list of
12 serious reportable events that states are
13 reporting publicly, and creating a sense of
14 urgency through that mechanism. But, at the
15 same time, I believe we ought to have public
16 reporting on who's implementing the safe
17 practices, taking the systems approach. And
18 I think the Quality Forum would be positioned
19 in a way that it's never been before through
20 that, to create that sense of urgency.

21 CO-CHAIR TYLER: Okay. Thanks,
22 Gregg. We have Kathryn, and then Diane.

1 MEMBER McDONAGH: I think these
2 points are excellent, as well. And I do feel
3 strongly that we need to make some strong
4 statements. I agree with Gregg, that when we
5 look at the totality of the work when we're
6 done, we've got to have a balance of really
7 creating a safety of culture, because we have
8 an issue with that in terms of just cultures,
9 and creating an openness in organizations.

10 But, yet, we want to really hold
11 people accountable, and increase that sense of
12 urgency, so I do that the way we've worded it
13 is fine, but then we've got to add some other
14 statements, and frame it very aggressively,
15 what we think needs to be required to be
16 reported, and really, I think, putting the
17 whole package together, so that it's a very
18 strong statement of accountability; but, yet,
19 it's balanced with, if we're really trying to
20 move healthcare to a high reliability
21 organization, it can't be done in a punitive
22 environment. It needs to be done in a culture

1 of safety. So, I think what we're trying to
2 balance there is, there's a natural dynamic
3 tension, but I think we can come out with very
4 strong statements.

5 MEMBER RYDRYCH: I agree on the
6 sense of urgency. And I think I talked a
7 little bit yesterday about the experience
8 we've had in Minnesota, and it's challenging
9 sometimes to balance, talking about the fact
10 that some of these things may not be
11 preventable, but still wanting to make sure
12 that they're kind of held above other types of
13 events, and taken seriously. And that can be
14 difficult to do.

15 I appreciate Gregg's point, but I
16 don't entirely agree that the consolidation
17 and updating of measures is going to create
18 that sense of urgency, because out in the
19 field, I think people -- we've talked about
20 this. There is Leapfrog, and there's NQF, and
21 there's CMS, and there are all these other
22 things. And when these measures get updated,

1 people notice that, but that, in and of
2 itself, doesn't really create a sense of
3 urgency. And I don't think the consolidation
4 will, either, in the absence of other action.
5 And it does feel like we need to focus on
6 those corrective actions.

7 What are -- we've got 27 states
8 that are -- that have implemented part, or
9 all, of the NQF list, and are doing public
10 reporting, and are collecting data. And, in
11 many cases, they're not sharing any of that,
12 and they're not sharing what's working in
13 their states. And there aren't really good
14 mechanisms for that, so there's a lot of good
15 work that's going on in individual hospitals,
16 and in different states, that there's not
17 really a good mechanism to capture.

18 There might be people who are
19 starting to figure out how you fix some of
20 these things, but it's difficult to really
21 know that. And it feels like that's the way
22 we end up energizing this, rather than dealing

1 just with the measurement and the reporting
2 side of it; although, that's important, too.

3 DR. GANDHI: Hi, this is Tejal on
4 the phone. Could I jump in?

5 CO-CHAIR TYLER: Sure, on the
6 phone, first.

7 DR. GANDHI: Okay. I just wanted
8 to make a comment about the sense of urgency,
9 as well. I mean, the term "never events" was
10 around for a long time, and at least in the
11 State of Massachusetts, the urgency, I think,
12 didn't really happen until it became a
13 reporting requirement.

14 I don't think the term "never" got
15 people's attention, as much as the
16 reportability piece. And, certainly, at that
17 point, got the attention of hospitals, who
18 then really starting putting additional
19 efforts towards these things. So, at least in
20 Massachusetts, and Gregg can agree or
21 disagree, but that was, I think, the
22 experience I've seen.

1 MEMBER DORON SCHNEIDER: One of the
2 goals of the work effort is to lead to further
3 harmonization of efforts, and I wonder if we
4 could gain something by adding a couple of
5 words on, which would, essentially, go
6 something like "that should not occur, should
7 lead to disclosure, and investigation of root
8 cause." That's really Joint Commission
9 language. Leapfrog has taken that on, and it
10 really does put a stamp on it that is a little
11 bit different than well, yes, we want you to
12 report this. Great. Well, we want to
13 disclose, and we want investigation of root
14 cause.

15 CO-CHAIR TYLER: John, and then
16 Leah.

17 MEMBER MORLEY: I think you may
18 actually have another agenda item. I'm not
19 sure that it will fit for today, but perhaps
20 the next time. But I think there is a very
21 strong feeling, I have a very strong feeling
22 that whatever we can do, short of the "never"

1 word, but by other mechanisms to increase the
2 urgency, and to support this issue, in
3 general, of reporting.

4 Some of the things that Doron was
5 just describing, I mentioned at our meeting a
6 few weeks ago that even though we call this a
7 reporting system, there's a lot more to this
8 than reporting. I think, unfortunately, the
9 press hooks onto that word "reporting", and
10 there's a belief out there, maybe that's too
11 strong a word for the press, that just
12 reporting is going to fix the problems. And
13 I've commented in testimony to the state
14 legislature that if reporting were the answer
15 that was going to fix everything, just
16 reporting, we would have fixed things nine
17 years ago.

18 It's about a lot more than that.
19 So, any opportunity to increase urgency and
20 provide backgrounds, and support for doing
21 more than reporting, for PDCA, would be a
22 major plus for this report.

1 CO-CHAIR TYLER: I think Leah was
2 next, and then Michael.

3 MEMBER BINDER: I can only speak
4 from my experience, but I can tell you that I
5 have spoken to New York Times, Washington
6 Post, CNN, I can name major broadcasts, or
7 major newspapers about never events. This
8 captures the imagination.

9 This will be a major story, and I
10 think Gregg has brought up the point, modern
11 healthcare, if nothing else, will grab on to
12 this in a second. Where's the word "never"?
13 This will be the story, so you're right. We
14 better come up with some other language that
15 will clarify that oh, we're not lowering the
16 standard, we're just using a new word, even
17 though this is the word, "never events", that
18 has come into our language thanks to NQF in a
19 way that I have found to be very powerful,
20 very compelling, and a tribute to our health
21 care system, that providers are willing to say
22 no, we are going to go lay down the gauntlet

1 on certain events that should never occur.

2 And I want to go back for one
3 second to my airline analogy. An airline
4 crash is a never event. It should never
5 happen. Does that mean that it's always
6 preventable? No, there can be birds that fly
7 into your plane, and you have the best pilot
8 in the air, and he handled it, and the whole
9 crew survived, et cetera, but it's still a
10 never event. It's still -- and airlines still
11 stand up for that. That's a never event. We
12 will do everything in our powerful humanly to
13 avoid that from happening again.

14 The public understands that
15 sometimes it is preventable, but setting that
16 standard gives comfort to the public, that the
17 healthcare system, or the airline industry,
18 does understand that it is -- that they have
19 a special trust placed in them. So that word,
20 and that is why I think it's captured the
21 attention of the public.

22 CO-CHAIR TYLER: Michael, then

1 Helen.

2 MEMBER VICTOROFF: Well, I'm
3 getting more uncomfortable the longer we
4 discuss this. And despite my fondness for
5 Leapfrog, and your very good contributions, I
6 now envision dueling interviews with CNN,
7 where members of groups like our s are going
8 to explain in strong terms why one or the
9 other view about this word is absolutely
10 necessary, and critical. And that bothers me
11 a lot.

12 I think the "never" word should
13 never have been spoken. It was a mistake from
14 the beginning. It was a rhetorical device.
15 It's scientifically silly. It's logically
16 impossible. And no one in the airline
17 industry uses that word ever about anything.
18 In fact, if there's one thing you never say,
19 it's "never" in the safety business.

20 I'm particularly wanting to address
21 this issue about urgency. If you look at
22 global warming, or the rain forest depletion,

1 or any popular cause, there's a great deal of
2 hand waving possible about urgency, and the
3 urgency of the people in the meetings is
4 always dramatic, but I don't really care about
5 urgency. On the front line practicing
6 medicine, living in a hospital, going in as a
7 patient on a gurney, I don't care if people
8 are urgent about problems that can't be fixed.

9 I think the credibility of this
10 organization rests on being able to move from
11 hand waving and publicity, which are very nice
12 at Stage One. Stage Two of science, where
13 we're able to say and, look, we have a
14 vaccine. It's one thing to say, oh, my God,
15 we're all going to get HIV, heavens. Okay.

16 There was a hand waving at the time
17 for HIV, but now is really the time to look at
18 the molecules a little. And I'd love to
19 progress to that stage in the safety business.
20 And I think that this move -- I mean, my
21 interview with New York Times, heaven help us,
22 is going to say as we mature as scientists,

1 and strategists about remedies, we didn't find
2 it was necessary to use that word "never" any
3 more. We became more refined, and
4 sophisticated. That's my current
5 understanding.

6 DR. BURSTIN: I just want to make
7 two points, one of which is that NQF has not
8 supported the word "never event" since the
9 origination of the Serious Reportable Events.
10 I just want to make that clear. That's been
11 something that has been stricken from the
12 language, explicitly, because we made it clear
13 that we believe there are appropriate public
14 reporting and improvement, but never was not
15 a word that was really used beyond the 2000
16 initial definition.

17 I think the second thing is that I
18 think we've also tried to create a broader
19 corridor for more reporting. And I think the
20 only way to do that is, in fact, to make it a
21 broader definition. And that, I think, was
22 the basis of most of our discussion yesterday.

1 So, that broader corridor allows us
2 to get to that list John mentioned yesterday
3 of those 40 things that might be really
4 significant, but would have an incredible
5 amount of discomfort saying "never" associated
6 with, but some of them are equally bad. So,
7 I think that those two things together, we
8 would not support the term "never events",
9 haven't in years, so others may call it that,
10 but just to be clear, from NQF's perspective,
11 they are serious reportable events, they are
12 not called "never events."

13 And, secondly, the intention of
14 yesterday was to create a broader corridor to
15 allow us to bring in bad things that may not,
16 necessarily, fit a "never" designation.

17 CO-CHAIR TYLER: Okay. Just -- I'm
18 going to interject to see if you all -- if
19 there is any -- from what we're getting. I
20 mean, we're reinforcing positions, it sounds
21 like, but do people feel the need to take a
22 vote on what Doron offered, as far as adding

1 some modifying language? Would you offer that
2 again, Doron, just to make your suggestion
3 again?

4 MEMBER DORON SCHNEIDER: For the
5 intent of further harmonizing, it would read
6 defined as "preventable, serious, and
7 unambiguous adverse events that should not
8 occur, should lead to disclosure, and a search
9 for root cause."

10 CO-CHAIR TYLER: Should lead to
11 disclosure and search for root cause." Is that
12 right?

13 MEMBER DORON SCHNEIDER: Yes,
14 something like that.

15 CO-CHAIR TYLER: Causes.

16 MEMBER RADFORD: Search for and
17 correction of.

18 MEMBER DORON SCHNEIDER: I like the
19 correction.

20 CO-CHAIR TYLER: Yes.

21 MEMBER DORON SCHNEIDER: That's the
22 punch.

1 CO-CHAIR TYLER: Search for and
2 correction of.

3 DR. BURSTIN: The first one you
4 said investigation, by the way, which I think
5 is better.

6 CO-CHAIR TYLER: Yes.

7 MEMBER BINDER: And what about,
8 "should always lead to", and what about adding
9 an apology to the patient?

10 CO-CHAIR TYLER: Disclosure.

11 MEMBER BINDER: Should always lead
12 to disclosure, search for correction, apology
13 to the patient.

14 MEMBER BRENNAN: I think all this
15 language could be included in text, but I
16 would prefer to keep the definition of the
17 actual event crisp.

18 CO-CHAIR TYLER: Is that P.J.?

19 MEMBER BRENNAN: Yes.

20 CO-CHAIR TYLER: Okay.

21 MEMBER RYDRYCH: It feels a little
22 wordy, to me. It feels like we're -- I don't

1 like the idea of making it this broad, and I'd
2 prefer to keep the definition a little
3 cleaner. But I would like to see in the text,
4 or somewhere in the explanatory language, I'd
5 like to see more about disclosure and apology,
6 because I think that's something we certainly
7 encourage people to do, but having that be
8 sort of more -- getting a little more weight
9 from NQF around these events should be
10 disclosed to patients, and there should be an
11 apology would give more weight to that.

12 CO-CHAIR TYLER: Cynthia.

13 MEMBER HOEN: That's a great idea,
14 but not, necessarily, doable in every
15 instance. In the State of New Jersey, an
16 apology is admissible in the court of law.
17 The other problem is, in a lot of these
18 events, it's not clear -- I mean, you can say
19 I'm sorry this happened to you, and here's
20 what happened to you, and we do that. But to
21 go beyond that is not, necessarily, possible,
22 because you have multiple players involved.

1 And if you start pointing at each other before
2 you understand what really occurred, and what
3 needs to be corrected, it's very problematic.

4 So, I appreciate the research out
5 there. I've not seen a decrease in lawsuits
6 because we apologize. We've seen a decrease
7 nationally in lawsuits, because that's the
8 climate, so I'm not sure you can attribute it
9 to that. Although, I do think it's obviously
10 -- we do need to take care of our patients,
11 and be there for them when bad things happen.

12 CO-CHAIR TYLER: Michael.

13 MEMBER VICTOROFF: Unlike New
14 Jersey, Colorado has a robust apology statute
15 that allows those things to be not introduced
16 as evidentiary. And we have a very extensive
17 apology program in our malpractice environment
18 in Colorado. And we would never want to see
19 apology introduced as some sort of a
20 guideline, or some sort of a mandatory remedy,
21 or step in the management of a terrible event.

22 Although, we know that, at times,

1 it seems to be really a good idea, the problem
2 with sticking it in here, and I don't like
3 adding any of it. I mean, what you're saying
4 is logical, but I think it ruins the rhetoric
5 here. I just, for stylistic reasons, I'm
6 going to just say I can't support adding more
7 words now.

8 But, especially -- even adding to
9 the apology thing for the serious reportable
10 events, a different topic, the reason why we
11 probably wouldn't like that, is because then
12 it would single out serious reportable events
13 as the apology things. And where we're making
14 our great headway is in the not so serious
15 events, where there's a potential to preempt
16 litigation, and not even have it. Whereas,
17 most of the serious events are still ones that
18 are getting litigated. So, when an
19 anesthesiologist knocks a tooth out, we have
20 a chance to not even have litigation, if we
21 apologize, and actually offer some money,
22 early resolution. There are lots of things

1 you can do to not serious events.

2 So, putting apology into this
3 document would raise a whole bunch of
4 discussion, for me, in terms of whether the
5 unintended consequences were as good as the
6 intended ones. I haven't even -- I'm not even
7 prepared to think about that yet, so I caution
8 you to ponder it.

9 MEMBER RYDRYCH: I'm sorry, but if
10 apology is effective in reducing litigation
11 for the non-serious events, wouldn't it also
12 be effective -- I'm borrowing Michael's -- if
13 apology is effective in limiting litigation
14 for the non-serious events, wouldn't it also
15 be effective in limiting litigation for the
16 serious reportable events?

17 MEMBER VICTOROFF: We have no good
18 evidence about that. We'd like to think so,
19 sentimentally. And there's theoretical reason
20 to think that might be true, if we had
21 conducted a double blind trial. But the
22 problem is, I'm very nervous about putting in

1 too much sentiment with no evidence. You
2 know, if you want to put an appendix that says
3 gee, we should study apology, study the hell
4 out of apology, because, look, it might be
5 good. Oh, I'll subscribe to that. But this
6 is too much toward the front of the document.

7 MEMBER RYDRYCH: I agree. I don't
8 want it in this definition, either.

9 CO-CHAIR TYLER: Christine wants to
10 get in on this.

11 MEMBER BRENNAN: Peter, if I could
12 interject here, it seems like this is beyond
13 the scope of the project. I mean, it seems
14 like we're getting into issues of
15 implementation after the discovery and
16 reporting of an event.

17 CO-CHAIR MEYER: This is Gregg.
18 Just one of the Safe Practices is explicitly
19 around disclosure and apology, so there's an
20 existing Safe Practice on this issue.

21 I think that what we may want to do
22 in this report is somewhere in the text note

1 that -- to cross-reference the serious
2 reportable event with saying that, and by the
3 way, there is this patient -- there is this
4 Safe Practice related to disclosure and
5 apology. So, I think this is a great
6 opportunity for linkage. I agree, it's
7 probably beyond the scope of this document,
8 but I do think it's a good way to link the
9 work.

10 MEMBER BRENNAN: Leah, would it
11 help your concerns about "never" to include
12 language in the text that speaks to the issue
13 of never, rather than putting it in the
14 definition, and explains that never is -- we
15 believe these events should never happen, but
16 are not always preventable, and should not be
17 -- and to points that Michael made earlier,
18 goes on to make points about the effect, in
19 terms of litigation, and how they should be
20 construed.

21 CO-CHAIR TYLER: I think Christine
22 had a point, and we're going to, hopefully,

1 then kind of put a beat on this, wrap it up.

2 MEMBER GOESCHEL: My point was
3 exactly that. I kept going back to the
4 definition, and my immediate thoughts were
5 scope creep. This is a definition of serious
6 reportable event, not what we do about it, how
7 we do what we do about it.

8 So, I would be highly in favor of
9 the minimalist approach that we took
10 yesterday. And I just wanted to go on record
11 supporting what Michael and others have said
12 all along, and I believe that Gregg said the
13 same thing, is that we want to move the
14 evolution of this towards science and
15 evidence. And, as we go down that path, I
16 think clear and succinct definitions of terms
17 are going to be critical. So, that was it.

18 CO-CHAIR TYLER: Given what we've
19 discussed, and it sounds like that is where
20 the sentiment of the group is, but are people
21 -- can we vote for confidence in leaving it as
22 it originally was, after occur, and then

1 adding in the text of the report trying to
2 capture as much of this discussion, and some
3 of the various thoughts, particularly around
4 "never", and what that concept means to
5 people. Are people comfortable with that? Do
6 we want to actually vote for that?

7 MEMBER BINDER: I'd like to say
8 something.

9 CO-CHAIR TYLER: Okay, Leah.

10 MEMBER BINDER: I just want to make
11 a point about Michael's point, just to be
12 really clear. I'm not talking about calling
13 up the New York Times, and I can't -- I'm not
14 trying to do a dueling thing here. I just
15 want to be clear about that.

16 I raised that point, because this
17 group should be cognizant of how the public,
18 consumers, and purchasers are perceiving
19 what's done here. And I'm just telling you
20 from my experience, purchasers are extremely
21 passionate about the issue of never events.
22 And we do call it that. It is our policy, and

1 others have replicated it. So, purchasers
2 have conferences on this all the time.
3 There's one coming up in a month that's done
4 by a big purchaser out in Ohio.

5 In fact, the Purchasers Coalition
6 in Ohio has dedicated their whole year to
7 eliminating never events, to addressing never
8 events in hospitals, or something. I mean,
9 this -- so, when this comes out, you can bet
10 they're going to notice the word.

11 So, I understand maybe "never"
12 should have been there to begin with. We
13 certainly could debate that. It was there.
14 It captured a lot of attention, and it set a
15 standard that I happen to support. But I
16 understand the issues, I understand that
17 that's a difficult -- I understand the
18 difficulties, but I also think that this is a
19 serious move, to remove that word. And I hope
20 that it's understood that I'm bringing this
21 forward in the way that I have to, to
22 represent my constituency, which will notice

1 this.

2 CO-CHAIR TYLER: Okay. Let's go to
3 a vote. The vote would be to leave it as it
4 is on the screen, what we had agreed to
5 yesterday, but elaborate further in the text
6 particularly around "never", and why it's not
7 in the definition at this point. Okay. If
8 you think that's sufficient, that's what
9 you're voting yes for. If you think it's
10 insufficient, then there would be some other
11 remedy. But, do people vote -- is this what
12 people want? Yes? All those voting yes?

13 (Vote taken.)

14 CO-CHAIR TYLER: And on the phone?

15 CO-CHAIR MEYER: I'm sorry. That
16 wasn't clear to me. Could you -

17 CO-CHAIR TYLER: Okay. What we're
18 voting on is to leave the definition as we did
19 at the end of the day, which is defined as
20 "preventable serious, and unambiguous adverse
21 events that should not occur." And then we
22 would also in the text of the report really

1 flesh out a bit about why the term "never" was
2 removed, and substituted with "not".

3 CO-CHAIR MEYER: Okay.

4 CO-CHAIR TYLER: And some of the
5 thoughts around this debate.

6 CO-CHAIR MEYER: Okay.

7 CO-CHAIR TYLER: Okay. That's what
8 we're voting on. And we saw the hands of
9 support here in the room. On the phone, do we
10 have yes for that, or -

11 (Chorus of yes.)

12 CO-CHAIR TYLER: Okay. No's?
13 Okay. On the phone, any nos?

14 DR. ANGOOD: Sorry. Diane, you had
15 a quick question?

16 MEMBER RYDRYCH: Yes, I do just
17 have a quick question. I know that with any
18 changes to the list of events that this group
19 makes, it goes to a membership vote of NQF.
20 Do changes to the definition go to a vote, as
21 well, so the membership will be voting on that
22 change?

1 DR. BURSTIN: The entire document,
2 definitions, all of it, will go actually first
3 out for comment. The comment is going to be
4 where I think a lot of this debate will
5 happen, more so than the vote at the end. And
6 I guess one question might be, is there a need
7 to think about putting some of these
8 definitions out for comment, even in advance
9 of the call for SREs. We'll have to think
10 that through.

11 MEMBER BRENNAN: I do think that
12 would be helpful.

13 DR. ANGOOD: All right. So, we
14 have a couple of more slides just to make
15 sure, similarly, on the same page, as best as
16 we can. So, we've all now just agreed on the
17 definition of SRE.

18 The further language on the
19 definition, for those on the phone, this is
20 the second slide that was sent out earlier
21 today. "Current set of SREs is not intended
22 to capture all events, but the events are of

1 concern to both the public and healthcare
2 professionals and providers, clearly
3 identifiable and measurable, thus, feasible to
4 include in reporting, and of a nature that's
5 such that the risk of occurrence is
6 significantly influenced by policies and
7 procedures of the healthcare facility."

8 We did not change any language in
9 this one, so we'll presume that everybody is
10 still comfortable with that. I'm not seeing
11 any heads nodding in the opposite, so the next
12 slide.

13 The third slide, for those on the
14 phone, is the SRE Criteria. And this is,
15 basically, where we chose to get rid of the
16 and/or in-between each of the three bullets.
17 So, "An event must be unambiguous,
18 preventable, serious in any of the following
19 adverse indicative of a problem in a
20 healthcare facility, safety systems, important
21 for public credibility, or public
22 accountability." Any further discussion on

1 that? Seeing and hearing none, so the next
2 one.

3 And then this slide is defining the
4 individual terms of the larger definition. We
5 have "event", which is unchanged, means "a
6 discrete, auditable, and clearly defined
7 occurrence." "Adverse", we got rid of the
8 latter part of that definition, so that it now
9 reads, "Adverse describes a negative
10 consequence of care that results in unintended
11 injury or illness." "Preventable" is
12 unchanged, describes "an event that could have
13 been anticipated or prepared for, but that
14 occurs because of an error or other system
15 failure." "Serious" has some changes. We
16 added a couple of words, and deleted half of
17 the definition from last time. So, it
18 currently now reads, "Serious describes an
19 event that can result in death or loss of a
20 body part, disability, or loss of bodily
21 function, or risk thereof." The added words
22 were "can result in death", as well as the

1 term "or risk thereof."

2 And then the final term,
3 "Unambiguous" was unchanged, and that refers
4 to, "An event that is clearly defined and
5 easily identified." So, I guess we'd ask for
6 comments, or affirmation that that's what we
7 all agreed to yesterday.

8 MEMBER BRENNAN: Peter, this is
9 P.J. I think these are -- I agree with these
10 definitions. I think I would just like to see
11 in the text under serious, not in the
12 definition, but in the accompanying text,
13 language related to psychological harm, as
14 well, so that that's clearly included.

15 DR. ANGOOD: Yes, that's a good
16 point, P.J., and we certainly talked about
17 that. Thanks. Okay. Everybody still
18 comfortable with those sets of slides? All
19 right. Next slide, please.

20 And now we have the Venn Diagram
21 that was floated around in a few different
22 versions. We tried to clean it up, and we

1 already have a few shaking heads in the room.
2 And this is an important set of discussions,
3 because my sense was, as we left yesterday,
4 not everybody was on the same page. And does
5 anyone on the phone not have this? I don't
6 want to try to do the -- describe a Venn
7 Diagram to the outside world, if we don't have
8 to.

9 MEMBER BRENNAN: I think we all got
10 it. Thank you.

11 DR. ANGOOD: Yes, so we've got -

12 DR. GANDHI: I got it.

13 DR. ANGOOD: We've got the larger
14 circle, which encompasses the so-called white
15 matter of all events. We, as near as we can
16 tell yesterday, agreed that the serious
17 reportable events were their own little
18 subgroup, HAIs, because they are an entity
19 that's out there, are their own subgroup. And
20 that there was a whole collection of these
21 other types of events in the broader groupings
22 that were not necessarily as serious, and not

1 necessarily reportable, but they were
2 certainly items that needed to be taken into
3 account. And then in our discussions later,
4 we sort of added an extra circle, sort of to
5 recognize that other small subgroups may or
6 may not show up in this realm, not to suggest
7 that we need to make any more of those, but
8 that just their existence over time may occur.

9 So, I'm going to turn this back to
10 Sally in a moment, but we've got Michael and
11 Diane, who are jumping on us here. So, Mike.

12 MEMBER VICTOROFF: Looking at this
13 now, it doesn't resemble what I thought I
14 agreed to yesterday, and I don't want to
15 discuss it any more.

16 (Laughter.)

17 MEMBER VICTOROFF: Apparently, I
18 didn't even get anything out of yesterday's
19 discussion. I don't see any need for this
20 diagram, and if a diagram like this were to
21 show up in the report, I couldn't explain it.
22 And I don't think it adds anything. That

1 isn't to say the discussion yesterday wasn't
2 useful, because it really was. I thought that
3 the process we went through taught me a lot.
4 And I think it helped me articulate stuff that
5 I hadn't really. But now that I look at this
6 version of somebody's version of what they
7 thought happened yesterday, I don't recognize
8 it, so I really think the prudent thing to do
9 would be to not have a Venn Diagram, because
10 I don't want to perfect a Venn Diagram today.
11 We've got too much else to do.

12 DR. ANGOOD: Well, just, again -
13 sorry, Sally. The discussion got started
14 because we were struggling with this
15 healthcare acquired, or healthcare associated
16 conditions. And it kind of evolved along in
17 this, and this is where we had left off.
18 That's why we're opening it again today.

19 MEMBER VICTOROFF: And just for --
20 I mean, you're reminding us that the problem
21 of the two lists was the reason for the Venn.
22 And we solved the problem of the two lists, in

1 the course of which, I think the Venn has now
2 become not useful. And, as it looks to me
3 here now, it's definitely not useful, because
4 I don't know what it really means.

5 MEMBER RYDRYCH: Yes. I think what
6 we had decided on -- I agree with Michael. I
7 don't think we should spend much time on this,
8 but I think what we had decided on was just
9 the big circle of all events, one circle for
10 SREs, one circle for HAIs, and that was it.
11 Because, otherwise, we're created new
12 categories that we then have to define. And
13 what struck me about the discussion yesterday
14 was that we spent a lot of time having these
15 important conversations, but we ended up right
16 back where we started, which was with the
17 statement in the briefing document that said
18 SREs are a subset of the larger set of HACs.
19 And then we were just showing it visually, so
20 I don't know that it really adds much, either.

21 CO-CHAIR TYLER: Philip.

22 MEMBER PHILIP SCHNEIDER: I agree.

1 I think the use of this -- the evolution of
2 this was derived from our attempt to clarify
3 the difference between HACs and SREs. And
4 since we're no longer discussing HACs, I don't
5 see any reason to have it.

6 CO-CHAIR TYLER: Okay. Given the
7 fact that we did have a good discussion, which
8 sounds like it did get a lot -- people got a
9 lot out of it, and largely did resolve the
10 situation with the two lists, can we take a
11 vote for removing the diagram from the report,
12 but just knowing that we -- what it stands
13 for. Yes, remove the -

14 (Vote taken.)

15 CO-CHAIR TYLER: Anybody on the
16 phone supporting removing the diagram from the
17 report?

18 CO-CHAIR MEYER: This is Gregg. I
19 definitely support. It was a great
20 conversation starter yesterday, but I think at
21 this point it's superfluous.

22 DR. BURSTIN: This is Helen, I

1 support.

2 MEMBER BRENNAN: P.J., I agree.

3 CO-CHAIR TYLER: Okay. Thank you.

4 MEMBER DORON SCHNEIDER: Just a
5 quick -- Diane's last statement is where we
6 started, and it concerns me that you just said
7 that, because you just said that SREs are a
8 subset of all healthcare acquired conditions.

9 MEMBER RYDRYCH: No, a subset of a
10 broader group.

11 MEMBER DORON SCHNEIDER: Okay.

12 MEMBER RYDRYCH: I think we
13 abandoned the HAC term. Yes, the bad things
14 list.

15 MEMBER DORON SCHNEIDER: Okay. So,
16 maybe you misspoke, but that's -- okay, we're
17 clear.

18 CO-CHAIR TYLER: Okay. Is there
19 another slide?

20 (Laughter.)

21 MEMBER RYDRYCH: It was a breakdown
22 in the communication system. It happens.

1 DR. ANGOOD: I want to just make
2 sure that we're clear, then, that as just
3 articulated, we've got all events that occur.
4 We've got these serious reportable events, and
5 we've got this cluster of healthcare acquired
6 infections, which have their own sets of
7 initiatives. And there may or may not be
8 other types of similar things that occur over
9 time.

10 We still will need to go back to
11 HHS and say okay, this group does not feel
12 that the term "healthcare acquired", or
13 "healthcare associated" conditions is a term
14 to be used. Is that what we're still saying
15 now?

16 DR. BURSTIN: Just to be clear, the
17 HAC term was always a term of CMS, so we were
18 trying to decide if we needed -

19 DR. ANGOOD: That's hospital.

20 DR. BURSTIN: Right. We were
21 trying to decide if we needed yet another
22 categorization of our events, NQF's side of

1 this to capture those. And I think what the
2 group came to was the idea that we have a
3 broader corridor now that can encompass a
4 broader set of events, so that I think from
5 where NQF sits, the SREs, and I would
6 obviously welcome CMS' feedback when we put
7 this out for comment, but our broader
8 conceptualization of SREs should capture that
9 broader space.

10 CO-CHAIR TYLER: Michael.

11 MEMBER VICTOROFF: Again, I am
12 happy leaving this the way I -- I kind of
13 think of it as -- the reporting process at CMS
14 has found a way to make itself happy capturing
15 certain bad things. I'm not sure how you can
16 capture all the SREs, because there's a
17 capture identification, intervention. There's
18 a lot of things after the definition step that
19 you've got to do. So, there are some of them
20 that CMS looks like they figured out in their
21 own system a way to capture through their use
22 of ICD, and whatever they have. And we could

1 talk to them about that, but I think that, for
2 me, the lower level -- a different level than
3 the plane of defining events, and my confusion
4 yesterday that got clarified was that we're
5 not talking with healthcare acquired
6 conditions, whatever that is, but defining
7 certain kinds of events. We're talking about
8 capturing some reportable stuff that might be
9 good fodder for intervention. So, if that's
10 generally agreed, then I don't have any
11 trouble talking to CMS and saying we didn't
12 say your list is no good, but we see that it
13 fits in a different plug than in the
14 definitions of the bad things we care about.

15 MEMBER BRENNAN: Peter.

16 DR. ANGOOD: Yes.

17 MEMBER BRENNAN: P.J. here. Don
18 Wright at HHS has been leading a Steering
19 Committee to coordinate activities across HHS,
20 and to create a national plan for the
21 reduction of HAIs. And I think we ought to be
22 in touch with him. That plan was published in

1 January of 2009, and has five-year goals,
2 incorporates the term "healthcare associated
3 infections". And I think to the extent that
4 we can align ourselves with that, it would
5 help reduce confusion for hospitals, and
6 promote that agenda.

7 DR. ANGOOD: Yes. No, I certainly
8 agree, P.J., and we actually have had several
9 discussions with Don, and we actually followed
10 up with Don after the State-Based Reporting
11 meeting of a couple of weeks back. And Don is
12 very keen to harmonize with what NQF is doing,
13 with what the State-Based Reporting entities
14 are doing. And, hopefully, in his new
15 position, which was just announced yesterday,
16 he will continue along this HAI action plan,
17 as it rolls itself out over the next few
18 years. But a very good point, thanks.

19 CO-CHAIR TYLER: Okay. Do you have
20 other to review?

21 DR. ANGOOD: No, I just -- I mean,
22 I just want to make sure we're comfortable.

1 CMS, it's the hospital acquired conditions.
2 HHS came to us with this healthcare type of
3 term. And I think with us redefining SREs,
4 we're able to back off that healthcare
5 acquired thing. And I just want to make sure
6 everybody is comfortable with that.

7 I think it's important, just
8 because the CMS term of the hospital will
9 continue to be a confusion generator, but
10 that's their business, and they can move
11 towards taking some of our SREs, if they so
12 choose to do that, but that's their business,
13 not our business. And adding this other
14 healthcare acquired/healthcare associated
15 would be, I think, more confusing to the
16 field, rather than less. So, I just wanted
17 to, again, reaffirm that we're comfortable
18 leaving that term alone. Don't even go there
19 any more, and we'll just convince HHS they
20 don't need to go there any more, either.

21 MR. GARCIA: Peter, this is Eddy
22 Garcia.

1 DR. ANGOOD: Yes.

2 MR. GARCIA: Just so it's clear,
3 we're probably going to be creating other
4 terms, such as nursing home acquired
5 conditions, home health acquired conditions.
6 So, we were looking for a term that would
7 encompass all of those as an umbrella. And
8 then my thinking was under each of those,
9 there are SREs, so I think that you've also
10 defined with your Venn Diagram, which you're
11 not publishing, that there is a larger term,
12 and SREs fits under that. HAIs also fit under
13 that. So, I guess my question is, what is
14 that larger term that you're defining?

15 DR. ANGOOD: Yes, I can certainly
16 understand the question, Eddy, and I sense
17 that we'll certainly have more discussions
18 between your guys' groups, and ours in moving
19 forward, but from yesterday's discussion, the
20 broader full context of events is what we just
21 are calling the adverse events, or all events.
22 Within all healthcare events, there are these

1 SREs. And, as we go through the rest of this
2 Steering Committee's deliberations, we'll
3 begin to -- and the use of the TAPS, we'll
4 begin to make them more environment-specific.
5 But another term isn't necessarily needed at
6 this point in time. And it would actually
7 make more sense to have SREs for home health,
8 SREs for ambulatory, if you will. And they
9 may be similar in each of those environments,
10 but that would be another way of identifying,
11 or specifying, as opposed to creating new
12 terms all of the time.

13 Helen, did you want to add other
14 comments?

15 DR. BURSTIN: No, I think it's a
16 conversation I think that will continue. I
17 don't think it's something we're going to
18 resolve today. I think the idea of creating
19 this broader corridor, our hope was, in fact,
20 if you look at what's on the CMS Never Events
21 List, at the moment, I think what we talked
22 about yesterday was all of those would now fit

1 in the broader category of SREs. So, I think
2 our hope is, by broadening the definition, we
3 have created something that works for the
4 purposes of what CMS is trying to get at, and
5 I think that's a discussion to follow, that I
6 think we'll continue to have, but I think that
7 was the hope, that we could actually -- if you
8 look at that list, based on the definitions we
9 talked about yesterday, all of those now would
10 fit under the broadened - I'm sorry -
11 diagnosis. I can't help myself, sometimes.
12 The broader definition of SREs, and I think
13 that's our hope, that we can consolidate under
14 one term. But, again, further discussions are
15 certainly welcome.

16 CO-CHAIR TYLER: Leah.

17 MEMBER BINDER: I just want to say,
18 I appreciate Helen's comments, because I'm
19 vaguely uncomfortable with it. I just want to
20 make sure that there's harmony with CMS. I
21 mean, I think they've made major inroads.
22 There's been a lot of attempt on their part,

1 and on NQF's part, to create better harmony.
2 I think that's all of our goals, so I just
3 want to make sure that as we go forward, we're
4 mindful of that. That's a discomfort that I
5 have with it right now. Do we have any
6 opinion from CMS, or have we talked about this
7 to anyone at CMS to get their feedback?

8 DR. BURSTIN: Eddy Garcia, who's on
9 the phone, was here with us yesterday, and is
10 here with us today, who just made those
11 comments. Obviously, this is a broader
12 discussion, including the payment side folks,
13 which Eddy is not on. Eddy is on the quality
14 side, so we'll have those discussions. I
15 think our goal is, as much as possible, with
16 the majority of the work we do, harmonization
17 is the end game. If there's a way to make
18 that work for all purposes, and get at the
19 magical list John talked about of those 40
20 events, I'm in. It seems like the way to go,
21 but see if we can get there.

22 CO-CHAIR TYLER: Okay.

1 DR. BURSTIN: It's going to forever
2 be that magic list of John's events, by the
3 way, in my mind. Always going to be those --
4 and if we don't get to 40, I'll be very sad.

5 (Laughter.)

6 DR. ANGOOD: Yes, and the way
7 things are, it'll shift from Never Events to
8 John's 40 list.

9 (Laughter.)

10 DR. ANGOOD: Not quite the same
11 sense of urgency, Leah, but -

12 CO-CHAIR TYLER: Okay. Peter, did
13 you have anything else from yesterday you
14 wanted to review?

15 DR. ANGOOD: No, I believe that was
16 it.

17 CO-CHAIR TYLER: Okay. Good.
18 Before we plunge into what we had on today's
19 agenda, we still need to pick up from
20 yesterday, jump back into the list of serious
21 reportable events. We got, I guess, about
22 halfway through that list, so we're going to

1 plow on with that, if we can get -- we under
2 the care management events, 4A, if we can get
3 that up. I think when we last left, Eric had
4 updated us all that older people kill
5 themselves by dumping their wheelchairs into
6 jacuzzis. I remember that, that was our -
7 so we've all had a lot to think about
8 overnight.

9 (Laughter.)

10 CO-CHAIR TYLER: Okay. So, now
11 we're in Care Management Events, 4A. Patient
12 death or serious disability associated with a
13 medication error, e.g., errors involving the
14 wrong drug, wrong dose, wrong patients, wrong
15 time, wrong rate, wrong preparation, or wrong
16 route of administration. Okay. Let's see.

17 The new language excludes
18 "reasonable differences in clinical judgment
19 involving drug selection and dose, includes
20 administration of a medication to which a
21 patient has known allergy and drug
22 interactions, for which there is known

1 potential for death, or serious disability."

2 Okay. What do we want to comment
3 on? Diane.

4 MEMBER RYDRYCH: One thing that's
5 never really been clear to me with this event
6 is how to deal with cases where a medication
7 should have been administered, but was not, as
8 opposed to the wrong medication being
9 administered. Examples that have come up, for
10 us, include cases where like a pre-op
11 antibiotic was supposed to be given, but
12 wasn't, and then a patient got an infection,
13 or should have been DVT prophylaxis, that was
14 not provided. And then there ended up being
15 a serious disability to the patient, as a
16 result.

17 I don't know what the intent was at
18 the event around those types of situations.
19 My guess is that they're not captured. I
20 don't know if they were intended to be
21 captured, or not.

22 CO-CHAIR MEYER: Diane, this is

1 Gregg. I think that that's been an ongoing,
2 I think, vexing issue with this. And I think
3 it's one of the fundamental issues with both
4 this work, and to some extent, the Safe
5 Practice work. And that is, is that we
6 largely focus here on execution, meaning what
7 was done, rather than design, rather than was
8 the plan right. And that's, actually, a
9 limitation across much of safety right now, is
10 that we focus much more on you gave the wrong
11 antibiotic in terms of an allergy, rather than
12 asking the question, did the patient need the
13 antibiotic at all. And I would say that
14 that's something that, when we think about
15 what are the areas for future research, and
16 what needs to be kind of focused on in the
17 future, I'd like to see that highlighted here.
18 And, again, that cuts across both this, and
19 the Safe Practices.

20 CO-CHAIR TYLER: Philip.

21 MEMBER PHILIP SCHNEIDER: Wouldn't
22 that be covered in the second bullet point in

1 the middle column, "Occurrences which a
2 patient dies or suffers serious disability as
3 a result of a failure to administer prescribed
4 medicine"? And, secondly, but as an
5 additional point, though, if you think of
6 medication use as being comprised of a number
7 of steps, starting with prescribing, would
8 this encompass a failure to prescribe a drug
9 that was needed, to encompass the whole
10 process, as opposed to simply the
11 administration of the medicine?

12 CO-CHAIR TYLER: Michael.

13 MEMBER VICTOROFF: I have a problem
14 like that -- with that. I appreciate the
15 comment here, but I think we heard the
16 clarification, there's a difference between
17 commission and omission, and the commission
18 ones are a lot easier to capture, and the
19 omission ones are actually different in kind.

20 When -- and this one skirts the
21 boundary here, when we say that it was
22 prescribed. There's an order. We saw it, it

1 was ordered. The order was not taken off, or
2 whatever, didn't get into the right IV. That
3 still is, in a way, an error of commission.
4 I'm opening to hearing it both ways. But
5 guideline adherence is not comprised by this
6 kind of error, this particular error.

7 I don't see -- you didn't realize
8 that people with heart disease are supposed to
9 get statins or something. We don't have beta
10 blocker, we don't see aspirin, we don't see
11 whenever you have a broken leg, you should put
12 a splint on it. There's a lot of guideline
13 management processes that are not in here at
14 all.

15 I'm very open to talking about
16 them. In fact, I want to open that up. We're
17 going to start talking about additions, but I
18 don't think that this canoe carries that
19 baggage. This looks, to me, more like -- and
20 I'm a little disturbed about that bullet you
21 pointed out, but this looks, to me, pretty
22 much more like we gave something, and it was

1 wrong.

2 DR. GANDHI: This is Tejal from the
3 phone. Another, I don't know if we want to
4 open another can of worms, but the other issue
5 is monitoring. Usually, when we think about
6 the medication process, it goes all the way
7 from ordering, dispensing, prescribing,
8 administering, and then monitoring. So, I'm
9 wondering if you want to put any language --
10 again, it's more of an omission, but I'm
11 thinking of failure to appropriately monitor
12 an INR, for example, or a PTT, or something
13 like that, leading to a serious event. So,
14 I'm wondering if you want to put in the term
15 "monitoring", at all.

16 CO-CHAIR TYLER: Okay, thanks.
17 Michael, again, and then Cynthia.

18 MEMBER VICTOROFF: Again, good
19 comment, good addition. I don't want to put
20 it in this canoe. You hurt the category if
21 you put in so many things that everything to
22 do with -- I mean, you could have a category

1 that any bad thing conceivably having to do
2 with anything to do with a drug, but that's
3 too big for me. So, I'm going to be a
4 splitter in this case.

5 CO-CHAIR TYLER: Cynthia.

6 MEMBER HOEN: This is one of those
7 categories that concerns me, because we have
8 a lot of medication errors, but very few of
9 them rise to the level of the definition here.
10 And, I guess, that as we talk about how we
11 share this information going forward in an
12 attempt to broaden our knowledge, and put in
13 preventative measures, or give risk alerts, or
14 whatever you want to call them, to other
15 organizations, that this is one where I would
16 like to consider whether we put in wording
17 that death or disability, or could have
18 resulted in death or disability, such that
19 those events which just because we caught them
20 before they reached the patients, have the
21 likelihood of occurring in other venues, or
22 hospitals, could then get that information out

1 to the state, for then sharing amongst other
2 facilities.

3 CO-CHAIR TYLER: Eric.

4 MEMBER TANGALOS: There's currently
5 a very nice way of starting to look at those
6 near misses in a variety of different
7 environments. And it's through a medication
8 process where you look at rescue drugs. So,
9 you can just do -- and Pittsburgh has done a
10 lot of this work, and Steve Hadler has done.
11 And, again, it's in the process steps, but it
12 starts to address a lot of those questions
13 that now come to the surface, because you can
14 look at drugs that rescue patients from
15 disaster.

16 CO-CHAIR TYLER: I don't think we
17 have any other -- Martha, and then Philip.

18 MEMBER RADFORD: I wonder if this
19 is -- part of this is in reporting about the
20 structures around medication management in an
21 organization, any type of organization, versus
22 the specific events, themselves, reporting

1 specific events themselves. So, I'm concerned
2 about where we are on the specificity,
3 sensitivity spectrum here, and, for this
4 particular one, I'm going to go with Michael
5 and be a splitter.

6 CO-CHAIR TYLER: I'm not sure I
7 understand what you're getting at. I mean, we
8 are meant to begin applying these to other
9 contexts. That's part of our -

10 MEMBER RADFORD: What I mean is
11 that the sins of commission are different. I
12 am agreeing with Michael, they are different
13 than the sins of omission. In addition, the
14 fixes around near misses are organizational
15 fixes. They're not, necessarily, event fixes.
16 And I think that if we -- we risk the
17 possibility of losing the potential fixes,
18 because there's usually more than one, in the
19 -- if we broaden the reporting category. You
20 don't have to report everything to get some
21 good clues about what needs to be fixed.

22 MEMBER PHILIP SCHNEIDER: I'd like

1 to ask a question of procedure, because I
2 don't -- I'd like to see included, a method
3 defined where we could include errors of
4 omission from prescribing, through monitoring.
5 Errors of omission in prescribing, dispensing,
6 administering, and monitoring therapy,
7 somehow. I'm not going to fall on a sword to
8 say it has to be in this, but I would like to
9 know how we would go about making sure that
10 those kinds of events are captured, because I
11 think they're equally important.

12 CO-CHAIR TYLER: Okay.

13 MEMBER PHILIP SCHNEIDER: I can
14 rest, if I know that there will be a method
15 developed in order to do that. I notice we've
16 looked at surgical complications, and diced
17 that up a lot of different ways. I went back
18 and looked at, there's probably four different
19 things that relate to -- events that relate to
20 surgical procedures, and the medication used
21 is no less complicated. It's less dramatic,
22 but I think we need to, potentially, tease

1 that out a little bit more than embedding
2 everything in one standard.

3 CO-CHAIR TYLER: So, do you think
4 it makes to have a separate event around
5 omission through monitoring?

6 MEMBER PHILIP SCHNEIDER: I'm not
7 sure I do, but I sense that there's enough
8 people that do, that that would be okay, as
9 long as it's captured.

10 CO-CHAIR TYLER: Michael.

11 MEMBER VICTOROFF: Since you're
12 asking for a possible mode, I'd like to
13 propose that we keep in mind that we're
14 allowed to add stuff. And I have a whole
15 shopping list to make it up to 40 of things
16 like this. And, for me, near miss events are
17 completely separate, because they're analyzed,
18 captured, and dealt with separately. And I
19 want to put them on, and make sure they get on
20 here, but I don't want to load these boats
21 with all of this diffusing stuff that actually
22 complicates the analysis of these fairly crisp

1 ones. So, what I would propose is that when
2 we say oh, you know, there's something else
3 that's kind of like this, but not the same,
4 what I'd encourage us to think is, do we want
5 to dilute, or do we want to add something at
6 the bottom of the list, that then needs the
7 same kind of scrutiny as all the rest. Are
8 they identifiable? Are there remedies? Are
9 there interventions? Can we count them? Do
10 they matter? Are they important? Rather than
11 concealing -- sneaking in some stuff in these
12 that I already kind of like.

13 CO-CHAIR TYLER: John. You're
14 next, John.

15 MEMBER MORLEY: Okay. I agree with
16 Mike, and in this particular case, I guess, as
17 I'm looking over the list and the concept of
18 medication errors, I'm becoming more and more
19 of a splitter on this. I think the world of
20 medication errors is the world of safety.
21 It's massive. It's far bigger than we can
22 bite off.

1 At the end of a year of data
2 collection, whether it be for a state, a
3 region, or the country, you're going to have
4 far more information than you can dissect at
5 one time. And the information that's related
6 to the pediatric issues are going to be
7 clearly different than the issues related to
8 chemotherapy, which are going to be a lot
9 different than heparin issues.

10 I'd like to see us be able to
11 identify a more focused area, or focuses
12 within medication, so that at the end of the
13 year when you've collected the data, the boxes
14 are a neater pile of information, not just
15 data, that can be used to drive that change.
16 And you're not going to get that if you have
17 one report on heparin, one report on Coumadin,
18 one on daunorubicin, one on pediatric dosing
19 issues, one on Fentanyl, and so, and so on.
20 So, some mechanism by which you can create
21 more biteable, more fixable sections of
22 medication error would be much more useful for

1 people.

2 CO-CHAIR TYLER: I was going to
3 check to see if anybody on the phone want to
4 weigh in on that? Okay. Philip.

5 MEMBER PHILIP SCHNEIDER: I'd like
6 to hear if there's an explanation for the last
7 bullet point in the middle column. I read
8 this many times, and I don't understand it
9 even this morning. I just don't understand
10 what that means.

11 CO-CHAIR TYLER: The bullet point
12 to which he's referring, "All situations in
13 which two or more medications are administered
14 for which there are drug-drug interactions
15 with known potential for death, or serious
16 disability, only those that result in death or
17 serious disability." I do not know the
18 answer, if there is a specification
19 justification. Peter, can you weigh in?

20 MEMBER MORLEY: Would meperidine
21 and MAO inhibitors fall into that category?
22 Something with known drug interactions that

1 are potentially lethal. Patients that are on
2 MAO inhibitors shouldn't be getting
3 Meperidine. We're talking a very small --
4 that's not going to get you a lot of
5 interactions that I can think of.

6 MEMBER RYDRYCH: Isn't the
7 clarification there just to say that that
8 would only be reportable if it actually did
9 result in the serious disability or the death.
10 Right? Not just the potential, thereof.

11 DR. ANGOOD: Right.

12 MEMBER VICTOROFF: This says events
13 that are not intended for capture. What I
14 don't understand is the drug interaction that
15 was known and caused a fatal event, then it
16 should be included, I think. It seems like a
17 paradoxical statement.

18 DR. ANGOOD: It's more along the
19 lines of what -- as I understand it, anyways,
20 I'm still relatively new to NQF, wasn't part
21 of the genesis of the original list, but I can
22 do some more homework to further clarify, but

1 my take on it is basically sort of what John
2 was saying in terms of the significant
3 interactions that do result in death or
4 significant disability.

5 MEMBER PHILIP SCHNEIDER: But
6 shouldn't those be reported, John?

7 MEMBER MORLEY: Yes.

8 MEMBER PHILIP SCHNEIDER: So why is
9 it under a list of things that -- the
10 statement above those two bullet points at the
11 bottom is, "This event is not intended to
12 capture", so it strikes me as a paradoxical
13 statement. It should be it's intended to
14 include drug interactions that can be
15 predicted.

16 MEMBER RYDRYCH: I think if you
17 rephrase that to say unless they result in
18 death or serious disability. But, you're
19 right, it would make more sense to kind of
20 move that out of the exclusions category.

21 DR. ANGOOD: I agree. Got that
22 note.

1 CO-CHAIR TYLER: Okay. We have
2 anything else on this one? Have you all
3 discussed it thoroughly? All right. Move on
4 to 4B. "Patient death or serious disability
5 associated with hemolytic reaction due to the
6 administration of ABO, HLA, incompatible
7 blood, or blood products. What do we know
8 about this one? Anybody have anything they
9 want to add?

10 CO-CHAIR MEYER: The only thing I
11 would consider adding here is to consider ABO
12 incompatible organs, as well.

13 CO-CHAIR TYLER: Incompatible
14 organs. Okay.

15 DR. ANGOOD: Gregg, this is Peter,
16 or was that P.J. I'm not sure, you both sound
17 similar on there.

18 CO-CHAIR MEYER: It was Gregg.

19 DR. ANGOOD: Thanks. That topic
20 that you just brought up actually has
21 generated a fair amount of discussion in the
22 Common Format Steering Committee in terms of

1 trying to decide and differentiate between
2 blood, blood products versus organ donation
3 types of issues. And the way this one is
4 sitting now, it's pretty clear it's just
5 blood, blood product as opposed to bringing in
6 that larger scale of issues. If we want to
7 have something -

8 CO-CHAIR MEYER: The organ events
9 are blessedly, incredibly rare, but they are
10 of great import, and delving into why they
11 happen is incredibly valuable.

12 DR. ANGOOD: Oh, I certainly agree,
13 and I don't discount the importance of it.
14 It's a matter of trying to keep it clean and
15 crisp between where the boundaries are. You
16 know, if we want to have a -

17 CO-CHAIR MEYER: So maybe we should
18 put this on a list of something for the
19 future.

20 DR. ANGOOD: Yes, I was just going
21 to say it may become part of what we actively
22 seek out in terms of solicitations for other

1 SREs, because it's an important topic by
2 itself.

3 CO-CHAIR TYLER: Okay. So, maybe
4 you'll look at that in the future. If we have
5 no other discussion on that, then we'll move
6 on to the next one.

7 Okay, 4C. "Maternal death or
8 serious disability associated with labor or
9 delivery in a low-risk pregnancy while being
10 cared for in a healthcare facility." Let's
11 see. The added language includes "events that
12 occur within 42 days post delivery, excludes
13 deaths from pulmonary or amniotic fluid,
14 embolism, acute fatty liver of pregnancy, or
15 cardio myopathy." Okay. Michael.

16 MEMBER VICTOROFF: This, to me,
17 looks like another legacy of the blame
18 paranoia philosophy that I thought we were
19 moving away from. I don't see any reason to
20 exclude a reported death from any cause,
21 because, to me, I'm considering all of these
22 causes blame neutral, or blame irrelevant.

1 We're not doing a root cause analysis here.
2 I think if there's women dying from stuff, the
3 only issue that I have is whether there should
4 be dual reporting, because what we have here
5 is a condition that is universally, as far as
6 I know, reportable to State Health Departments
7 under some other rubric than whatever NQF's
8 rubric is. And we haven't even discussed
9 that. But I surely think that every instance
10 of maternal death, regardless of cause, should
11 be counted, and collected, and reported.

12 DR. GANDHI: But the term
13 "preventable" is in the definition on the SRE.

14 CO-CHAIR TYLER: Tejal, is that
15 you?

16 DR. GANDHI: Sorry, this is Tejal.
17 Yes. I agree that we need to know about all
18 maternal deaths, and potentially the DPH or
19 the Board of Registration Medicine wants to
20 know about them, but in terms of actually
21 calling it an SRE, if we're going to keep this
22 term "preventable" in our definition, I think

1 we have to be cognizant of that as we go
2 through defining these various categories.

3 CO-CHAIR TYLER: John, then Eric,
4 then Kathryn.

5 MEMBER MORLEY: I agree with Mike
6 100 percent. I think we would want to know all
7 of them. I think there is one area of
8 limitation or refinement, and that would be
9 time limitation. So, not somebody that dies
10 as they're walking out of the hospital, run
11 over by a car. But anybody that dies within
12 a reasonable time period, or some other
13 criteria, not getting into the reasons. And
14 I think we were talking yesterday about
15 potentially preventable, so I would not want
16 to see an institution get into an internal
17 discussion about whether we have to report to
18 somebody because it's potentially, or not
19 potentially, and argue that point. Just
20 report them all. We sort them out in the end.

21 In terms of a subcategory that's
22 not listed there, that's becoming an

1 increasingly important issue, we've got this
2 thing called the obesity epidemic, and the
3 obstetricians are more cognizant of that than
4 the average person. We've had two maternal
5 mortalities. We happen to be reviewing
6 maternal mortalities in New York State right
7 now. New York State has approximately 25
8 maternal mortalities per year in one state.
9 Obviously, some of those are into that
10 category that we would likely say is not
11 preventable, but some are still hemorrhage,
12 and are preventable. But two of the patients
13 that I reviewed, one had a BMI of 60, and the
14 other had a BMI of 70. And we're particularly
15 interested in beginning to track those cases,
16 and start to talk about should those cases be
17 referred to a center that just has the
18 expertise and ability to deal with those types
19 of issues.

20 CO-CHAIR TYLER: I have a question
21 for clarification just on the consumer end.
22 So, I mean, if someone is that morbidly obese,

1 would they still be considered in a low-risk
2 pregnancy, or would that put them in a high-
3 risk category?

4 MEMBER MORLEY: It would be high-
5 risk at 60 or 70 for sure. The obstetricians
6 I've spoken with suggest a cutoff of about 50
7 or 55. But I would -- but that just goes back
8 to what Mike was saying about I'd want all of
9 them, all maternal mortalities, I believe
10 should be reported. Then let's sort them out
11 at the end.

12 CO-CHAIR TYLER: I was just
13 clarifying. So, those deaths would not fall
14 into this category, anyway, because this is
15 for low-risk. But you're talking about
16 certainly reporting all. Yes. Okay.

17 MEMBER TANGALOS: My concern is, as
18 we expand our horizons again, what if a low-
19 risk pregnancy death occurs at the hands of a
20 healthcare provider in the home.

21 CO-CHAIR TYLER: Well, this just
22 refers to in a healthcare facility. Right?

1 MEMBER TANGALOS: Well, but that's the point.

2 The point is -

3 CO-CHAIR TYLER: Right.

4 MEMBER TANGALOS: I mean -

5 CO-CHAIR TYLER: Should it apply.

6 MEMBER TANGALOS: Should it apply.

7 And how would you measure it?

8 CO-CHAIR TYLER: I think Kathryn

9 was next, then Michael.

10 MEMBER McDONAGH: Actually, that

11 was my point, too, is that I thought

12 healthcare facilities should be removed,

13 because if we begin to think about the

14 continuum of care, then a home delivery would

15 be included here, too.

16 MEMBER VICTOROFF: But now we're

17 into exactly what I thought was going to be

18 the fun part of today, which is to expand the

19 locus of care. I think that's an enormously

20 relevant question, and it gives us -- I would

21 defer it for now, but it's a perfect model for

22 asking what I've been struggling with. Okay,

1 when we have the same event that occurs in two
2 different things, two different places,
3 antibiotic reaction at home, tonsillectomy on
4 the kitchen table, whatever it is we're doing.
5 Is the -- don't laugh. Is the problem we have
6 one of defining -- are they really the same
7 error, or is there something about the locus
8 of care change the nature of the error, or
9 does it change the remedy, or the collection
10 process, or the way we're going to report it,
11 to whom we report? And I think all those
12 things are on the table, but for right now,
13 for the purpose of ending this list, what I
14 would say is yes siree, home delivery
15 catastrophe should be one of the things in the
16 40, the Morley 40. Right? But it isn't this
17 one, because we're just doing facility now.
18 That's what all these are. If you allow me to
19 introduce home stuff, then I've got to go back
20 over the whole list again.

21 DR. ANGOOD: I think that's a good
22 clarification for us, because the focus right

1 now is, does the existing list still make
2 sense for what its original purposes were, and
3 with our new definition. Moving forward, then
4 we'll start getting into these other
5 environments, and the applicability of the
6 list to other environments. If we start doing
7 both processes simultaneously, we'll be here
8 until next week, and still looking for
9 clarity.

10 CO-CHAIR TYLER: Christine.

11 MEMBER GOESCHEL: Yes, I just have
12 one question, being new to this. So, the spec
13 here that says initially on the
14 maternal/child, in the original things it
15 talked about within 42 days post delivery. Do
16 we no longer have that time? I'm look at the
17 initial -

18 (Off mic comment.)

19 MEMBER GOESCHEL: Right. Exactly.
20 So, it includes -- so, one of my questions
21 that I'm sure there's a crisp answer to, I
22 have one of these events after a low-risk

1 pregnancy at day 30, and I'm home. And I
2 don't go to the hospital, where I delivered.
3 I mean, when we're talking about issues of
4 public reporting, one of the things we always
5 think about is attribution. It begins to get
6 at the continuum of care, but if it's going to
7 be publicly reported that I had 30 deaths of
8 low-risk women, and they occurred 15 days
9 after delivery, but they didn't deliver at my
10 hospital, I think that's just something we
11 need to keep in consideration when we explain
12 what this means, because at an institutional
13 level, that is highly relevant.

14 CO-CHAIR TYLER: Leah.

15 MEMBER BINDER: I'm sorry.

16 Christine, can -- I'm sorry, what's your -

17 MEMBER GOESCHEL: Chris.

18 MEMBER BINDER: Oh, you are Chris.

19 Okay. Can you just explain that? I was
20 confused by what you were talking about.

21 MEMBER GOESCHEL: Okay. So, this
22 says this includes women within 42 days after

1 delivery. And we're going to publicly report
2 these deaths. A woman delivers at Hospital X,
3 she gets sick, and goes on day 30 post
4 delivery and dies at my institution,
5 Institution Y, so it's going to be reported as
6 a maternal death at my hospital, but she
7 didn't deliver at my hospital. I tried to
8 save her at my -- do you know what I'm saying?
9 It just gets at the public -- how we use
10 public reporting, not only to improve, but
11 issues of attribution, issues of some of the
12 emotional responses to what the numbers mean
13 or don't mean.

14 CO-CHAIR TYLER: Okay. That
15 clarifies. Stan.

16 MEMBER RILEY: I was just going to
17 say as a part of that, what we usually do is
18 we usually run down the original hospital. I
19 don't know if John and Diane do that, but we
20 try not to attribute it to the second
21 hospital. We try to attribute it back to the
22 first one for these events.

1 MEMBER MORLEY: For HAIs, that's
2 clearly what we attempt to do. It's not
3 always easy, but that's what we attempt to do.

4 MEMBER BRENNAN: Pennsylvania does
5 that in the Health Care Cost Containment
6 Council's reporting. It's not a perfect
7 system, but mostly it gets it right.

8 CO-CHAIR TYLER: Okay. Great. Any
9 other discussion on this? Okay. We'll move
10 on to the next one, 4D. "Patient death or
11 serious disability associated with
12 hypoglycemia, the onset of which occurs while
13 the patient is being cared for in a healthcare
14 facility." Stan, what have you got?

15 MEMBER RILEY: I guess the
16 hypoglycemia part, particularly the definition
17 part, where you have a blood sugar of less
18 than 60, if you're a pediatric hospital, for
19 instance, lots of children have much lower
20 blood sugars than that, so one of the real
21 problems is setting the limit at 60 doesn't
22 work for all institutions. And for some, it's

1 just -- it seems sort of crazy, particularly
2 for children's hospitals.

3 CO-CHAIR TYLER: Okay. Any other
4 concerns, considerations on this one?

5 CO-CHAIR MEYER: This is Gregg. It
6 just strikes me that we ought to reach out to
7 the children's hospital community, NACHRI, or
8 another group to give us official kind of
9 feedback on that specific issue.

10 CO-CHAIR TYLER: Okay. All right.
11 Making note of that. Okay. Next, 4E. "Death
12 or serious disability, kernicterus associated
13 with failure to identify and treat
14 hyperbilirubinemia in neonates. Let's see.
15 And it has a definition, it is defined as
16 "bilirubin levels greater than 30 milligrams."
17 Neonate refers to the first 28 days of life.
18 Anybody have any concerns on this one?

19 MEMBER MORLEY: I'm not sure that
20 concern is the right word, but I just think
21 that the only ones -- I'd be curious to know
22 if that's happened in a hospital in the United

1 States in the last couple of years. It hasn't
2 in Colorado. I would have thought for the
3 home deliveries, perhaps, but I'm surprised to
4 -- very little surprises me about hospitals,
5 but I'm surprised that's a -

6 MEMBER VICTOROFF: It was biliary
7 atresia that was not diagnosed.

8 DR. BURSTIN: Just as quick
9 clarification. This came up in one of the
10 measures this past year. The U.S. Preventive
11 Services Task Force recently came out, not
12 quite as controversial decision as the one
13 they had just a couple of days ago, with an
14 evidence report about six months ago
15 indicating there was insufficient evidence to
16 routinely recommend testing of bilirubin prior
17 to discharge on all neonates. So, there may
18 still be some confusion in places. I know in
19 a lot of places, like in D.C. when I deliver,
20 there wasn't any choice. It was D.C. law that
21 you did it, but there's still, I think,
22 perhaps some issues around the lack of clear

1 evidence that, unfortunately, tracking
2 bilirubin at discharge is not always
3 necessarily going to not have kernicterus
4 happen.

5 MEMBER RADFORD: Again, for my
6 edification, is that something that NQF does
7 again track, which states do have it as law,
8 which don't? Do you -

9 DR. BURSTIN: No, we don't, but I'm
10 not sure who does. These are the kind of
11 things I think are kind of holes out there
12 that I think we need to better understand.

13 MEMBER BINDER: Leapfrog -- there
14 is an NQF endorsed measure which Leapfrog uses
15 on the survey, so we have data on which
16 hospitals are using that.

17 DR. BURSTIN: Do you also have data
18 about state laws, which state by law?

19 MEMBER BINDER: No, we don't.

20 DR. BURSTIN: Okay.

21 MEMBER BINDER: We just track it by
22 hospital.

1 DR. ANGOOD: This is one of those
2 topic areas, this particular one, that
3 generates a lot of debate in terms of the
4 weight of the evidence versus the need. It's
5 in here, it's a part of other major
6 initiatives out there, National Patient Safety
7 Goals, et cetera. And it was the point that
8 Helen just made, I think is still some
9 actually worsening confusion. It's not up to
10 the same level as the whole breast screening
11 this week, but in some circles it generates a
12 lot of debate, and a lot of discussion. I
13 think removing it would really generate a much
14 more hostile environment, but, you know -

15 DR. BURSTIN: I wasn't making -

16 DR. ANGOOD: No, no. No, I know
17 you weren't.

18 DR. BURSTIN: I just think it's
19 important to understand the context that the
20 evidence base is not as firm as I think many
21 of us would have suspected. It was a very
22 surprising evidence report, if you haven't

1 seen it. You kind of leave, and you go
2 really?

3 DR. ANGOOD: Yes, I know.

4 CO-CHAIR MEYER: This is Gregg. I
5 think this is a -- this being on the list, I
6 think, as some folks know, it's a testimony to
7 a small but vociferous group trying to make
8 sure that something never ever happens again.
9 And all the more power to them. I think that
10 regardless of the testing strategy issues, my
11 sense is that these are incredibly rare, but
12 probably important failures when they occur.

13 CO-CHAIR TYLER: Doron had
14 something, and then Leah.

15 MEMBER DORON SCHNEIDER: I actually
16 had a comment about 4D, if we can come back,
17 just one comment I'd like to make about that,
18 after this discussion.

19 CO-CHAIR TYLER: Leah, you're on
20 4E. Right?

21 MEMBER BINDER: Pardon me?

22 CO-CHAIR TYLER: You're on the

1 current one. Right?

2 MEMBER BINDER: Yes. Just to make
3 -- I think we should make the distinction, I
4 think what Helen was referring to was the
5 screening protocol. This is referring to the
6 consequence of not detecting hyperbili, and
7 that's very different. So, I think we need to
8 be clear about -- I think it's perfectly
9 appropriate, regardless of how you feel about
10 the screening tool, perfectly appropriate to
11 have this as an SRE.

12 DR. BURSTIN: The problem is at
13 times you can't tell, necessarily, by clinical
14 exam is what the Task Force really pointed
15 out. So, you may still miss people. You may
16 not be screening people for whom there's not,
17 necessarily -- again, I'm not an internist,
18 that is not necessarily clear evidence that
19 they are hyperbilirubinemic, yellow, whatever
20 the case may be. So, it's a related issue,
21 but you're right, this is a stronger point.

22 CO-CHAIR TYLER: Okay. Anything

1 else on this rule? Okay. Then we can go back
2 to hypoglycemia.

3 MEMBER DORON SCHNEIDER: Just a
4 quick comment in support of what John was
5 saying before about the specificity of some of
6 these never events. You know, we have this
7 medication error section, and then we have a
8 4D, which I actually like, and hope we keep,
9 where we can then define hypoglycemia, usually
10 due to insulins or oral hypoglycemics. And if
11 we're going to do that, then it's sort of
12 inconsistent that we don't have
13 anticoagulants, or narcotic sedation, et
14 cetera, in there as separate categories. So,
15 I think there is lack of consistency in
16 breaking that out, and I just point that out.

17 MEMBER LAU: This is Helen. I
18 concur with that point.

19 DR. BURSTIN: And in terms of
20 expanding the SRE's, it's exactly that kind of
21 thing that we'd want to get a sense. I mean,
22 we know the top three causes of ED, adverse

1 events are exactly the ones you listed, plus
2 insulin, so you just named them, and that
3 would be a logical approach, very evidence-
4 based, to add SREs.

5 MEMBER VICTOROFF: It's now the
6 Morley 80. I've been keeping track.

7 CO-CHAIR TYLER: The list grows.
8 Okay. Move on to the next rule. Let's see,
9 4F. "Stage Three or Four Pressure Ulcers
10 acquired after admission to a healthcare
11 facility, excludes progression to Stage Two
12 and Stage Three, if Stage Two was recognized
13 upon admission." Okay. Diane wants to start.

14 MEMBER RYDRYCH: I'll start with a
15 small comment, and then the bigger one. We've
16 made some changes in how we define the scope
17 of this one in Minnesota, which may be
18 controversial or not. The little one is just
19 to say, if Stage Two is recognized and
20 documented upon admission, because that gets
21 at -

22 (Music in background.)

1 CO-CHAIR TYLER: Musical

2 accompaniment.

3 DR. ANGOOD: Yes, those of you who

4 are on the phone -

5 MEMBER LAU: What's that?

6 CO-CHAIR TYLER: Yes, someone on

7 the phone has music when they put us on hold,

8 I think.

9 MEMBER LAU: Oh, okay.

10 CO-CHAIR TYLER: It doesn't appear

11 to be on any more. Okay.

12 MEMBER RYDRYCH: It kinds of get at

13 the present on admission issue, that if it

14 isn't actually documented, you can't,

15 necessarily, say whether it was recognized on

16 admission, so that's a change we made. But

17 the larger one, which people may or may not

18 agree with, and it had upsides and downsides,

19 was to expand it to include unstageable

20 pressure ulcers, in addition to Stage Three

21 and Four. Based on the fact that almost

22 always those unstageable pressure ulcers, when

1 they can be staged, are going to be staged at
2 Three or Four. We do allow people to remove
3 them if they end up being staged at Stage Two,
4 but that doesn't happen very often. We also
5 include, if something progresses from a
6 suspected deep tissue injury to a Stage Three
7 or Four.

8 CO-CHAIR TYLER: Doron.

9 MEMBER DORON SCHNEIDER: This
10 documentation piece is creating all kinds of
11 havoc in the regard of whose documentation we
12 will accept, and the physician documentation
13 is, in many settings, the one that is
14 accepted, when we have physicians not really
15 completely understanding it, as well as
16 nursing, and specialists within wound care.
17 So, as we define the implementation guidance,
18 I'd love to see us be able to accept wound
19 care nursing and other specialists that are
20 not, necessarily, physicians in that
21 documentation present on admission, I think is
22 the way to go.

1 CO-CHAIR TYLER: Anything else on
2 this one? Helen.

3 DR. BURSTIN: Just point out that
4 NQF has just got out for vote a framework, an
5 updated framework for classifying pressure
6 ulcers based on the sort of latest thinking
7 that, in fact, the actual number stages are
8 very problematic. There's not a logical
9 progression from One, to Two, to Three, to
10 Four. Some people start at different stages.
11 You guys, again, probably know some of this
12 more than me, but the point they made was
13 really trying to look at deep tissue versus
14 superficial, so I'll make sure we share that
15 report with the group. I think this is one
16 we're going to have to come back to and take
17 a pretty serious look at in light of some of
18 the new evidence.

19 DR. ANGOOD: And we're doing the
20 same thing with the Safe Practices sort of
21 pending this report.

22 CO-CHAIR TYLER: I have a question

1 for edification on the consumer end. Somebody
2 give me a really quick thumbnail, why would a
3 pressure ulcer be unstageable?

4 MEMBER RYDRYCH: I'm not a wound
5 care expert at all, but, generally, it's
6 covered with -- for the lay person's term
7 would be sort of a scabbing. They're sort of
8 scabbed over, and you can't see the depth of
9 the wound.

10 CO-CHAIR TYLER: Cynthia had
11 something, then Michael.

12 MEMBER HOEN: Yes, I would have to
13 get back to the group with specifics, but in
14 New Jersey, we have changed our classification
15 of pressure ulcers to recognize things like
16 multi-system organ failure as taking pressure
17 ulcers outside of reportable. And I think
18 there are some other clinical criteria which
19 have been applied, which have been
20 demonstrated to suggest that those are not
21 preventable, and that's helped us tremendously
22 with respect to focusing in on events which we

1 can prevent, versus those which we are not
2 able to do anything about.

3 MEMBER RYDRYCH: And I would just
4 say, too, again, not being a clinical person,
5 I'm at a disadvantage here, but I do know that
6 we've had discussion about end of life ulcers,
7 and Kennedy ulcers, and whether those are
8 really pressure ulcers, as well. And that's
9 been a difficult conversation. I think where
10 we came down on that is that they're still
11 reportable, but that we did get a lot of push-
12 back from people saying if someone is
13 developing a sore in the last days of life
14 because their system is shutting down, that's
15 a different situation than other pressure
16 ulcers.

17 MEMBER TANGALOS: Yes. I think
18 this is where you're going to have a technical
19 panel help you with this. As we expand into
20 this universe, again, I brought up the hospice
21 question, the near death, I'm not sure where
22 the right answers are.

1 MEMBER LAU: This is Helen. I
2 concur. In California, when I review death,
3 that pops up a lot. And I think we really
4 need some other experts to help.

5 DR. ANGOOD: This is Peter. This
6 is another example of if you don't nudge the
7 reporting to look at all events, then you're
8 not going to learn what's actually out there,
9 and you run the risk of complacency occurring.
10 And the home health pressure ulcer, it's a hot
11 debate, but we want to be able to at least
12 have the discussion, whether it was
13 unpreventable, or actually could have been
14 prevented.

15 MEMBER TANGALOS: Again, I think we
16 have to be really careful, because there is a
17 trend with pressure ulcers to throw in the
18 towel, and make the claim that the patient is
19 terminal, and then they get put on hospice.
20 So, there's an untoward action that goes on
21 with these ulcers right now. It's a free
22 pass.

1 CO-CHAIR TYLER: Michael has wanted
2 to get in for a while, and then Doron.

3 MEMBER VICTOROFF: You know, this
4 is such a wonderful topic that I totally
5 support the idea that this is for an expert
6 panel. There is an enormous discussion to be
7 had here with pros and cons, terminal care,
8 what do you mean by preventable? What do you
9 mean by something that might be preventable,
10 but we elected not to, because it was
11 inappropriate to take the action that would
12 have prevented it for other reasons that were
13 totally good. And, therefore, what I would do
14 is just put a big asterisk in the discussion
15 of this thing saying that, you know, to be
16 continued, because I don't think I'll be happy
17 -- as long as the word "facility", you know,
18 this is about healthcare facility. I'm not
19 quite clear I understand for this purpose what
20 the definition is. And when you admit a
21 terminal person who broke their hip, but now
22 they're still terminal, but they're in a

1 hospital. Have I illustrated why this is a
2 good thing to move off to somebody else?

3 CO-CHAIR TYLER: Well, it sounds
4 like we definitely need help from TAPs on this
5 one, and maybe developing some separate
6 reporting around this. But, Doron, you're
7 next.

8 MEMBER DORON SCHNEIDER: I'd want
9 the TAP also to come in on trach care, and
10 pressure ulcer definition, therein, because,
11 obviously, that's a very different set of
12 processes, care processes, that sometimes get
13 intermixed within this larger heading. So, we
14 may need to have implementation guidance on
15 that.

16 MEMBER TANGALOS: Twenty years ago
17 I would never see a home patient for any
18 reason have pressure ulcers, but we take care
19 of home patients now with greater and greater
20 frailty, and it is not -- it's just a shock to
21 see -- I mean, they come in with pressure
22 ulcers, and you just never used to see that.

1 DR. BURSTIN: Again, the TAPs we're
2 talking about are sort of setting specific, so
3 long-term care, nursing home, so we can
4 utilize the Steering Committee from the
5 pressure ulcer framework to give us -- they
6 are the experts in measuring these things, so
7 we'll specifically bring whatever comes out of
8 that TAP to the Steering Committee for their
9 input.

10 Again, I think this one may need to
11 be pretty radically changed in terms of the
12 staging and things like that, to some of the
13 newer ways of thinking about partial versus
14 full thickness, and things like that.

15 CO-CHAIR TYLER: All right. We'll
16 move on to 4G. "Patient death or serious
17 disability due to spinal manipulative
18 therapy." Anything on this? Diane.

19 MEMBER RYDRYCH: Just a comment,
20 that I've always found this one to be kind of
21 odd, because -- not because we've never had
22 this reported, or because I don't even know

1 how often spinal manipulative therapy happens,
2 at least in a hospital setting, but because it
3 seems to be focused on a provider, rather than
4 a system. And if you're going to talk about
5 death or serious disability related to one
6 type of therapy, why wouldn't you be talking
7 about death or serious disability related to
8 other kinds of therapy? I don't know why you
9 would single out spinal manipulative therapy,
10 as opposed to any other death or serious
11 disability that happens due to the therapeutic
12 process in a hospital.

13 CO-CHAIR TYLER: Anyone else on
14 this? Mike.

15 MEMBER VICTOROFF: Well, you raised
16 a question that I've been real nervous about,
17 because so far I haven't found any category of
18 these things that I really felt like dropping.
19 And we're sensitive to the political potential
20 ramifications of our deciding oh, well, we
21 changed our mind, that's not so serious any
22 more. Go ahead and do it, to make a

1 burlesque. But if there were one on this that
2 I really think is fishy for the reasons you
3 said, and others, it would be this, because
4 the frequency is incredibly rare, and it isn't
5 a hospital event. There's more than one
6 specialty that yanks on spines, but it looks
7 to me as though this one -- am I misreading or
8 do I have the mild odor of a political agenda
9 here?

10 It's just that -- I mean, really,
11 this one just has a kind of a sense to it,
12 that it's not like the others, and I don't
13 know what to do about that. It's your
14 problem.

15 DR. ANGOOD: Well, it's like a lot
16 of things, you know, once you create
17 something, it's always hard to get rid of it.
18 And I think what we need to do on our side is
19 do a little bit more homework on the genesis
20 of why this showed up on the list to make sure
21 we're not running the risk of taking it off,
22 when there was a perfectly good reason for it

1 being on there. So, we'll get that feedback
2 on the history of the genesis to the group.

3 But, to your point, all items on
4 the list are open for addition, deletion,
5 modification, and it's just a bigger step to
6 remove, as opposed to add.

7 CO-CHAIR TYLER: Chris, and then
8 John.

9 MEMBER GOESCHEL: Quick point. I
10 would be curious as to the background, having
11 lived through spinal manipulative therapy in
12 an osteopathic facility where there were
13 serious untoward effects, and it was a
14 clinician, I mean, different ways to deal with
15 that. I think understanding where it came
16 from, and if could go away would be
17 interesting, need to raise that, and I'm not
18 a television person, but the new thing about
19 getting your massage and becoming paralyzed in
20 the process, so whether people would confuse.
21 I mean, I think there are some other dynamics
22 in the general public going on about having

1 people mess around with pressing on your spine
2 and ending up incapacitated. I put that out
3 there as an aside, public to be aware.

4 CO-CHAIR TYLER: John, and then
5 Helen.

6 MEMBER MORLEY: I agree with
7 Diane's comments, and Mike's comments both.
8 I would just say that this is an example, in
9 my mind, of one of those things that is
10 already on the list relative to outside the
11 hospital environment. The same with 4H, for
12 the most part. 4G and 4H these days
13 frequently, if they're occurring, are outside
14 the hospital environment. Maybe they'll end
15 up being moved over to another list that says
16 outside hospitals.

17 DR. BURSTIN: And I just want to
18 make a point. It actually doesn't say in a
19 facility, which is one important
20 consideration, and neither does the second
21 one. But, also, I don't think there should be
22 concern of a political issue around removing,

1 or adding, or anything. The point here is,
2 does this remain true to the criteria? Could
3 it be incorporated into another one, I think
4 is a very valid point. We want to try to
5 minimize as much as we can harmonize these
6 events, make it easier on -- John's list of 40
7 becomes 39, I don't think he'll mind that too
8 much. But it needs to be justified, and
9 grounded in the evidence, not because of a
10 perception of whatever the politics may be.

11 CO-CHAIR TYLER: Okay. John,
12 again.

13 MEMBER MORLEY: One thing that just
14 strikes me just now is that, as we look at
15 many of the other things on the list, those
16 are things that I have major interest in
17 understanding how those things are happening,
18 and leading to change. Getting this report is
19 one that, towards the point Mike made about an
20 agenda that somebody may or may not have, I'm
21 not sure what I would do at the end of the
22 year with this information.

1 Trying to prevent this. Well, how
2 do you try and prevent this? Do you go to the
3 chiropractor or osteopathic societies and say
4 how do you prevent this, or do you refer
5 somebody for professional conduct issues, or
6 practice? They don't strike me as the rest of
7 the list as process issues, and looking for
8 something that we can do to create a safety
9 net. And one of the things that Jim Bagian,
10 and some other nationally recognized folks
11 have commented on, we would like to reduce
12 errors, for sure, but we're not going to
13 eliminate errors, so let's figure out ways to
14 prevent the error from reaching the patient.
15 And I'm not -- this is an event that occurs
16 between one person and another. It's a single
17 step. And, again, I can't see a process, or
18 anything that would intervene to prevent that,
19 if there's an error made, of having an impact,
20 a direct impact on the patient.

21 DR. BURSTIN: That raises an
22 interesting issue with me about whether we

1 should consider our criteria for these around
2 this issue of provides additional information
3 that can be used to drive improvement. Just,
4 again, something -- I'd prefer to have these
5 things codified, rather than feeling like
6 we're -- so, just something to think about,
7 because I think that does add value to the
8 list in a different kind of way.

9 CO-CHAIR TYLER: Okay. Well, we'll
10 say that we can count on getting some more
11 information about the genesis of this rule.
12 And, after that, we may think about whether it
13 needs to be in there, or take further action.
14 Okay.

15 Next, 4H. "Artificial insemination
16 with the wrong donor sperm, or wrong egg." We
17 already had a comment on this. Anybody else
18 have any others? Okay. Nothing on -- anybody
19 on the phone? You guys still there?

20 MEMBER LAU: Yes. Someone
21 mentioned -- this is Helen. Someone mentioned
22 early on this might be potential moved to

1 another list, not in a hospital setting. I
2 tend to agree with that.

3 MEMBER RYDRYCH: And I would
4 actually not move it. I think it's typically
5 not a hospital event, but it can be a hospital
6 event, so I wouldn't remove it. I'm just
7 saying that from the perspective of someone
8 who's collecting reports on all of these
9 events.

10 CO-CHAIR TYLER: Okay. All right.
11 Now we're in 5A. "Patient death or serious
12 disability associated with an electrical shock
13 while being cared for in a healthcare
14 facility." Let's see, the language.
15 "Excludes events involving planned treatment,
16 such as electric counter shock, electrocardio
17 version." Okay. Doron.

18 MEMBER DORON SCHNEIDER: I'd just
19 throw into deliberation, should it be patient
20 or staff?

21 CO-CHAIR MEYER: This is Gregg.
22 That was the addition that I would make, as

1 well.

2 CO-CHAIR TYLER: Okay.

3 MEMBER RYDRYCH: I'm wondering, why
4 do we exclude electroconvulsive therapy? I
5 mean, certainly -

6 CO-CHAIR MEYER: It's not
7 electroconvulsive therapy that's being
8 excluded. It's defibrillation, and
9 cardioversion that are for restarting the
10 heart. So, death during ECT would be --
11 during electroconvulsive therapy for
12 depression would be reportable.

13 CO-CHAIR TYLER: Actually, Gregg,
14 in the implementation guidance it does say,
15 "This event is not included to capture patient
16 death or disability associated with emergency
17 defibrillation, ventricular fibrillation, or
18 electroconvulsive therapies." So, Diane is
19 right.

20 CO-CHAIR MEYER: Well, I don't have
21 that exclusion in front of me here, but I
22 would say we should revisit the ECT one.

1 MEMBER RYDRYCH: Yes. I mean,
2 certainly, death or serious disability during
3 ECT was not the intent of that therapy.

4 CO-CHAIR MEYER: Yes. I think
5 that's very different than the others.

6 MEMBER LAU: This is Helen. I
7 agree.

8 DR. ANGOOD: Although, I think the
9 original intent of this was -- again, this is
10 environmental issues. You shouldn't get
11 shocked from some environmental exposed
12 wiring, or faulty equipment with wiring, et
13 cetera, as opposed to bad outcomes from
14 medical treatment, which is what ECT is, or
15 cardioversion, et cetera. And it's a
16 differentiation here, I think we need to be
17 cognizant of.

18 CO-CHAIR TYLER: Okay. Philip,
19 then Michael.

20 MEMBER PHILIP SCHNEIDER: Is there
21 any reason -- I'm not a physician or
22 cardiologist, but reason to exclude elective

1 electrocardioversion? It seems to me that if
2 it's an elective procedure, if there's a
3 death, it's a reportable event, or does this
4 fall under the sitting craniotomy story, where
5 you've got a medical procedure that has such
6 a high risk, that it's just part of the
7 process. But it's -- and I don't know the
8 data. I mean, it could be that elective
9 cardioversion, electrocardioversion is well -
10 is developed to an extent where that really
11 shouldn't happen, a death shouldn't happen.

12 MEMBER RADFORD: Again, I think it
13 gets to the intent of this -- I'm a
14 cardiologist, so I'm chiming in here. I mean,
15 deaths associated with medical care. It's
16 kind of like a death after surgery. You know,
17 some people are ASA 5, and stuff happens.

18 MEMBER PHILIP SCHNEIDER: That
19 could be said of medication therapies, too.
20 And we actually did -- on some of the other
21 ones, do have ASA limitations, so that a low-
22 risk patient, so that may be applicable here.

1 I don't want to chase this too hard. It just
2 seems to me that we ought to avoid setting
3 safety nets that are arbitrary.

4 MEMBER RADFORD: I think if we want
5 to have death or serious disability related to
6 the electrical delivery of care, which is what
7 we're talking about with ECT, I think that's
8 a little bit different than getting shocked
9 from a light switch.

10 MEMBER VICTOROFF: Okay. That was
11 the point I was going to make. And it seems
12 to me there are implicitly two issues here
13 that should be teased apart. And one of them
14 has to do with using electrical machinery
15 therapeutically, deliberately. And that would
16 include -- unfortunately, that would include
17 Bovies, but the risk of Bovies is the not the
18 electricity, it's the fire, a burn. But
19 however we settle that, and I don't propose to
20 settle it in one sentence, the environmental
21 safety hazard thing, no one should get
22 electrically shocked because there's a short

1 in the TV in their room, or no one should get
2 killed, crushed to death by falling stairways,
3 or eaten by rats. I don't know what else
4 there is in institutions, so I would really be
5 in favor of pulling out the environmental
6 hazards in a facility safety thing. You know,
7 like there should be non-slip treads, whatever
8 the heck, fire extinguishers, OSHA, OSHA,
9 OSHA. And make sure that that doesn't
10 contaminate this if the intent here is
11 misadventures using electrotherapeutic
12 devices.

13 MEMBER MORLEY: The patients that
14 undergo not ECT, but cardioversion that have
15 an adverse outcome like death, the ones that
16 would interest me, that would be excluded, I
17 think, if we were to eliminate associated with
18 that, are the ones with an anesthesia issue,
19 an airway issue, an overdose of a drug, or
20 those types of things that may not have been
21 recognized as an overdose of a drug, may not
22 have been recognized, but I would like to find

1 out about those deaths, and then do a more
2 careful analysis. I would not like to see
3 this eliminated.

4 MEMBER RADFORD: I concur. I just
5 think it's a different category.

6 CO-CHAIR TYLER: Okay. Philip.

7 MEMBER PHILIP SCHNEIDER: Yes, I
8 think I would agree with that. I think it's
9 kind of like a medication error. It's a
10 treatment that results in a preventable
11 injury, so environmental hazards versus
12 treatment hazards -- I think maybe this is a
13 splitter category, like Michael suggested.

14 DR. GANDHI: This is Tejal from the
15 phone. I agree, as well. I think that sounds
16 much more like a care management type of
17 issue, as opposed to environmental. And then
18 you can broaden it. There's a whole lot of
19 other categories of treatments that we give,
20 that you don't expect someone to die from, but
21 sometimes they do. So, I think it could end
22 up opening a lot of other options, but I think

1 it should be under care management, as opposed
2 to environmental.

3 MEMBER LAU: This is Helen on the
4 phone. I agree.

5 CO-CHAIR TYLER: So, potentially
6 move this to care management. Leave it in
7 tact, but potentially just move it.

8 CO-CHAIR MEYER: This is Gregg. I
9 agree, as well.

10 MEMBER BRENNAN: Me, too.

11 CO-CHAIR TYLER: Okay.

12 MEMBER LAU: This is Helen on the
13 phone. If we move it to care management, I
14 think someone suggested earlier, on patient
15 and staff, I think we need to remove the
16 staff.

17 CO-CHAIR TYLER: Remove the what?

18 MEMBER LAU: Someone suggested
19 earlier on patient or staff.

20 CO-CHAIR TYLER: Okay.

21 MEMBER LAU: So, we need to remove
22 the staff, focus on patients.

1 DR. GANDHI: But I thought we were
2 potentially splitting, because, I mean, the
3 light switch electrical shock thing could stay
4 in environmental, but then the one that's more
5 of a treatment-related issue would go to care
6 management.

7 MEMBER LAU: Okay. Good.

8 MEMBER DORON SCHNEIDER: I would
9 hope the staff wouldn't die during those
10 treatments, as well. It should be reported.

11 CO-CHAIR TYLER: I concur.

12 MEMBER VICTOROFF: Okay. Just to
13 get even more splitty, the staff is subject to
14 characteristic misadventures during treatment,
15 the most common of which is needle sticks.
16 And getting zapped, I mean, I've burned myself
17 with a Bovie too. I shouldn't say that, but
18 there probably is another category for hazards
19 of providers in the course of care. But,
20 typically, we don't die, or die right away, or
21 die from the same cause pathway as the patient
22 does. So, for me, that suggests different

1 definitions, and different remedies, and
2 probably then different categories.

3 CO-CHAIR TYLER: But this isn't
4 just death, it's or serious disability. I
5 mean, staff certainly could incur serious
6 disability from -

7 MEMBER VICTOROFF: Yes, if I get
8 Hep C from a needle, that should be definitely
9 reported.

10 CO-CHAIR TYLER: Right.

11 MEMBER VICTOROFF: But then that's
12 another category, for me.

13 CO-CHAIR TYLER: If we have nothing
14 else on this, we can move on to 5B. "Any
15 incident in which a line designated for oxygen
16 or other gas to be delivered to a patient
17 contains the wrong gas, or is contaminated by
18 toxic substances." Cynthia.

19 MEMBER HOEN: This is one of those
20 areas I think is too narrow. We've seen
21 instances where oxygen was hooked up to IV
22 lines, or the potential for IVs, or oxygen to

1 be hooked up to trach ports meant for
2 suctioning. There's any number of
3 opportunities to misconnect lines to line in
4 our environment, and I think that we ought to
5 be cognizant of those so that those devices
6 get pulled from other entities, and those
7 things are taken care of.

8 CO-CHAIR TYLER: John.

9 MEMBER MORLEY: I agree, and I
10 would feel very strongly about that. We've
11 certainly seen and read a number of different
12 cases, as have been described. I think those
13 things are preventable, very preventable. I
14 think that we used to see a lot of different
15 gases being hooked up, and I think the
16 engineers were always, always, always looking
17 for an engineering response. You know, it's
18 not a bad idea to have a meeting in a place
19 where you can't get a signal, that way people
20 don't play around on their Blackberry, or
21 whatever. It's an engineering solution to a
22 problem. And they engineered the fact that

1 oxygen tanks can only be hooked up because of
2 a pin system to certain lines.

3 We still hear cases of tube feeding
4 being hooked up to the pilot cuff of a trach,
5 tube feedings hooked up to IVs. There's a
6 number of different types of those
7 connections, and I'd love to see that
8 information, and then an engineering response
9 to that.

10 CO-CHAIR TYLER: Okay, Doron.

11 MEMBER DORON SCHNEIDER: So, I
12 concur entirely. However, I think that
13 they're two separate issues, very similar to
14 our last discussion. This is an environment
15 of care consideration that is structurally
16 different than process of care, so I think
17 that we need two categories here. You can
18 have this in your facility if you've
19 mislabeled your lines, if you have tubing
20 misconnections, that's more nursing or care
21 processes, not environmental events.

22 CO-CHAIR TYLER: But you would have

1 two rules, one under care management, and one
2 under environmental. Is that what you're
3 saying?

4 MEMBER DORON SCHNEIDER: Yes,
5 that's what we're proposing.

6 CO-CHAIR TYLER: Stan, did you have
7 something?

8 MEMBER RILEY: I guess for Doron's
9 comment, I'm not sure that I've ever seen on
10 that was the lines mislabeled, at least not in
11 the wall in terms of the facility. But in
12 terms of plugging things up, just like John
13 has said, we've seen, certainly, the oxygen
14 plugged into the feeding -- I mean, the
15 feeding tube plugged into the oxygen,
16 everything, every kind of combination of tube
17 plugged into the wrong thing that you can see,
18 we've seen. So, I think that's a huge thing
19 that needs to be captured somewhere.

20 DR. ANGOOD: Yes. I'm sort of
21 struggling with how we deal with this, because
22 while this existing SRE is very specific, and

1 it's gas lines, and all those horrendous
2 things that used to happen once upon a time,
3 those have almost pretty much gone away
4 because of the structural engineering
5 strategies. But this broader based topic of
6 tube misconnections is a huge topic. It's not
7 addressed anywhere in here, but as we go to
8 solicitation for SREs, it might be something
9 that we have language for, because it is a
10 huge topic, and we don't have an easy avenue
11 at this point in time to get them corrected.

12 CO-CHAIR MEYER: This is Gregg.
13 I'm also strongly in favor of creating a
14 separate -- I don't think you can lump it in
15 with this one, but creating a separate issue
16 around the kind of line mishaps that were
17 stated there. And I would suggest that
18 perhaps we can reach out to one of the
19 biomedical engineering societies and ask them
20 to help us craft this. I think that they
21 would actually welcome this.

22 MEMBER GOESCHEL: We actually have

1 a small Robert Wood Johnson Foundation grant,
2 and are working with some manufacturers and
3 other to do some of that initial work, so I
4 can pursue that and get you some baseline
5 information and background.

6 CO-CHAIR TYLER: Philip.

7 MEMBER PHILIP SCHNEIDER: Just for
8 the sake of completeness of the record, in the
9 first bullet point in the comment section, I
10 would say, "the wrong lines being connected,
11 i.e., enteral feeding tubes connected to an IV
12 line." I don't think I've ever heard of an
13 oxygen line being attached to an IV line,
14 although I guess it's technically possible.
15 Since we're going to -- this will probably be
16 part of our permanent record, I think that's
17 a more common, and often fatal situation.

18 DR. ANGOOD: We can put that under
19 the air embolism one.

20 DR. BURSTIN: Just as a process
21 point, you should feel part of the role of the
22 Steering Committee is going to be recommending

1 whether some of these need to be retired. So,
2 I think it would be very appropriate, if you
3 think this is really past its time, to
4 recommend retirement of this SRE, and then
5 recommend the creation of the SRE that you
6 just talked about under care management.

7 And, again, these are not the usual
8 kind of classic measures that require an
9 external entity to develop a measure to submit
10 to NQF. The work of the SREs was typically
11 done by the Committee. The amount that's
12 actually submitted is minimal, so I think
13 we'll cast the net to say here's our new
14 definition. Here are the sites of care.
15 Please submit your ideas. But the actual work
16 of writing these, is actually you guys with
17 the TAPs. So, just to be clear, it's you, so
18 you've just given yourself some work on a new
19 SRE.

20 CO-CHAIR TYLER: Anything else on
21 this one before we move on? Okay. Hearing
22 nothing, move on to 5C. "Patient death or

1 serious disability associated with a burn
2 incurred from any source while being cared for
3 in a healthcare facility." Anything?

4 MEMBER DORON SCHNEIDER: Or staff,
5 and staff.

6 CO-CHAIR TYLER: Well, I'm glad at
7 least Doron is standing up for the staff.

8 MEMBER VICTOROFF: And, again, I --
9 when we're thinking about criteria, I think
10 about can we identify it as a precise -- is
11 there an intervention? Is it important? And
12 when I look at burn in its own little universe
13 isolated, I say well, yes, that's important.
14 But there may be other injuries like burns.
15 You shouldn't drown, you shouldn't be scalded.
16 Do we mean scalding, including burns, or how
17 about slips and falls, and how about
18 lacerations?

19 I'm content leaving it burns,
20 because burns are good. Let's not lose the
21 burns, but do -- for future consideration, my
22 note here is simply, is this -- is there

1 evidence to expand because of importance or
2 intervention, the other things, to some other
3 injuries beside burns, specifically?

4 CO-CHAIR TYLER: Stan.

5 MEMBER RILEY: And, I guess that if
6 this is a burn, as in the closet is on fire
7 kind of burn, that's one thing. But what
8 about the burn that happens in the OR, where
9 somebody is using alcohol-based prep, and then
10 the Bovie is on, and somebody has a facial
11 burn, or something like that. So, I think
12 it's one of those splitter kind of things,
13 again.

14 DR. BURSTIN: We do currently have
15 a measure in the ambulatory surgery
16 environment on OR fires. It's actually,
17 unfortunately, not as rare as one might hope.
18 And I assume this would be covered under that.
19 But, again, the blending to care management is
20 going to get a little tough on some of these,
21 like the Bovie example earlier.

22 CO-CHAIR TYLER: Any other thoughts

1 or comments on burns?

2 MEMBER BRENNAN: I just wonder
3 about whether it should be limited to death or
4 serious disability. Reporting less serious
5 events could have a significant impact on
6 safety, as well. We've had burns, and they've
7 all been minor, but they've been pretty
8 alarming events that galvanize a lot of
9 action.

10 DR. ANGOOD: Yes, I think, P.J.,
11 this is Peter. That's a good point, and I'll
12 put my old Joint Commission hat on. Huge
13 under-reporting of these burns, because the
14 language of the SREs is well, it's not a bad
15 one, so we'll send you home with your blisters
16 anyway, but we don't have to tell anybody.
17 So, I think that's a good suggestion that the
18 group should think about.

19 CO-CHAIR TYLER: Doron.

20 MEMBER DORON SCHNEIDER: We talked
21 about the selective use of the words, "or risk
22 thereof", and this would be an example of the

1 time to use it.

2 CO-CHAIR TYLER: Diane.

3 MEMBER RYDRYCH: Well, just an
4 observation. I think part of what's difficult
5 about this is that we've set the system up so
6 that we have death or serious disability, or
7 neither, which is sort of this no harm
8 category. I'm not suggesting that we add some
9 other level of harm, and then define it, but
10 sometimes it is difficult to figure out what's
11 that line between no harm and serious
12 disability, and is there a need for kind of a
13 middle ground? Because if somebody has a
14 teeny little burn versus something that does
15 require some treatment, there's a gray area
16 in-between there that can be difficult to
17 define.

18 CO-CHAIR TYLER: Michael.

19 MEMBER VICTOROFF: This is
20 illustrative of the difference between an end
21 point, which a burn can be, burn being the end
22 point injury, which could be serious or not,

1 and a pathway of harm, which is -- the word
2 "burn" is being used, as in this case. We have
3 the endpoint, which is you're dead, and the
4 pathway is you burned to death. And in this
5 case, I think it would be possible to say
6 because burn as a mechanism of death
7 illustrates almost always an important safety
8 issue, that if there's any burns, burns of any
9 degree in the pathway, that the fact that it
10 killed you or not is not as important as
11 there's something to learn from looking at the
12 fact that a burn event occurred to a human,
13 because that's almost never intentional in
14 this context.

15 So, okay. That's a long way of
16 saying here's where I would invoke the
17 exception clause and say get rid of death or
18 serious disability. And I would just say any
19 burn to patient or staff, unintentional -- any
20 unintentional burn that occurs in a facility.
21 Then we'll deal with homes, and hospices
22 later.

1 MEMBER TANGALOS: It will be a huge
2 issue.

3 MEMBER VICTOROFF: Much larger than
4 it is in the hospital.

5 MEMBER LAU: This is Helen. For
6 clarification, does that also include chemical
7 burns?

8 CO-CHAIR TYLER: The question is
9 does it also include chemical burns. Right,
10 Helen?

11 MEMBER LAU: Yes.

12 DR. ANGOOD: This is Peter. My
13 interpretation of it over time has been yes,
14 it's any kind of burn. We tend to think about
15 it, electrical, et cetera, but a burn is a
16 burn. It shouldn't happen.

17 CO-CHAIR TYLER: Scalding, as well.

18 DR. ANGOOD: Yes, scalding would be
19 part of that.

20 CO-CHAIR TYLER: Philip.

21 MEMBER PHILIP SCHNEIDER: This is
22 probably way out of chemical burns, but

1 extravasation injuries, does that fall in any
2 of these categories, particularly ones that
3 require surgical -- surgery?

4 DR. ANGOOD: Well, this would be my
5 own personal view on that. That, to me, is
6 more of an administration error, and kind of
7 in the medication management area, as opposed
8 to what we're talking about here. But your
9 point is very well taken, because those are
10 sometimes horrendous outcomes.

11 CO-CHAIR TYLER: John.

12 MEMBER MORLEY: I just heard Martha
13 make the comment about second degree burn.
14 But I agree, Peter said burn is a burn, is a
15 burn. But is there any limitation in terms of
16 first-degree burns, if somebody has a heating
17 pad on the operating room table, and they're
18 on the OR table for several hours, end up with
19 some erythema on their skin. So, perhaps
20 second-degree burn. I don't know.

21 DR. ANGOOD: Well, it's like a lot
22 of our discussions, you know, where is your

1 line, and do you want to have -- do you want
2 to promote an excess of reporting, just so
3 you're not missing stuff, versus do you want
4 to allow things to be hidden because they
5 don't meet your criteria. And the
6 subjectivity in meeting your criteria is
7 always the bugaboo.

8 DR. BURSTIN: I do think, though,
9 there is -- I think Diane and John both raised
10 really good points about we still have left
11 the definition of being serious, which at
12 least implies disability or risk thereof. And
13 we've not really kind of gone -- risk thereof
14 is a pretty far place away from pretty bad
15 injury, but maybe not disability. So, the
16 question might be, is there a need, if we want
17 this corridor of these not so bad events, but
18 they're reportable because they're important,
19 and getting back to John's point, I can learn
20 from them. We may need to think about -- I
21 was just looking at the definition of adverse,
22 for example. At least have a definition of

1 adverse, which is, "It describes a negative
2 consequence of care that results in unintended
3 injury or illness, which may or may not" -- we
4 got rid of the parental part. So, at least
5 there's an injury involved, and what some
6 would argue the question is, you know, is a
7 little redness an injury? And we may need to
8 actually play some of the legalistic games we
9 played when I was part of the Harvard Medical
10 Practice study. Actually, there's a real
11 gradation of injury, and it may not be a bad
12 idea to codify this, although, it would
13 complicate it a bit. But it would give us the
14 corridor for reporting in a way that sticks to
15 our definitions.

16 CO-CHAIR TYLER: Diane.

17 MEMBER RYDRYCH: Just a brief
18 comment. I was glad that we added that risk
19 thereof statement in one of our definitions,
20 but just to throw another thing out there, we
21 never really did talk about how we would
22 define risk thereof. And we are kind of

1 creating more ambiguity there, because it's
2 what -- how much risk is considered risk
3 thereof, and whose assessment of risk? That's
4 something that we probably have to circle back
5 to at some point.

6 CO-CHAIR TYLER: Doron.

7 MEMBER DORON SCHNEIDER: I just
8 want to capture radiation burns here, as well.

9 CO-CHAIR TYLER: Anything else on
10 burns before we move on? All right. Moving
11 on, 5D, I believe. Right? "Patient death or
12 serious disability associated with a fall
13 while being cared for in a healthcare
14 facility." New language, "Includes, but is
15 not limited to fractures, head injuries, and
16 intracranial hemorrhage." Any comments?

17 DR. BURSTIN: I'm being Deborah,
18 who had to leave. She handed me her notes.
19 This was one of them. She had concerns about
20 this one, specifically patient death
21 associated with a fall. She said she would
22 consider moving it into care management. I'm

1 speaking as her now. She thinks that
2 environmental -- as an environmental event, it
3 plays down the role of caregivers and the
4 assessment, and the use of strategies to
5 minimize harm if a patient falls. A fall may
6 not be preventable, but there are effective
7 methods for reducing harm from a fall. So, I
8 think just the fact that it's an environmental
9 here was her concern. Maybe that same issue
10 we've had before, is this really a care
11 management event, as well, or in addition.

12 CO-CHAIR MEYER: Yes, I would
13 second that. The problem here is not the
14 floor that the patient impacts, it's the
15 management process.

16 MEMBER BRENNAN: Agreed.

17 MEMBER LAU: Agree.

18 CO-CHAIR TYLER: Diane.

19 MEMBER RYDRYCH: I have one
20 question. Is that second -- is the exclusion
21 under implementation guidance from a different
22 event, because it's talking about

1 defibrillation and ECT. Yes, I'm not sure how
2 I feel about all this splitting, but I do
3 think when I look at the falls that we get
4 reported to us, some of them are environmental
5 still, and some of them are care management.

6 We've had cases where falls are
7 related to the color of the shower curtain, or
8 the way the door works, or the slippery floor,
9 or the slippery blanket on the bed. I mean,
10 we've had environmental, as well as care
11 management. It definitely mixes up both of
12 them.

13 CO-CHAIR TYLER: Do we have
14 implementation guidance for that that can be
15 plugged in, or just -- no, we're just kind of
16 missing it. Okay. Helen. Leah.

17 MEMBER BINDER: I would agree care
18 management approach on this one. I mean, I
19 really do see, even issues that are
20 environmental, in some of the hospitals that
21 we've seen, they've anticipated those
22 environmental issues. They found the slippery

1 blanket, or the shower curtain, or whatever.
2 They've actually looked that closely at their
3 systems to prevent falls, and have really seen
4 results. So, I think, fundamentally, this is
5 a care management issue.

6 DR. BURSTIN: Just going to make
7 the point that, again, to be -- I think you
8 should feel that this is really your
9 opportunity to kind of explode this list a
10 bit. So, I guess the question might be, and
11 I don't know it from the states' perspectives,
12 but how important is it to have them
13 categorized in this way, care management
14 versus environmental. And why not come up
15 with events that are logical and make sense,
16 that's more patient-centered.

17 And then, lastly, might there be a
18 group of these sort of more environmental
19 things - I told you I was a lumper yesterday -
20 that you might be able to lump together, to
21 not necessarily significantly increase the
22 size of the list, but just thoughts.

1 MEMBER RYDRYCH: I would say from
2 our perspective, the categorization doesn't
3 really matter that much, because we focus on
4 what works to prevent them. It's not
5 environmental events only -- we only focus
6 environmental solutions on those.

7 CO-CHAIR TYLER: Okay. I think we
8 can move on, next one, 5E. "Patient death or
9 serious disability associated with the use of
10 restraints or bed rails while being cared for
11 in a healthcare facility." Does anybody have
12 any thoughts on this?

13 DR. BURSTIN: In essence, same as
14 above. This is a care management event, not
15 environment. So, perhaps if we just exploded
16 that, it's okay.

17 CO-CHAIR TYLER: All right. John,
18 and Stan.

19 MEMBER MORLEY: The question just
20 comes to mind of the issue that CMS is tackled
21 with physical restraints versus chemical
22 restraints, or pharmacological restraints. I

1 mean, this doesn't suggest a distinction, so
2 I'm not sure exactly how it would be covered.

3 MEMBER RILEY: That was my comment,
4 exactly. What about chemical restraints?

5 DR. ANGOOD: I think the original
6 intent - obviously, the way it's worded is to
7 the physical piece. Whether we want to add a
8 second category, or put it as new, I mean,
9 that's -

10 MEMBER TANGALOS: In this regard,
11 again, hospitals have had the free pass on the
12 chemical restraints. The regulations within
13 the long-term care industry have been there
14 forever, but hospitals are left off of this
15 one.

16 CO-CHAIR TYLER: Philip.

17 MEMBER PHILIP SCHNEIDER: Might
18 that also fall in the category of medication
19 errors. And we've started to tease out some
20 things, like hypoglycemia, that relate to the
21 use of medicine, so this -- the chemical
22 restraints might fall into the category of

1 medication error.

2 MEMBER TANGALOS: Actually, there
3 is replete literature in long-term care
4 regulation. And it's very complete, and it's
5 very different from what you observe in the
6 hospital. And the physical restraints that
7 you see oftentimes in the hospital, you can't
8 get away with in long-term care at all, so the
9 literature, again, is very prolific with
10 regards to chemical restraints, and how it's
11 taken care of. And, again, a technical expert
12 panel is going to help you with that.

13 CO-CHAIR TYLER: Okay.

14 DR. ANGOOD: Sorry, if I could.
15 Actually, the last five, ten minutes, for me,
16 is helping me understand that maybe as part of
17 what our group needs to do is to not just look
18 at our individual events, but perhaps we need
19 to look at the categorization of these events,
20 as well, and make sure we're still on the
21 right track. Again, what started off in '02-
22 03, isn't necessarily the same as right now,

1 but we don't want to get wild and crazy here.

2 But we should -- if we're going to do a deep
3 analysis on everything, we should.

4 CO-CHAIR TYLER: Okay. Anything
5 else? Yes, Michael.

6 MEMBER VICTOROFF: Well, actually,
7 I'm following up on that tangent. You may
8 want to table this for later, but I envision
9 a grid here that has more columns. And in my
10 fantasy, the categories have disappeared, and
11 we're just alphabetizing or something, or
12 arbitrarily listing the left column, but
13 across the right, my fantasy columns have
14 bullets or stars, or something indicating the
15 relevance and interpretation to several
16 different venues for care. Because the
17 discussion is very different of some of these
18 things, as soon as you move to a different
19 kind of care environment. So, I actually -- I
20 don't think that there are -- well, maybe
21 there are like global comments that apply to
22 them all, but I think the solution to the

1 categories is to drop them. And then capture
2 the value of what we used to have in
3 categories by looking much more precisely at
4 the venues.

5 DR. ANGOOD: Well, Helen and I go
6 back and forth amongst ourselves on this, and
7 whether there's a matrix sort of strategy that
8 can be applied, not just to the SREs, but to
9 the practices, even to some degree the
10 measures, and the other side of the matrix
11 would be conditions, environments, even
12 procedures, and to some degree you could even
13 get down to disciplines or teams. Yes, you're
14 building your matrix. It gets hugely complex
15 over time, but conceptually, it helps you sort
16 of frame these things up, so that you're in
17 the home care, and it's a nurse who is looking
18 after a patient with this condition. You kind
19 of know what the issues are. That's a long-
20 term project to populate that type of a
21 framework, but, conceptually, it helps move
22 you along.

1 MEMBER LAU: This is Helen on the
2 phone. Something just came to my mind. I'm
3 not a behavioral health or a psych area expert
4 in that area, but I would think that a
5 situation, some of those psych patients may be
6 locked up in certain area, that will also
7 define as restrained in that case. So, these
8 examples here, I don't see those really
9 mentioned there. Should that be included?

10 CO-CHAIR TYLER: Okay. Making note
11 of that. Helen, can you repeat what you like
12 to be included specifically, just so we'll
13 make sure we note it.

14 MEMBER LAU: I would like to have
15 some language around the behavioral health and
16 psych patients being -- I don't know what the
17 term is, that they are in seclusion. That
18 might be expanding the whole restrain -

19 CO-CHAIR TYLER: Okay.

20 MEMBER LAU: I don't know.

21 CO-CHAIR TYLER: Okay. Well, we
22 had said -- one of the notes we made here is

1 that we need the TAP to give a lot of input on
2 chemical restraints, which I think would
3 include that. Right? The use of psych and
4 behavioral medications?

5 MEMBER LAU: Yes, and also one is
6 on seclusion, that got locked up.

7 CO-CHAIR TYLER: Okay.

8 MEMBER LAU: That also need to get
9 included.

10 CO-CHAIR TYLER: Okay. Got it.

11 Okay. Thank you. And, Cynthia.

12 MEMBER HOEN: Going back to what
13 Peter was saying, it might be helpful if the
14 TAP groups could take a look at what reporting
15 IT equipment is out there, and what buckets
16 they have. I mean, that may be helpful in us
17 determining where certain things may fall, and
18 not turning our systems on their head, if
19 there are already tools out there to capture
20 some of this, what they call them. Do we want
21 to follow that metric?

22 CO-CHAIR TYLER: Okay. One more

1 thing from Michael.

2 MEMBER VICTOROFF: The word
3 "corrections." We don't have corrections
4 facilities here, and there are astonishingly
5 interesting issues that begin to overlap
6 behavioral, and get acute in the corrections
7 environment. And let's not forget them, when
8 we are going to our TAPs.

9 DR. ANGOOD: Yes, we haven't
10 actually given them a lot of thought. And
11 having, as a trauma surgeon and background,
12 looked after a lot of those criminal types,
13 and those criminal environments. They get very
14 poor care, and so I think it's a sub-category
15 that we need to not overly profile, but
16 certainly not forget.

17 DR. BURSTIN: Actually, the bigger
18 issue, from training in a public hospital, the
19 bigger issue is the care that we provided to
20 prisoners who were chained to their beds, when
21 you couldn't do an adequate physical exam. I
22 mean, there are real issues there in our

1 healthcare facilities, as well.

2 CO-CHAIR TYLER: Well, your mention
3 of corrections kind of gives us a nice segue
4 to criminal events, which is the next section,
5 moving into Category 6. Starting with 6A,
6 "Any instance of care ordered by, or provided
7 by someone impersonating a physician, nurse,
8 pharmacist, or other licensed healthcare
9 provider." Any comments? Anybody on the
10 phone want to weigh in? Okay. Hearing none,
11 we'll move on to 6B. "Abduction of a patient
12 of any age." Any concerns?

13 DR. BURSTIN: It seems like there
14 may be some harmonization concerns, our whole
15 code pink discussion yesterday. It sounds
16 overlapping, to me.

17 DR. ANGOOD: Yes, that's the one --
18 that was 3A. It was the infant discharged to
19 the wrong person. And we had a discussion, if
20 you might remember, is this just newborns, is
21 it the within one year, is it anybody? What's
22 competent, what's not competent, that whole

1 discussion which we had.

2 CO-CHAIR TYLER: Cynthia, you may
3 be able to shed light on this. I mean,
4 abduction is very -- a legal term. Right?
5 Abduction, it's a very specific term.

6 MEMBER HOEN: Yes. When you get to
7 this level, I mean, this is an event that
8 you're calling the police about, you're
9 reporting to the state, I think it's good to
10 keep track of it, but that's kind of a
11 secondary thought. You're going to let the
12 police take over that, as opposed to a
13 discharge to the wrong parent, or something
14 that's more controllable by the hospital and
15 its environment.

16 CO-CHAIR TYLER: Okay. Martha.

17 MEMBER RADFORD: With this one, and
18 the next one, I wondered about staff, as well.

19 CO-CHAIR TYLER: Okay. Good thing
20 to add. Okay. Michael.

21 MEMBER VICTOROFF: And also for
22 opening to the next one, the healthcare

1 facility becomes much more problematic here in
2 each of these. And we're going to have to do
3 more thinking as we spread our rows to the
4 other venues. So, what that means to me is
5 that, if we're -- you're going to have a left-
6 hand column sort of in my fantasy that
7 describes the general definition, then I'm
8 going to have to go back over the list a
9 little, and look at all those ones where we
10 said healthcare facility, and see if it bears
11 just clipping that off, because we're going to
12 address the facility in my right-hand columns.
13 So, then am I happy with calling this sexual
14 assault on a patient or healthcare provider,
15 which broadly means staff. And I think yes,
16 I think sexual assault on a patient or
17 healthcare provider, and then leave the
18 facilities over here on the right.

19 And, in my mind, I'm beginning to
20 think that that might be the model I want to
21 use for some of these other things, where the
22 word "facility" is now irritating me in the

1 left column.

2 (Off mic comment.)

3 CO-CHAIR TYLER: P.J., do you have
4 a comment on the phone?

5 MEMBER BRENNAN: No, I'm sorry, I
6 don't.

7 CO-CHAIR TYLER: Okay. I just want
8 to make sure that we're done with abduction.
9 Right? Before moving onto sexual assault.
10 Everybody is okay with comments on that?
11 Okay. Any more comments on the sexual assault
12 category? Chris.

13 MEMBER GOESCHEL: I just have one
14 question, and that is, if we're taking this
15 from patients to providers, is there any room
16 in here for visitors? I mean, those things
17 happen, and we're getting -- we're talking
18 about criminal events. And there have been
19 times when our providers have allegedly
20 assaulted families or visitors. I just raise
21 the question.

22 CO-CHAIR TYLER: Doron.

1 MEMBER DORON SCHNEIDER: Just as a
2 -- for clarity for me, some of these may not
3 apply in some of the settings. And they just
4 have an N/A when you go down that column, so
5 I wouldn't box ourselves in to make sure that
6 it applies across all.

7 DR. ANGOOD: And this may be one of
8 those lumping categories, to use Helen's
9 favorite term, where you can just simplify
10 that no criminal events should occur, period.
11 And in our definition footnote, dot, dot, dot,
12 dot, dot. And that allows you flexibility in
13 the individual states, et cetera.

14 CO-CHAIR TYLER: I certainly would
15 think that visitors should have an expectation
16 of safety when they come. Pretty basic to me.

17 MEMBER PHILIP SCHNEIDER: Just a
18 question of whether the NQF focuses on care
19 provided to patients or the running of an
20 organization, as we continue to broaden these.
21 I mean, they're all undesirable events, but is
22 it outside of the scope of the work of NQF to

1 talk about the quality of healthcare to begin
2 looking at management issues that relate to
3 employees and staff. And I'm not -- I'm just
4 asking a question. That's not an opinion.

5 DR. ANGOOD: Helen may have a
6 different opinion than I, but we're certainly
7 in this evolving new era for NQF very much
8 focused on improving health quality, and
9 health safety on all fronts.

10 CO-CHAIR TYLER: Michael.

11 MEMBER VICTOROFF: And, again,
12 although I have some sympathy with lumping,
13 like any illegal act, here's an instance where
14 I think we might to keep the sexual assaults,
15 or the sexual improprieties, or misdemeanors
16 separate. And the reason I will invoke is
17 that when I went to the Colorado Board of
18 Medical Examiners 25 years ago with a taxonomy
19 of medical errors to help sort disciplinary
20 actions for physicians, what they said to me
21 was well, look, we get one or two of these
22 cutting off the wrong legs things a year, but

1 we get eight complaints per month about sexual
2 impropriety, or alleged sexual something or
3 other, or hanky panky of some kind involving
4 providers. That's our big problem here at the
5 Board. So, in recognition of that, I kind of
6 think that this very sensitive issue of
7 inappropriate sexual behavior, which has the
8 full spectrum, probably deserves special
9 attention, if not being highlighted in some
10 way. So, that's where -- I wouldn't just lump
11 it in with other batteries, and other theft,
12 you know, whatever else.

13 CO-CHAIR TYLER: Just to be clear,
14 I mean, the term is sexual assault, so it's
15 not inappropriate sexual activity, which
16 there's a distinction. Obviously, you know
17 that.

18 MEMBER VICTOROFF: Well -- so, I --
19 this is almost a time for an expert panel for
20 this one, because I'll tell you that it's one
21 of the longer and more tedious issues that we
22 run physician risk management seminars about.

1 We have boundary seminars, we have all kinds
2 of discussion. And I don't know how much of
3 that ought to be reportable, and not. And I
4 don't know the difference between what a
5 criminal definition of sexual assault is, as
6 opposed to a tort. But this is so big for me,
7 that I think it ought -- we ought to move it
8 to a place where we can really focus on it.

9 CO-CHAIR TYLER: Cynthia.

10 MEMBER HOEN: From the standpoint
11 of the hospitals, an assault, to me, as a
12 lawyer, and when we report this is when the
13 patient or somebody else alleges that there
14 was an assault, or a battery. It's not the
15 in-office, allegedly improper touching by a
16 physician with a patient, where the patient
17 could then go complain to the Board of Medical
18 Examiners. This is where it rises to a level
19 where I believe under the law, I'm required to
20 report it to the police. And that's when the
21 patient says I've been assaulted. I've been
22 improperly touched, dah, dah, dah, dah. So,

1 to me, there's a very clear cutoff line as to
2 when these are reported, and rise to a
3 criminal level.

4 DR. ANGOOD: Well, this, in my
5 mind, just sort of prompted up, and I really
6 don't think it fits into this activity here,
7 but there is that whole issue of providers who
8 are not just misbehaving in terms of sexual
9 confrontations, but perhaps they're engaged
10 with substance abuse, or all of the elements
11 of disruptive behavior. And that is clearly
12 an element that's getting a lot of attention,
13 and will continue to do so. How we put that
14 in the SRE categories, I don't -- I'm not sure
15 we have a fitting for that, but it does bump
16 up in some instances towards the criminal
17 activities, and there are expectations of what
18 the providers are going to be providing in
19 terms of their interactions to the patients in
20 those populations.

21 And, as we all know, there's a
22 number of individuals on all disciplines that

1 will go and practice in different
2 environments, so they know where they can
3 hide. And how do you unmask that? Again, it
4 may not be the purview of this whole set of
5 activities, but it is an issue.

6 CO-CHAIR TYLER: Okay. One more
7 thing from Leah.

8 MEMBER BINDER: I really like
9 Michael's suggestion about an expert panel.
10 I actually didn't realize, you're enlightening
11 me that this was something that may be more
12 common than perhaps we might have understood.
13 But it is a -- and I like it as a particular
14 category of criminal offense, because there's
15 such a high level of bodily vulnerability that
16 a patient feels in going into a healthcare
17 setting, that sexual impropriety is probably
18 compounded, and more damaging, possibly, than
19 it would be otherwise. And they're more
20 vulnerable to it, so I think -- and that I'm
21 sure goes for any kind of healthcare facility.
22 So, I do think that it raises an important

1 issue. I agree.

2 CO-CHAIR TYLER: Okay. If we have
3 nothing else on this, then we've wrapped up.
4 It was a great job of ploughing through the
5 rest of these, the list of SREs. And now I
6 think we are going to take a break.

7 (Off mic comment.)

8 CO-CHAIR TYLER: Oh, we do have
9 one, one more, so close, so close. All right.
10 We're not done. One more, 6D. "Death or
11 significant injury of a patient or staff
12 member resulting from a physical assault,
13 i.e., battery that occurs within or on the
14 grounds of a healthcare facility." Michael,
15 then Diane.

16 MEMBER VICTOROFF: And, again,
17 here, for me, the argument is, do we want to
18 broaden it to include any, and are we able to
19 define it, if we broaden it to include any?

20 MEMBER TANGALOS: Well, we have a
21 celebrated case going on in Minnesota right
22 now. A professional wrestler killed his

1 roommate. The professional wrestler is with
2 the Alzheimer's disease, he will not be
3 charged for a criminal assault. And it's yet
4 to see what will happen with the facility, but
5 it will be an important issue that has to be
6 addressed, because the facility does have a
7 fair amount of culpability with regards to the
8 events leading up to the death, so we'll see.

9 CO-CHAIR TYLER: Diane.

10 MEMBER RYDRYCH: Just two short
11 observations. Just, one, this is the only
12 event where we talk about significant injury,
13 rather than disability. So, for consistency's
14 sake, we might want to deal with that. The
15 other issue is, we have, in the past, had
16 physical assault events that involved only
17 staff members, staff members assaulting each
18 other, so we probably want to be clear, if
19 there's no patient involvement at all, whether
20 that -- whether this category was intended to
21 capture that type of event.

22 CO-CHAIR TYLER: Anything else on

1 this? Helen, you had something.

2 DR. BURSTIN: I just want to
3 follow-up on Diane's point about significant
4 injury. I do think we need to go back and
5 think about, is that that middle category? Is
6 there another term that's better. But I think
7 that's there because they wanted, I assume, to
8 get broader than serious disability or death,
9 so I just think it might be worth -- and I'm
10 assuming it's not an accident, but it could
11 have just been. We'll find out.

12 CO-CHAIR TYLER: Okay. Anybody on
13 the phone have anything on this?

14 CO-CHAIR MEYER: This is Gregg.
15 Just responding to, I think it was Diane who
16 made the earlier comment, my interpretation of
17 this is that staff-on-staff violence would be
18 included here. And I'm not sure if -- we
19 should be hearing from the folks in the states
20 if that's their interpretation, as well.

21 MEMBER RYDRYCH: I think that was
22 our interpretation, but I'm somewhat

1 ambivalent whether it should be -- whether it
2 should include the brawl in the break room
3 between two staff members. I just think we
4 need to clarify it for anyone who's
5 implementing this, whether it does apply or
6 not, rather than kind of dealing with it case-
7 by-case, or state-by-state.

8 CO-CHAIR TYLER: Stan.

9 MEMBER RILEY: I think, for us,
10 that we would agree that staff-on-staff is a
11 huge issue, too, mostly because everybody
12 deserves to have a safe place to have
13 treatment. So, if that environment is there,
14 it frightens everybody.

15 DR. ANGOOD: Sorry. While you were
16 finishing your comment, Stan, I was just
17 reminding ourselves that before we take our
18 break, we should ask if there are any members
19 of the public on the phones, so, operator, if
20 you could please check. And then if there is,
21 do any of those members of the public on the
22 phone have questions or comments around what

1 has been discussed so far this morning.

2 OPERATOR: There are only Committee
3 members on line.

4 DR. ANGOOD: Okay. So, I think -

5 CO-CHAIR TYLER: Okay. So, we can
6 do a break then, which is good. I need one,
7 at least. Okay. Let's say 10:05, I mean
8 11:05. Will that allow people enough time to
9 take a break, stretch your legs? Okay, see
10 you back then.

11 (Whereupon, the proceedings went
12 off the record at 10:54 a.m. and resumed at
13 11:11 a.m.)

14 CO-CHAIR TYLER: Okay. Well, it
15 looks like we have most of our folks back in
16 the room, so I think we're going to go ahead
17 and start back. And Peter is going to pick up
18 on our agenda on the second day. We're going
19 to try to keep on schedule in terms of time,
20 at least, because we know everybody else has
21 prior commitments, including flight plans
22 home, so we're still going to break at the

1 same time, which means we're going to collapse
2 some of the things, and rework the agenda a
3 bit, and get through as much as we can in a
4 meaningful way today.

5 So, Peter is going to talk about --
6 are you going to do the TAPs first?

7 DR. ANGOOD: A bit of both.

8 CO-CHAIR TYLER: Okay. He's going
9 to talk about role of TAPs, and also about how
10 we're going to select other environments of
11 care to expand these beyond hospitals. Okay.
12 Peter.

13 DR. ANGOOD: Thanks so much. And
14 a slide that we're putting up in preparation
15 for this is Slide 28 from the slide deck that
16 Helen and I had up for you yesterday.

17 Basically, outlines the three applicable
18 healthcare settings. So, just for those of
19 you on the phone, if you want to find that.

20 Now, in terms of my comments, I was
21 just kind of musing that well, here we are at
22 11:15 on the second day, and we're just

1 starting the second day's morning agenda. So,
2 I think that's a reflection on the complexity
3 of this whole topic, and the robustness of the
4 discussion. So, I think I'm actually very
5 happy with where we've landed so far, and I
6 think you all should be, as well.

7 I'm obviously going to truncate my
8 comments, basically, to sort of give a bit of
9 background further on this sort of concept of
10 other environments, or expanding into other
11 environments, and then however we then agree,
12 and after some discussion, that will drive how
13 we then want to begin utilizing the TAPs, sort
14 of rounding out the processes here.

15 As Helen made mention, the original
16 genesis of the SREs was a few smart people
17 sitting in a room generating a list, and then
18 it got ratified through the consensus
19 development process. And the Committee at the
20 second iteration was the main driver for
21 developing and reviewing the existing current
22 SRE list. So, there still is a fair amount of

1 expectation that you will be the ones to help
2 generate the ideas for where we take this
3 current version of the list and move forward.

4 We will, as we've said, solicit
5 some external, or outside inputs on this, and
6 that's part of what we do with the measures
7 consensus process. But the Safe Practices and
8 the SREs are different than the measures, so
9 we don't run it as -- in the same sort of
10 rigorous expectation for submissions from
11 externals to put into our process. So, I just
12 wanted to further clarify that for you.

13 DR. BURSTIN: A point of
14 clarification. The real distinction is the
15 fact that the actual steward of the Safe
16 Practices and the SREs is NQF.

17 DR. ANGOOD: Yes.

18 DR. BURSTIN: So, we are
19 responsible for the content and the
20 maintenance, unlike the measures, where an
21 external steward is responsible. So, we
22 wouldn't write their measures for them, but

1 there is an expectation that you guys will
2 really be the source of the SREs.

3 DR. ANGOOD: Thanks, Helen. That,
4 I think, is an important distinction. So, the
5 reason I go through all of that and lead up to
6 this part of the agenda is, as we were
7 submitting our work plan proposal to HHS on
8 those three deliverables, we were struggling
9 with this issue of what conditions are going
10 to be ultimately covered? Well, there's the
11 top 20 CMS conditions, which are sort of a
12 start point, but we don't have to define that
13 for ourselves, necessarily. The specific on
14 the request from HHS was, well, we need to
15 expand into other environments beyond the
16 hospital setting. So, we looked -- well,
17 let's still stick with CMS, and there's
18 basically 10 CMS environments of care. And we
19 realized well, that's far too many, and,
20 certainly, there are some overlaps for many of
21 these areas. And we, initially, worked towards
22 four of these clusters, and then because of

1 resources, basically, decided no, we need to
2 really pretty much stick with trying to work
3 on three clusters of environments of care.
4 So, those are the three that we've got labeled
5 up here, recognizing that this is less than
6 perfect, but it represents pretty good
7 clustering, overall. But we wanted you all to
8 have some input, and some deliberation on
9 these three.

10 And then, depending on how this
11 deliberation goes will drive the Technical
12 Advisory Panels that we'll put into place and
13 get the technical experts on those TAPs to
14 help us take our new definition of the SREs,
15 and to sort of begin generating some of the
16 ideas around what are the appropriate SREs for
17 those different environment clusters. Okay?
18 Clear so far?

19 The use of the TAPs are expert
20 input, but it's still the Steering Committee
21 that makes the choices in the end, based upon
22 the input from the TAPs. And then, in terms

1 of process, what the Steering Committee does
2 is submit its final iterations after we go
3 through all of our process up to our Consensus
4 Standards Approvals Committee, the so-called
5 CSAC. And that's where the approval actually
6 occurs, and then the Board ratifies it. So,
7 the TAPs are experts with input, but the
8 Steering Committee still drives the final
9 document, and the final content. And then the
10 CSAC approves, and the Board ratifies. So,
11 any quick questions on that?

12 DR. BURSTIN: Make one comment on
13 the environments of care. We did do some
14 lumping, as you'd imagine. And I just want to
15 see if what the group thinks is -

16 DR. ANGOOD: That's where I was
17 headed.

18 DR. BURSTIN: Good. It is logical,
19 and I figured you might question home health.
20 So, there you go.

21 DR. ANGOOD: Yes, so here's our
22 proposal, but it's open for deliberation. And

1 just before we dive in, because this group,
2 they like -- you guys are great, actually. I
3 mean, Helen and I both comment, you guys are
4 a great group. But in terms of, we're still
5 going to finish on time this morning. Don't
6 start changing your flight patterns around.
7 The final product doesn't have to be out
8 today. We want to do some brainstorming with
9 you in the last bit after we get through this
10 piece, as well, what other types of SREs would
11 be relevant or helpful in the general list,
12 and then that will help, between this
13 discussion, and initial brainstorming on other
14 SREs, that will drive us for our next several
15 weeks, which we'll continue electronically and
16 by some phone calls.

17 MEMBER TANGALOS: Well, there's
18 nothing wrong with the items that are there,
19 but they're not organized the way I usually
20 think about it. I mean, they're not even
21 close to the way I would think about them.
22 So, it's very -- let me -- I'm not going to

1 try to sort it just yet, but we think of home
2 and community-based services nowadays, and
3 that's the concept that we think about. We
4 think about long-term care settings. That's
5 the vernacular that we use. We oftentimes
6 leave hospice and palliative care in its own
7 little universe, as well. And when we think
8 about rehabilitation, we think about it as
9 being at some site, whether it's the hospital,
10 the home, or a long-term care facility. And
11 a healthcare -- a nursing healthcare setting,
12 I can't put anywhere. I don't know what that
13 means. I don't know -- nursing, as a separate
14 entity kind of fits in.

15 DR. BURSTIN: They're called
16 nursing homes.

17 MEMBER TANGALOS: Well, we don't
18 call them that any more.

19 DR. BURSTIN: I'm just saying, but
20 CMS list -- that's where that comes from.

21 MEMBER TANGALOS: But if that's
22 what it was, it -

1 MEMBER TANGALOS: Skilled nursing
2 facility is another story within long-term
3 care settings, and that has a very definite
4 definition. There's no question about it. But
5 that's how that would be. So, within the 10
6 environments that we had from the CMS, it
7 would be fine, but the reorg here, you know,
8 it's not there yet.

9 DR. BURSTIN: And just to be clear,
10 the only intention of the reorg is to try to
11 think about what the logical groupings of
12 experts might be who could think through these
13 issues. That's all. You guys will have a
14 chance to do further work on any of these.
15 It's just a question of who are the logical
16 people who would logically come together? So,
17 that's why I think a lot of that last group,
18 we'd want to make sure we've got nursing,
19 geriatrics, rehab, those kind of folks. For
20 the ambulatory care, you want to make sure you
21 bring the voice of primary care, and others.
22 So, that was the logic, but I could certainly

1 -- the home health was the one I thought might
2 be questionable.

3 CO-CHAIR TYLER: Michael.

4 MEMBER VICTOROFF: Actually, the
5 one that's questionable for me is dialysis.
6 You know, we're playing the game of which one
7 of these is not like the other things. And I
8 can see that a person could be versed in
9 ambulatory office outpatient hospice, as well,
10 because when I think of internists, and family
11 docs, and even pediatricians, there is an
12 overlapping skill set to those things.
13 However, very few of them monkey around with
14 dialysis units, and the nature of the way
15 dialysis is run, organized, paid for, staffed,
16 and administered is a different beast from
17 those others. So, I have to just sort of
18 question whether the TAP would feel confident
19 -- whether they would think their own skills
20 would need to be augmented. And my answer, if
21 I were on that committee, would be yes. All
22 the rest of them, I'm smart. Dialysis, no.

1 So, I would actually propose relocating
2 dialysis, if we only are allowed three
3 choices, to the one that's called inpatient
4 hospital, because dialysis looks more like an
5 ambulatory surgical center, or a radiation
6 treatment center, than it looks like a
7 doctor's office.

8 MEMBER LAU: This is Helen. I
9 concur.

10 DR. ANGOOD: Okay, thanks. And
11 just in your pre-meeting packet, we did you
12 that listing of the so-called 10 environments.
13 But that was just a starting point.

14 MEMBER RADFORD: It's on page 87.

15 DR. ANGOOD: Page 87 of the packet.
16 Thank you, Martha. If you, as a group, want
17 to make up three new different ones and
18 cluster them, so be it. It'll take us a
19 little bit longer, but we're trying to stick
20 with ambulatory environments, the inpatient
21 setting, and then sort of that intermediate
22 zone in-between the ambulatory and the

1 hospital setting.

2 DR. BURSTIN: And just one more
3 clarification. We're talking about bringing
4 people together in person. We've got funds to
5 do that. If you think there are groups that
6 are truly different, we'll just pull them out
7 and deal with them as calls. I mean, that's
8 fine. If you think dialysis truly is just a
9 different universe, we'll try to pull together
10 some dialysis folks on a technical panel, set
11 of technical advisors to advise. So, tell us
12 what should get pulled out, I guess.

13 MEMBER TANGALOS: Well, even in
14 long-term care, wherever that continuum is,
15 the dialysis piece does separate out. It's
16 just in its own world. Again, when you think
17 about rehab, that one actually crosses all of
18 these things, but it's not just rehab. It's
19 speech, occupational therapy, PM&R. And,
20 again, you can have them in any site, but the
21 discipline is more than the site-specific
22 stuff, as far as I'm concerned.

1 CO-CHAIR TYLER: That's not one of
2 the 10 sites, rehab.

3 DR. ANGOOD: That's a good
4 clarification. Why did we bring that one back
5 in? Oh, you know where that came, in part, is
6 that -- and I may not have the exact
7 knowledge, but someone was pointing out that
8 SNF, Skilled Nursing Facility, is very
9 specific on the payment side for a particular
10 population. So, we want -- in terms of trying
11 to generate broader-based discussion here, we
12 kind of took it back to nursing and rehab --
13 rehabilitation centers.

14 MEMBER TANGALOS: But I would put
15 the skilled nursing in with that other long-
16 term care, because those provide -- and those
17 patients bang around back and forth, as well.
18 So, that's a logical connection with that
19 group.

20 DR. ANGOOD: So, just SNFs and
21 long-term care?

22 MEMBER TANGALOS: Actually, the

1 umbrella is long-term care, and within that
2 you've got the SNFs.

3 DR. ANGOOD: Okay.

4 MEMBER VICTOROFF: My question
5 would be, and I'm happy to have it either way,
6 hospice has probably 50-50 shared skill set
7 between ambulatory primary care, and long-term
8 care. And, often, it's different docs doing
9 it, but they have the same credential. I
10 would be happy to see hospice moved out of
11 that first group, into the long-term care
12 category, if someone felt that made more
13 sense.

14 MEMBER TANGALOS: Well, it doesn't,
15 and the reason it doesn't is hospice is time-
16 limited, presumably, six months or less.
17 Long-term care presumes a much different time
18 continuum. And we were just talking about
19 that. We have hospice in the hospital, we
20 have hospice in the nursing home as a Medicare
21 benefit. We have hospice in the community
22 that's freestanding. Hospice is kind of on

1 its -- it overlaps, but it's kind of its own
2 discipline, and it's becoming more of its own
3 discipline with regards to palliative care.
4 And the palliative care piece is what you
5 really want to capture as you expand this, as
6 well.

7 CO-CHAIR TYLER: Cynthia, and I
8 think, Stan, you also want to -- Cynthia
9 first.

10 MEMBER HOEN: Actually, this is
11 probably obvious, but I just need for my own
12 clarification. Ambulatory surgery centers
13 would be included in ambulatory care? And
14 also uryg centers, or are they out of this
15 grouping? Urgent care centers.

16 DR. ANGOOD: Again, as I made my
17 opening comment, it's far from a perfect
18 clustering. And we chose, initially, that the
19 ambulatory surgery would be in the ambulatory
20 setting, since there's -- obviously, many of
21 them do occur as part of hospital settings and
22 systems, but there's many freestanding ones,

1 as well. And there's a huge accreditation
2 program out there for that whole set of
3 settings, too. As far as the urgent care
4 piece, we sort of felt that was basically
5 ambulatory, but there's debate on that, as
6 well. Sorry.

7 MEMBER RILEY: The ambulatory
8 surgery care was my question, as well.

9 DR. ANGOOD: Okay. Thanks.

10 MEMBER VICTOROFF: Again, it really
11 doesn't matter. We're going to have to do
12 these all -- I'm not going to want to be the
13 one that holds this all up. But if I was
14 looking at the safety issues that one
15 encounters, and the remedies one encounters,
16 and the reporting channels through which one
17 reports, again, the one that doesn't look like
18 the others in that first group is ambulatory
19 surgical center, because they're paid for,
20 administered, managed, and staffed, and
21 operated quite a bit differently from an
22 outpatient clinic.

1 Again, I think you're going to get
2 experts together that are going to be able to
3 handle this. So, I'm not too worried that we
4 have to do it perfectly, because we can't.

5 But if you were thinking about the experts
6 that are all going to feel comfortable in the
7 room together, the SU guys are going to be a
8 little bit out of place in that first group.

9 DR. GANDHI: This is Tejal from the
10 phone. Do you mind reading out what's on that
11 first group to me on the phone?

12 DR. ANGOOD: Sure. It's
13 "Ambulatory Care, and Home Health" is the main
14 title, and that is bracketed with [including
15 physician offices, outpatient clinics,
16 dialysis facilities, and hospice settings].

17 For completeness, the second bullet is
18 inpatient hospital [including related
19 inpatient services and emergency departments].

20 And then the third one is "Nursing,
21 Rehabilitation, and Long-Term Care." And it
22 was -- yes, the recent suggestion was just

1 long-term care with some sub-bullets under
2 there, which would be skilled nursing
3 facilities, and others.

4 MEMBER TANGALOS: Long-term care
5 settings.

6 DR. ANGOOD: Yes.

7 DR. GANDHI: So, ambulatory
8 surgical centers is in that first bullet.

9 DR. ANGOOD: Yes.

10 DR. GANDHI: I think it's a
11 reasonable place to put it, because some of
12 the ambulatory clinics also are doing
13 significant procedures, and so I think a lot
14 of the procedural issues, even though I know
15 that ambulatory surgical centers are different
16 in a lot of ways, but I think a lot of the
17 safety issues do overlap with some of the more
18 procedural ambulatory specialties.

19 CO-CHAIR TYLER: Chris.

20 MEMBER GOESCHEL: Could I just ask
21 just to clarify, so long-term care settings
22 would include long-term acute LTACs and rehab

1 hospitals, and long-term psych hospitals.

2 We're talking about all of those. Is that
3 correct? Okay.

4 CO-CHAIR TYLER: Martha, Leah, and
5 then Doron.

6 MEMBER RADFORD: I'm also, like
7 Michael, not too worried about this. I think
8 maybe we're trying to -- we should do this in
9 three waves instead of two, the first wave
10 being acute care that's already been
11 discussed. And pick the big ticket items. I
12 might leave hospice for a later edition. I
13 might leave some of these other for just a
14 later edition, to get the big ticket items, a
15 variety of others one.

16 DR. BURSTIN: And if I could just
17 add to that, we said we would expand to the
18 likely -- to the applicable settings. We
19 didn't say we'd do all ten.

20 MEMBER RADFORD: Right.

21 DR. BURSTIN: So, I think it would
22 also be very useful for you to prioritize

1 based on your thinking of our broadened
2 definition of SREs, what sites make the most
3 sense, especially for the state folks. What
4 are the kind of sites you don't tend to get,
5 that you worry about?

6 MEMBER RADFORD: You know, I like
7 Michael's idea about the grid and the columns.
8 And there's nothing to prevent us from having
9 10 columns, eventually, except for you'd have
10 to get 17 inch paper. Oh, well.

11 CO-CHAIR TYLER: Leah, Doron, and
12 then John.

13 MEMBER BINDER: By dividing these
14 into three categories, I assume it's more of
15 a -- just for interest, as opposed to any kind
16 of use. The reason I'm asking that is simply
17 because it's odd to me that we're sort of
18 dividing inpatient hospital from their
19 outpatient clinics. So, one hospital, I
20 guess, is in two categories. I don't think
21 that matters unless, for some reason, we're
22 asking them to do some kind of reporting on

1 two different bullets. It doesn't matter, but
2 I just want to make sure it doesn't.

3 And then the second thing is, do we
4 want to -- we had some discussion earlier
5 about home birthing, or freestanding birth
6 clinics. Is that something we want to add to
7 this, as well?

8 MEMBER DORON SCHNEIDER: So, I
9 think the outpatient clinics are okay with
10 ambulatory care, because the events that occur
11 there are the same that occur in physician
12 offices. My issue is with the ambulatory
13 surgery unit, and what Tejal was saying, in
14 that the procedures that I'm considering
15 ambulatory surgery are those that require
16 anesthesia. And I think if I had to put them
17 somewhere, I would them more in inpatient
18 hospital, and have the outpatient clinic folks
19 speak very eloquently to the smaller
20 procedures that don't require anesthesia, and
21 really just require smaller time out, and
22 those issues.

1 CO-CHAIR TYLER: John, then Eric.

2 MEMBER MORLEY: You struck a nerve

3 when you asked the question about which ones

4 of those are we most interested in. We've

5 got, in New York, a law that was passed two

6 years ago that requires reporting for office-

7 based surgery, so that's an area of intense

8 interest and effort in the last two years.

9 We've had some very interesting information.

10 One piece of information I would like to share

11 with the group, and that's just simply that

12 more and more care is being rendered in that

13 setting.

14 I need to say that again for my own

15 benefit, more and more care is being, so we're

16 seeing things like renal artery stents, and

17 prostate surgery being done in an office

18 setting, and more than that. So, it's an area

19 that I think we have interest in for lots of

20 reasons, but what caused the law to be passed

21 was some headlines of some patients that had

22 office-based surgery and passed away. We now

1 know that we had 600 reports last year, and 30
2 of those reports on adverse events were
3 deaths. Some of those deaths were dialysis
4 patients after a catheter manipulation, and
5 those patients are high-risk mortality without
6 procedures. But a surprising number of
7 patients expired as a result of office-based
8 procedures, surprising just to us.

9 Dialysis facilities is an issue
10 that keep cropping up around the country
11 related to infection transmission. And one of
12 the more regulated areas by CMS, but not one
13 of the areas where we know a great deal about
14 what happens.

15 Long-term care, highly regulated in
16 terms of the skilled nursing facilities, and
17 so forth. I think some of those areas offer
18 us the most opportunity for what I'll call
19 interesting information, actionable
20 information. Thank you.

21 CO-CHAIR TYLER: Eric.

22 MEMBER TANGALOS: Yes. I'm

1 thinking that you can divide up the work how
2 you want, but as far as the bullets, I'm
3 seeing five, more than three. And I really
4 see the ambulatory care with its DRGs, with
5 its payment system, relatively unique. Home
6 and community-based services is that catch
7 word, and where that jargon is right now. And
8 then hospice tends to be a unique piece. So,
9 I would pull home and community-based services
10 out of that first bullet, and I would make
11 hospice and palliative care its own bullet,
12 as well. So, I can only come up with five. I
13 can't get down to three.

14 DR. BURSTIN: Just, again, point of
15 clarification. We're just trying to think
16 about the logical groupings of experts.

17 MEMBER TANGALOS: No, but that -

18 DR. BURSTIN: So just think of it
19 from that perspective. And, again, if there
20 are specific settings, if ambulatory surgery
21 is such a big issue, we'll just convene an
22 Ambulatory Surgical Technical Panel. It's not

1 a big deal. We'll pull five people together
2 and have a phone call. Just tell us -- this is
3 really just for you to tell us what expertise
4 is really important, which of these settings
5 you really want to focus on. Are we ready, I
6 think going back to Martha's point, are we
7 ready to do hospice and palliative, or is that
8 something to save for the next time, perhaps?
9 Should dialysis be on its own? Again, we just
10 here to listen to you.

11 DR. ANGOOD: So, Eric, can you -
12 just so we can capture it on, perhaps, a fresh
13 slide, and let people see that, those five
14 categories.

15 MEMBER TANGALOS: Well, ambulatory
16 care is by itself. And I'm disappointed, but
17 that universe may not interface too well with
18 any of these other things. And it's home and
19 community-based services, is what it is. And
20 that gets the home health, that gets the rehab
21 that can occur at home, that gets some of the
22 other things that are there. But that's a lot

1 of community-based things there right now.
2 And you may find that there's no data set,
3 that there's no data set worth ploughing, as
4 there would be with the long-term care
5 settings. Okay? But I still think home and
6 community-based stands by itself. Then the
7 inpatient hospital, then the long-term care
8 settings, and then the hospice and palliative
9 care. Yes, that is the grouping that I kind
10 of see that politically works, and
11 organizationally works. Whether you want to
12 bite it all off, or pieces of it, but that's
13 where the expertise resides in those
14 individual camps.

15 CO-CHAIR TYLER: And just to
16 clarify, Eric, what you're suggesting, the
17 modifying language in the parens there, that
18 still goes with ambulatory care.

19 MEMBER TANGALOS: Yes.

20 CO-CHAIR TYLER: That "including
21 physicians offices". Right?

22 MEMBER TANGALOS: Yes.

1 CO-CHAIR TYLER: So, that needs to
2 be moved.

3 MEMBER TANGALOS: Yes.

4 CO-CHAIR TYLER: All right.

5 MEMBER RADFORD: And just where
6 does ambulatory surgery fit?

7 MEMBER RYDRYCH: I think part of
8 the issue here is we're trying to put
9 something into list based -- groups based on
10 settings, when really we're talking about
11 services. Right? And services that kind of
12 fit better together. Because, for us, we
13 already collect data from ambulatory surgical
14 centers, so, in effect, we're treating them
15 the same way as we do the inpatient hospitals.
16 And we apply the same list to them, and if a
17 certain event happens to not occur at an ASC,
18 then so be it. They just don't report those,
19 but we apply the same list to them. But from
20 a licensing perspective, they're very
21 different situations, and I would tend to
22 think of them as closer to -- I mean, just

1 what seems intuitive to me is to put them
2 closer to ambulatory care, if we're talking
3 just about the setting, but the services are
4 closer to inpatient. So, we seem to be having
5 that tension there, is this about a physical
6 type of setting, or is about the type of
7 services that are being provided?

8 CO-CHAIR TYLER: Doron.

9 MEMBER DORON SCHNEIDER: I would
10 think it's about the kind of harm that we're
11 trying to get -- find the reporting. So, it
12 really is the services, for me. And,
13 personally, I would think it would be more
14 inpatient like, because of the kind of
15 service, the intensity of the services that
16 we're talking about, as opposed to the
17 procedures, the smaller procedures that are
18 going to lead to different error types in the
19 ambulatory care.

20 MEMBER RYDRYCH: But I wonder then
21 if we want to change our nomenclature so we're
22 not talking about healthcare settings, because

1 it seems strange to say we're having this
2 technical advisory group on ambulatory, or on
3 inpatient hospital that includes ambulatory.

4 MEMBER RADFORD: So, it's really
5 service types.

6 DR. BURSTIN: I think what they
7 wanted was to get us out of just thinking of
8 all these SREs and hospitals. So, if you can
9 accomplish that, go for it. Just give us -

10 MEMBER LAU: This is Helen. I just
11 want to make a comment on ambulatory care. I
12 think we shouldn't forget those groups that
13 run emergency type of ambulatory care, or the
14 clinic, you know, those people that pay some
15 money, and then go to those emergency care
16 settings other than a hospital. Am I making
17 sense?

18 CO-CHAIR TYLER: Emergency room
19 service that would not be included under
20 inpatient hospital, is what you're saying.

21 MEMBER LAU: Yes.

22 CO-CHAIR TYLER: Because we have

1 emergency department there.

2 MEMBER TANGALOS: Well, what's
3 emerging is -- or re-emerging, there's a
4 finding, again, of the urgent care centers,
5 which are outpatient. But, even more so, the
6 unregulation of the "minute clinics."

7 MEMBER LAU: Yes. Yes.

8 CO-CHAIR TYLER: I just want to
9 make sure that Helen's point -- Helen, does
10 that clarify your point? Is that correctly
11 stated?

12 MEMBER LAU: Yes, as long as that
13 includes the group of people who go for those
14 emergency type of care, not in a hospital type
15 of emergency department, or emergency room,
16 but in a separate like clinic type of
17 location. I think there are lots of error in
18 those areas, so I just want to make sure those
19 areas are being captured.

20 CO-CHAIR TYLER: Okay. I think we
21 got that. Thank you. I think, Michael, and
22 then -

1 MEMBER VICTOROFF: You know, I can
2 see us cutting this pizza endlessly, but at
3 the end of the day, if you tell me there's
4 only three people that get pizza, divide it
5 however you want, then I'm not going to
6 actually worry too much. And what I would
7 think is that any of these groups, as they're
8 configured, or as I could conceive
9 configuring, would work. You'd get useful
10 stuff out of them. We ought to just plough on
11 and starting getting the useful stuff. And
12 then when we go through the process of seeing
13 what we missed, and what we did wrong, and
14 criticizing it, we'll, inevitably, pick up
15 some stuff that we goofed on.

16 DR. BURSTIN: Can I just ask maybe
17 a question a slightly different way for the
18 group? Going back to the question I was
19 trying to ask John. So, what are those sites,
20 that if you said boy, SREs really need to
21 expand, or services, SREs really need to
22 expand, you think are ripe for serious

1 reportable events. Let's start with that,
2 maybe, and work backwards, rather than
3 starting from the list.

4 MEMBER VICTOROFF: Physician
5 offices.

6 MEMBER MORLEY: I just want to say
7 thank you. You just said exactly what I was
8 going to say.

9 DR. BURSTIN: Well, tell me the
10 answer.

11 (Laughter.)

12 MEMBER MORLEY: You know, one
13 question for the group, asking the same issue
14 a different way, is do you really want to
15 start coming up with a list for all 10 of
16 these at the same time? And I'm thinking if
17 we picked a few and start, there'd be lessons
18 learned from those few that you would then
19 apply going forward. And each one would
20 subsequently go a little bit smoother, in
21 terms of its initiation.

22 As I was saying before, I mean, New

1 York has an office-based surgery program. I
2 would like to see that started at a national
3 level. I would like to see dialysis
4 facilities. There's a few other things that
5 while I'd like to see them, maybe 2011, as
6 opposed to 2010, seeing dialysis and office-
7 based surgery, ambulatory surgery type things.

8 MEMBER BRENNAN: Helen, this is
9 P.J.

10 DR. BURSTIN: Yes, go ahead.

11 MEMBER BRENNAN: From my
12 perspective, representing the ID society and
13 healthcare epidemiology, there is significant
14 interest in the ambulatory practices,
15 including physicians' offices, ambulatory
16 surgical centers in terms of infection control
17 hazards that are created in those areas. And
18 HICPAC is going to be working on culling
19 evidence-based guidelines, evidence-based
20 practices from existing guidelines, and trying
21 to apply them to those areas, and to pull
22 together some guidance. So, there have been

1 a number of outbreaks recently that have been
2 related to practices that just seem to fall
3 outside of regulation in these areas, either,
4 in part, because they're not regulated, or
5 because they're seldom visited by CMS
6 surveyors. So, I think that, from our
7 perspective, ambulatory surgery, dialysis, and
8 physician practices are important places.

9 DR. GANDHI: This is Tejal from the
10 phone. I would completely agree with those
11 areas, particularly, the physician offices,
12 and ambulatory surgery. And then the only
13 other one I would probably throw in there,
14 just based on if we're trying to be a little
15 more evidence-based, I mean, there's been a
16 lot of stuff about the skilled nursing
17 facilities, and issues there with some of the
18 stuff that Jerry Gurwitz has done, so I think
19 that might -- if we were limiting it to three
20 or four, I might throw that one, as well.

21 CO-CHAIR TYLER: Stan.

22 MEMBER RILEY: I guess the only

1 thing I'd add from my wish list, besides the
2 things that have already been spoken about, is
3 infusion centers, which are sort of completely
4 on a different level, you know, cancer
5 infusion centers, primarily, that we see sort
6 of the Wild Wild West. You know, there's not
7 any real reporting for them, and we don't know
8 exactly what happens there.

9 CO-CHAIR TYLER: Cynthia, then
10 Martha.

11 MEMBER HOEN: From a hospital
12 perspective, I know that we feel put upon that
13 we're more highly held to standards than the
14 ambulatory surgery centers, the urgent care
15 centers, and the doctor's procedural offices.
16 So, I would put in my vote for those things,
17 as well.

18 MEMBER RADFORD: I'd actually like
19 to put a vote in for weighting on dialysis
20 centers, because they are pretty heavily
21 regulated, and they do have a reporting system
22 around certain things that happen, not

1 everything. And maybe that's the next --
2 that's the wave after the next wave.

3 CO-CHAIR TYLER: Eric.

4 MEMBER TANGALOS: Even though I
5 would separate hospice and palliative care in
6 its own universe, I wouldn't focus there. I
7 know the science is almost non-existent, so
8 it's not -- science is very poor in hospice
9 and palliative care. It is not matured.

10 MEMBER RYDRYCH: I would agree with
11 that, and I would say I think we're biting off
12 plenty just trying to deal with a couple of
13 higher priority areas, and not getting into
14 hospice and palliative.

15 DR. ANGOOD: So, sorry to jump in.
16 We seem to be gravitating on office-based
17 surgery/ambulatory surgery centers, dialysis
18 with Martha's caveat, physician offices, and
19 perhaps SNFs. Can we just sort of take a hand
20 poll on that one, and then -- what I'm trying
21 to get us towards is to actually think of a
22 secondary list that we would put into the

1 pipeline, because I'm trying to anticipate the
2 discussions with HHS, in terms of well, here's
3 our expanded term of SREs, the definition.

4 Here's our revised list. Here's our tiering
5 approach to where the priority environments
6 need to be, because that's kind of how they're
7 approaching us with this. So, the first step
8 is office-based surgery/ambulatory surgery
9 centers, dialysis, physician offices, and then
10 SNF.

11 CO-CHAIR TYLER: I thought we had
12 said long-term care settings, broadly, and
13 SNFs would be under that. So, is that -

14 DR. ANGOOD: I was just reacting to
15 somebody's comment here a few moments ago.

16 CO-CHAIR TYLER: Okay. I thought
17 we were still focusing on -

18 MEMBER TANGALOS: I think the
19 science and the information is going to be
20 best in SNFs, so you can -- I don't see any
21 problem with still labeling it the whole
22 thing, and then bringing it down just to SNFs.

1 Representing the SNF, that universe, we are
2 delighted that NQF is interested in that
3 universe. I don't know about the other
4 parties, but we think it's neat that NQF is
5 interested.

6 DR. ANGOOD: We are making a
7 concerted effort to be neat.

8 MEMBER TANGALOS: Right.

9 (Laughter.)

10 CO-CHAIR TYLER: Doron.

11 MEMBER DORON SCHNEIDER: So, this
12 may take us back to the original list, but
13 there's increasing need and use for home care.
14 I mean, that is going to be where most of our
15 care is going to be occurring in the future.
16 The doctor's visits occur once a quarter, the
17 home care, the frequency of visits are going
18 to go up, and they're going to be a major
19 piece of how we're going to reduce re-
20 admissions. There's many error types that
21 occur that overlap there, everything from
22 mistubing, misinfusions, misadministration,

1 you know, of medications, et cetera. And for
2 us to not have that on the list, I think is an
3 oversight.

4 DR. ANGOOD: Well, it's a good
5 point, and I guess it'll be a matter, well,
6 how many do we have on our primary list, and
7 how many do we have on the secondary list.
8 And everyone is always going to have a
9 favorite, or a least favorite. So, if we
10 could, you know, you're not going to be held
11 accountable to it in the long-term, but why
12 don't we just do a little straw poll here on
13 those four items that we listed.

14 MEMBER VICTOROFF: I hate to do
15 this. Could I propose we vote individually
16 and count the votes for each one individually?

17 DR. ANGOOD: That's fine, too.

18 MEMBER VICTOROFF: Because that
19 would teach me something.

20 DR. BURSTIN: Let's look at this,
21 make sure we have the list. So, it's
22 ambulatory care including physician offices,

1 and outpatient facilities. I think that was
2 one of them, clearly. Then there was
3 ambulatory care surgery and procedure-based -

4 DR. ANGOOD: Office-based surgery.

5 DR. BURSTIN: And office-based
6 surgery. Those were surgical, but more
7 outpatient oriented. Infusion centers was
8 listed. I'm not sure where that would live.

9 DR. ANGOOD: That was a secondary
10 list.

11 CO-CHAIR TYLER: That would be
12 number two.

13 DR. BURSTIN: That goes on
14 secondary? Okay.

15 DR. ANGOOD: Yes.

16 MEMBER VICTOROFF: Phase two.

17 DR. BURSTIN: Phase two. And then
18 long-term care, and home health are the ones
19 that are currently on the table. Yes?

20 DR. ANGOOD: Dialysis.

21 DR. BURSTIN: We moved dialysis,
22 got moved to - they already moved it. Yes.

1 I thought you guys already moved dialysis -

2 DR. ANGOOD: Well, that was

3 Martha's comment. I'm not sure the rest of

4 the group was with Martha. Well, let's take

5 Mike's approach then. Sorry, we kind of

6 jumping on you here, but we're trying to

7 anticipate our interaction with HHS, I think,

8 and that is -- so, let's go one by one, and

9 just a straw poll. And if something falls off

10 the -

11 MEMBER RADFORD: So, we're voting

12 on -- this is the first tier. Is that right?

13 DR. ANGOOD: First tier, yes. And

14 then after we finish this, we'll try to get to

15 a second tier.

16 MEMBER RILEY: And how many votes

17 do we get?

18 (Laughter.)

19 DR. ANGOOD: Each item, one time.

20 Okay?

21 DR. BURSTIN: But I think it's okay

22 for us, I mean, one of the possibilities, the

1 question is, do we really need a technical
2 panel on hospitals, if that's sort of the
3 collective group here. So, one idea might be
4 to jettison the idea of a TAP on hospitals,
5 instead, think about technical panels in these
6 specialized areas where we need the expertise.
7 So, don't vote for hospitals.

8 DR. ANGOOD: So, office-based
9 surgery/ambulatory surgery centers. Who sees
10 that as an important one?

11 (Vote taken.)

12 DR. ANGOOD: And on the phone?

13 MEMBER LAU: Yes, this is Helen.

14 DR. ANGOOD: Okay. That's a strong
15 yes.

16 DR. GANDHI: Yes from Tejal.

17 DR. ANGOOD: Okay. Thank you. And
18 then we had physician office -

19 MEMBER BRENNAN: Yes from P.J.

20 DR. ANGOOD: Thanks, P.J.

21 Physician offices, and ambulatory care. We've
22 got a strong positive in the room. On the

1 phone?

2 MEMBER LAU: Yes from Helen.

3 DR. GANDHI: Yes from Tejal.

4 MEMBER BRENNAN: Yes from P.J.

5 DR. ANGOOD: Okay. Thank you. And

6 then we had dialysis centers, although, Martha

7 made a comment that they're already pretty

8 well regulated. Who would like to have

9 dialysis on this primary list? Less popular.

10 Okay. Anybody on the phone want it? Hearing

11 none. Martha, you're a strong influence. I'm

12 just teasing.

13 All right. That takes us to a

14 fourth item, which would be long-term care

15 with focus on the SNFs. Strong positive for

16 that in the room. And on the phone?

17 MEMBER LAU: Yes from Helen.

18 DR. GANDHI: Yes from Tejal.

19 MEMBER BRENNAN: Yes from P.J.

20 DR. ANGOOD: Okay. Thanks. So,

21 that gives us three groups to get started on.

22 Office-based surgery/ambulatory surgery,

1 physician offices, and ambulatory outpatient
2 care, and then long-term, and SNFs, with a
3 focus.

4 CO-CHAIR TYLER: I have a question.
5 Where -- I mean, it seemed like there was a
6 lot of consensus around home-based care, but
7 that's not on your list at all now. There
8 seemed to be much consensus on that, I think.

9 DR. ANGOOD: I was just sort of -
10 I know there was a lot of discussion.

11 MEMBER TANGALOS: Well, that's a -
12 I mean, it's a huge area, but, again, if
13 you're going to do some data mining and look
14 at the science, there's nothing there.

15 MEMBER RYDRYCH: I don't think
16 we're ready to go there, yet.

17 MEMBER TANGALOS: No.

18 CO-CHAIR TYLER: So that would be
19 parking lot, along with -

20 DR. ANGOOD: Secondary, yes.
21 Sorry. On the phone, there's lots of
22 mumblings off microphone here, and basically

1 everyone is accepting that home health is
2 important, but the science isn't quite there.
3 And, perhaps, we should put that on our next
4 wave of activity. I'm seeing a lot of heads
5 yes in there.

6 CO-CHAIR TYLER: Cynthia, you had
7 a comment?

8 MEMBER HOEN: Yes. Just with
9 respect to the physician offices, I agree,
10 that's a good thing to look at, but I would
11 ask that the TAP group also look at the
12 feasibility of those physicians implementing
13 anything that was recommended, because I think
14 that's going to be a very -- point of
15 contention and discussion.

16 DR. ANGOOD: Yes. My sense would
17 be a galvanizing statement from NQF, but not
18 easily implementable in terms of actually
19 getting stuff.

20 MEMBER DORON SCHNEIDER: Can you
21 please clarify what the second tier would
22 bring us? Home health care, I agree, there

1 may not be science there, but we, I think,
2 have an opportunity to understand what's
3 occurring there, by having reportable events.
4 If you have somebody in the home that is
5 misadministering medications, or putting the
6 tube feed into the IV line, or these kinds of
7 things that we're talking about, and we're not
8 really asking for reporting of these serious
9 events, there's an opportunity lost, I think.
10 So, what does it mean, actually, if it goes to
11 tier two?

12 DR. ANGOOD: Well, I think we have
13 to be careful about not, necessarily,
14 prioritizing, per se. You know, if we think
15 about those -- we started with a list of 10
16 from CMS as environments of care. We've gone
17 around, we've come up with three areas that
18 people think are good areas to get started for
19 a combination of concern, evidence, and
20 potential to try and create some important
21 change for improving quality.

22 The second, I would rather than

1 tier or class, it would be more of a second
2 wave, saying that let's get started on this
3 grouping, and then look for ways, as we get
4 better experienced with this, to then roll out
5 the next wave of environments, which would be
6 whatever we choose, home health, et cetera, et
7 cetera. That's my view on where the group is
8 at, but there's other opinions.

9 MEMBER GOESCHEL: Could I ask a
10 question about the feasibility of NQF staff,
11 I'm going to say even beginning for these next
12 wave, to begin to do some data collection. I
13 mean, I'm struck by our questions earlier
14 today to say how many states collect a report?
15 I mean, even to begin to do some of the
16 footwork on home health, what kind of data is
17 collected? The regulations are very different
18 state-to-state. I'm just wondering if it could
19 be on the list with the understanding that the
20 work that will be done right now is going to
21 be background work to help us get what we need
22 to determine what SREs would like that.

1 MEMBER RYDRYCH: Well, I think we
2 even need some of that on the first tier
3 groupings that we identified, because for
4 physician offices, and we don't even know
5 where they all are in our state. Just a
6 question, too. I mean, we know each physician
7 is licensed, but we don't know what all the
8 clinics are. They're not licensed separately,
9 so we don't even know what the universe is.

10 And just a question. So, inpatient
11 hospital is kind of the status quo group that
12 we already have. Is there a TAP that's
13 getting together to talk about the expansion
14 or modifications to the existing list for
15 hospitals, separate from these other groups
16 then?

17 DR. ANGOOD: You did that yesterday
18 and today.

19 MEMBER RYDRYCH: Right. But wasn't
20 there also going to be -- because we've sort
21 of just raised some of the issues, but we
22 haven't really fleshed any of them out.

1 DR. ANGOOD: Right. But that will
2 -- we kind of ran the list yesterday, and
3 today, and if we can get through this part of
4 the discussion this morning, we were hoping to
5 brainstorm a little bit on other potential
6 ones for the SRE list, which could be mostly
7 on the hospital setting.

8 DR. BURSTIN: Does the group feel
9 like a hospital TAP would be helpful?

10 MEMBER RYDRYCH: I just wasn't sure
11 if there was additional work beyond that kind
12 of initial brainstorming that we had done that
13 needed to happen with inpatient hospital, as
14 well.

15 DR. BURSTIN: There is, and the
16 question is, are you comfortable that you're
17 the group that will do that?

18 CO-CHAIR TYLER: And, Doron, I just
19 wanted to close the circle with you, a little
20 discussion about what would happen with that
21 secondary tier, putting home health on. Is
22 that satisfactory to you, or you think -

1 MEMBER DORON SCHNEIDER: In 2002,
2 then 2006, then 2009, so if you're in second
3 tier, does that mean 2012 for the next
4 environment, or are we moving to more of a
5 annual review for the additional environments,
6 or is it going to be a three-year cycle, or is
7 that not determined? And maybe I feel too
8 strongly about the home care, and wanting to
9 know what's going on there. I just -- I know
10 that services that are rendered there are
11 going to just go through the roof over the
12 next decade, and we don't know what's going on
13 there. And I know, we all know that harm is
14 being committed there, and it's just an
15 opportunity.

16 DR. ANGOOD: I think the short
17 answer is, it's not been determined, because
18 we wanted to see how the deliberations of this
19 group started, and it's up to this group to
20 sort of drive that future direction. We have
21 historically done an every three-year
22 maintenance update, but we have moved into an

1 annual update cycle for the Safe Practices.
2 Again, as Helen said, these SREs are NQF's, so
3 we can move them along in new directions, if
4 this group feels that's important.

5 CO-CHAIR TYLER: Martha.

6 MEMBER RADFORD: I'd like to -- we
7 have two definites here, the outpatient
8 procedure venues, and the long-term care
9 venue. And I did not vote for physician
10 office venues, because I just feel like the
11 feasibility issues are just too massive.

12 I'd like to offer that if we're
13 going to do a third one, it should be home
14 health, for the very reasons that Doron has
15 outlined. It'll be a challenge, both of them
16 would be challenges.

17 CO-CHAIR TYLER: I want to offer up
18 something, and also maybe get some
19 clarification/feedback. Because we use them
20 as though they're interchangeable, the terms
21 home health, and home and community-based
22 services, and they're not at all, not the way

1 they're being used now. So, in my way of
2 thinking, because we have a lot of workforce
3 involved in this, so this is -- but, I mean,
4 home health, visiting nurses, they do wound
5 care, whatever. Home and community-based is
6 so much broader than that, includes a lot of
7 just personal care services that don't fall
8 into healthcare and medical, although they may
9 be Medicaid reimbursed. So, that blurs the
10 lines. Also, these terms home and community-
11 based setting doesn't necessarily mean someone
12 is in their own home. That's so much broader.
13 It includes group homes, it includes very,
14 very small ICFs, and up to 16 could be
15 considered community-based services. So, it's
16 very broad, both in the services, and in the
17 settings. So, if we adopt that, we need to be
18 clear that we're looking at a pretty big range
19 there. And I just want to know, is that what
20 people are thinking about, or are you thinking
21 more of home health, rather than home and
22 community-based services?

1 MEMBER TANGALOS: Well, Sally, the
2 same might apply, you might disagree, that
3 just as we've put a bigger umbrella under
4 long-term care settings, and we will focus on
5 SNFs, you could argue that home and community-
6 based services would have within it, home
7 health services, and focus only on that.

8 In fact, I'm not convinced the data
9 is there, either, but it might be a better
10 challenge, and it might be more worthwhile
11 than the ambulatory care sites.

12 DR. GANDHI: This is Tejal from the
13 phone. I just would put in a plug for the
14 ambulatory practice sites. I think the vast
15 majority of care is given in those sites. I
16 think we have pretty good data, compared to
17 some of the other sites, in terms of what the
18 issues are. So, I just think that has to be
19 one of the things that was on this list in
20 terms of -- I mean, we know there's lots of
21 serious issues going on in those practices,
22 and they're a private site. Of all the sites

1 we've talked about, that's probably the site
2 with the most data to kind of back that up.

3 DR. ANGOOD: Okay. That's good.

4 So, we'll keep going around, but I just want
5 to offer a comment based on what Eric was
6 suggesting, and that is, maybe it's sort of
7 ambulatory with a focus on, maybe it's home
8 health, or home care settings with a focus on,
9 home care, long-term care with a focus on,
10 SNFs, that kind of an approach. So, we're
11 getting lunch delivery here, so I'll help
12 Sally get re-engaged, so why don't we just go
13 around the table, Leah, then Cynthia, then
14 Diane and Mike.

15 MEMBER BINDER: Well, I wonder if
16 one criteria we should use to think about
17 what's in the first tier is the level of
18 potential harm to the patient, and their
19 vulnerability to that potential harm. That's
20 why home care sounds very compelling to me,
21 especially after Doron's comments. Because
22 that is in a setting where serious adverse

1 events could do a lot of harm, and there's
2 very little oversight between the clinician
3 and their direct relationship with the
4 patient, so the patient is particularly
5 vulnerable if something happens. So, it would
6 strike me as a stronger need for reporting,
7 than maybe others. And I think that might be
8 one thing we should at least consider in
9 thinking through what's the tiering.

10 MEMBER HOEN: Leah, I agree with
11 you, and I also agree with Doron, but I'm kind
12 of on Chris' page. We've just started
13 collecting data with respect to our home care
14 services, and whether it's for profit or not-
15 for-profit, and we're finding some fairly
16 disturbing things, sometimes. But I don't
17 have enough data to even begin to carve out
18 what we should be concerned about, so I don't
19 know if this Committee could make a
20 recommendation that those areas start
21 collecting data on at least A, B, C, and D,
22 and prepare to report on them the following

1 year, or something like that, so that that
2 could be fleshed out more, because I suspect
3 we don't have a lot of information. But I
4 think it's very, very prime for question.

5 MEMBER LAU: Talking about that,
6 this is Helen on the phone. I see one
7 suggestion is the home care and hospice area.
8 There's a lot of shortage out there in
9 clinician providing those care, and a lot of
10 time it's delay in service. And that might
11 even cause an unnecessary readmission to the
12 hospital, so if we are looking at getting more
13 data on that, on harm -- and I think one of
14 that could be even on the timeliness on
15 starting those services.

16 CO-CHAIR TYLER: Helen, what was
17 your last suggestion? You thought that one of
18 them might even be what? I didn't hear the
19 end. Sorry.

20 MEMBER LAU: The timeliness in
21 starting the service, so you could have a
22 hospice patient should go to hospice, and

1 because of lack of clinician, they couldn't
2 start the service early, and patient end up go
3 back to the hospital.

4 CO-CHAIR TYLER: Okay. Thank you.

5 DR. BURSTIN: I was just going to
6 say, I mean, there are all kinds of ways for
7 us to stage this work. I think we've now heard
8 what's most important, but there's no reason,
9 for example, when we write the call for
10 events, we can't be very broad-based and say
11 these are the potential areas of interest. If
12 we get in 15 suggestions related to home
13 health, we might think differently than we do
14 right at this moment, so I'm not sure we need
15 to necessarily decide that right now.

16 The other thing is that you may
17 have some of the existing SREs that you'd
18 still feel comfortable that they be applicable
19 to a dialysis facility, even if you didn't,
20 necessarily, bring in dialysis facility-
21 specific events. So, I think there -- you can
22 kind of play it from both sides. And I think

1 we might be able to expand the sites to which
2 the existing SREs apply, even without,
3 necessarily, creating a whole new set of SREs.
4 And I think we could stage this to make that
5 work.

6 CO-CHAIR TYLER: Martha, then
7 Michael.

8 MEMBER RADFORD: I was just going
9 to put a plug in for Michael's grid. And if
10 we start to build that grid, then we'll know
11 where we need to go, I think.

12 MEMBER VICTOROFF: Okay. And
13 talking to you from the depths of the grid, I
14 want to reassure people who are nervous about
15 the potential for useful work in the office
16 environment, in this way, using the three Is
17 I've been quoting over and over again, I
18 believe that I can identify the top five or
19 ten injuries and events, and hazardous
20 procedures that occur in the office
21 environment, in terms of importance, using our
22 own claims data, looking just at lawsuits, and

1 claims that arose because there was a major
2 injury. Fifty-four percent of all of the
3 losses were outpatient in our company, and in
4 CRICO, and RMF, and other companies; whereas,
5 fewer of them were inpatient. And that's in
6 dollars, as well as in numbers. Our big
7 losses are all happening in offices, mostly.

8 MEMBER RADFORD: Is that office-
9 based procedures or offices?

10 MEMBER VICTOROFF: No,
11 unfortunately. And about 54 to 55 percent are
12 cognitive errors, as opposed to procedural
13 errors, and we can debate those. And then the
14 third I is intervention. I mean, is there
15 evidence that we know what to do, and the I
16 could tell you five or six things that I think
17 have at least tentative support in evidence as
18 being effective ways to remediate, mitigate,
19 or prevent those kinds of office-based errors.
20 So, I think there is science. Although, I'm
21 aware that not every state works the same way,
22 and this data is only coming from a few

1 pockets right now. But I think it's more than
2 enough to get started with.

3 And the one thing that I'm prepared
4 to defend strongly, is that the big problem is
5 in offices. And home health care, yes, there
6 will be a future quagmire, but it isn't now.
7 The deaths, and horrors, and miseries, and
8 problems that are rising to the level of
9 injury, harm, and urgency are happening in
10 offices more than homes, or even dialysis
11 centers, for that matter, because we insure
12 all those guys, and we kind of know who's
13 goofing up.

14 DR. GANDHI: This is Tejal on the
15 phone. I completely agree with that.

16 MEMBER RILEY: I was just going to
17 say, even though CRICO and RMF have data, they
18 have their own insurance data. As a reporting
19 state, we don't have any data from offices in
20 terms of what happens there, so it's a captive
21 population for RMF, and we don't have any idea
22 of what's actually going on there.

1 MEMBER VICTOROFF: We'll show you.

2 It's not hard.

3 CO-CHAIR TYLER: We may have
4 brainstormed our list on this. There's some
5 discussion, huh? Pretty satisfied with where
6 we are? Make sense, at least, in the
7 beginning? Okay.

8 DR. ANGOOD: Are we all on the same
9 page up here, Helen? Helen and I have good
10 strong opinions, but not always the same.

11 DR. BURSTIN: Yes, not always the
12 same ones. There you go. Although, you did
13 teach me that I could get monovision for my
14 near -- it is quite spectacular, so there you
15 go. Very helpful piece of information this
16 week.

17 DR. ANGOOD: I'm mollified that you
18 are teachable.

19 DR. BURSTIN: I am teachable.
20 There you go. I just find myself thinking
21 that it's probably time to think through some
22 next steps. And I think we've sort of reached

1 a point where maybe that would be useful. And
2 I have a few, and I assume you have a few, but
3 if you want me to start, I'd be happy to
4 start. Okay.

5 DR. ANGOOD: Yes, why don't we just
6 synopse, do this and -

7 DR. BURSTIN: Just one thought I
8 had, is I think that we're probably ready to
9 create the call for SREs broadly based on the
10 definitions you've given us, so I think one of
11 the next things we'll do is create a draft of
12 call for SREs, comments on existing SREs, as
13 well as call for new SREs. It will be very
14 broad-based in terms of environments of care.
15 We could potentially indicate the ones that
16 people -- the Committee indicated were highest
17 here, but not, necessarily, limit ourselves to
18 that.

19 I think we can create the Michael
20 grid, the SRE list, and send it to you with
21 the environments of care kind of listed out,
22 and ask you to, perhaps as a Committee

1 exercise, populate the ones you think
2 logically could be expanded to other sites of
3 care. And then I think we'll do the call, see
4 what we get in. And I think, at that point,
5 it might be the better time to think about
6 what are the expansion technical panels we
7 want to pull in for new SREs, and new settings
8 of care. I think we probably at least got two
9 or three of them for sure, but if there's four
10 or five that fit, we'll make it work.

11 DR. ANGOOD: Yes, I tend to agree
12 with what Helen just described. You know, we
13 could spend the rest of the afternoon teasing
14 out the environments, who's got which
15 priorities, and why nots, and all that sort of
16 stuff. But I think, as outlined, that was
17 pretty close to where I was thinking, as well.
18 The group has done terrific work in this day
19 and a half. It's given us good, I think,
20 focus, more focus than I had anticipated. So,
21 setting up the call, whether it's a matrix or
22 a grid, or whatever, it suits my bias, as

1 well.

2 We'll get that circulating
3 electronically for your guys' inputs and
4 further ideas, as you think about it further.
5 We'll discuss more in terms of the TAPs, and
6 we'll get that communicating to you, as well.
7 And we shall set up for some follow-up phone
8 call in the next month to six weeks, so that
9 we don't get too far past your guys' thinking.
10 And this is an 18-month process. We've got
11 built into the plan a number of phone calls,
12 obviously email is always there, and as we get
13 the ideas firmed up, I think that'll really
14 drive us in terms of putting the expansion, or
15 the maintenance document on the SREs together.
16 It'll give us opportunity to set up the
17 messaging within that document where the field
18 will need to go to in all of this.

19 CO-CHAIR TYLER: I think Leah has
20 something she wants to add.

21 MEMBER BINDER: It is a question,
22 when you say call, you mean call to the

1 membership, or just for us? You said you were
2 going to put out a call -

3 DR. ANGOOD: It would be both. It
4 would be both, because this group will
5 generate their own ideas. And we may have -

6 we're fast running out of time, but maybe we
7 can do through it Survey Monkey, or something
8 like that, solicit your other ideas for the
9 existing SREs, see how that comes. But we had
10 talked about, also, doing an open solicitation
11 for ideas to see what comes in there.

12 MEMBER BINDER: Okay. If there's
13 an open solicitation, I would just request, as
14 well, that we talked earlier about having the
15 revised definition of SREs -

16 DR. ANGOOD: That would be out
17 there.

18 MEMBER BINDER: -- put out as part
19 of the call to get comment.

20 DR. ANGOOD: Yes.

21 MEMBER BINDER: Thanks.

22 CO-CHAIR TYLER: Doron.

1 MEMBER DORON SCHNEIDER: This kind
2 of work, in my opinion, is -- could be
3 accelerated if we use some virtual workspace
4 kind of environments, whether it's Google
5 Documents, or there's other methodologies to
6 really see changes as they occur, the thread
7 of discussions. I sometimes get lost in
8 emails where documents are sent, and then it's
9 not the latest version, and versioning
10 control. And I don't know if NQF has embedded
11 within your website that kind of a workspace,
12 but this would, ideally, happen within a
13 workspace that we can log into, and see the
14 documents, see Michael's latest revision, or
15 my comment, or your comment, and kind of build
16 off of that. It will make the phone calls all
17 that much more productive. I just throw that
18 out there.

19 DR. ANGOOD: Sorry, we have moved
20 to a new platform, and we do utilize Google
21 Docs as one of the platforms. So, I certainly
22 agree with you that having kind of your own

1 little environment in space to hang out on
2 electronically, and go look whenever we pulse
3 you to go check, is the way to go. So, we'll
4 work on that. A combination of the electronic
5 forum, and the phone calls will be helpful.

6 Other suggestions, comments,
7 feedback on this day and a half? I always
8 think it's important to get your feedback on
9 how this worked for you, and to get some ideas
10 as to how it might work better. I think
11 Doron's idea is a good one, but others?

12 CO-CHAIR TYLER: I have a question
13 for the group, actually. How are you all --
14 have you been thinking about, and do you have
15 any specific mechanisms, if you -- those of
16 you who do feel that you have constituencies
17 you have to answer to, or try to involve in
18 this, to go back and involve them, or are you
19 doing anything like that? If so, what? What
20 are you doing? Anybody. Michael is nodding
21 his head.

22 MEMBER VICTOROFF: Well, I end up

1 being, inadvertently, in a lot of professional
2 and social networks, so I have gossiped to
3 everybody about gee, we're going to go over -
4 you know that NQF thing, and that horrible
5 list of stuff, and you have - now is your
6 chance, because they actually let me in, and
7 I can talk. So, I not only informally, but
8 formally have solicited opinions from people
9 I consider authoritative, and informed. And
10 I'll be bringing those. As soon as we have
11 whatever, the groupware site that helps that,
12 I'll be able to even give you sources and
13 footnotes for people that really had a message
14 that is valuable here.

15 MEMBER TANGALOS: I've already met
16 with the American Geriatric Society Quality
17 Group, which I'm on, and we've discussed this
18 process, and we've had other members on other
19 NQF activities, as well. So, they're very
20 supportive. It will show up in the
21 newsletters for them. It'll also show up in
22 the newsletters for the American Medical

1 Directors Association. There's an extra added
2 benefit, because of the relationships there,
3 too. And if something shows up that needs
4 membership review, the reason I'm here is
5 because I'm good enough at figuring out what
6 they need to know about, and let them know.

7 DR. ANGOOD: And that's exactly why
8 you folks have been chosen, in part, not only
9 just for your expertise, but for your
10 secondary networks for us to get -- this is
11 not a bunch of smart people with their own
12 personal ideas. This is all about open
13 transparency, and full inputs, as broad-based
14 input as we can get. Chris?

15 MEMBER GOESCHEL: I have one
16 question, and thank you for that, obviously,
17 connected to lots of networks, both across the
18 country as part of the HAI work that we're
19 doing, but also internationally in terms of
20 some work on reportable events, and the
21 National Health Service, where we'll be in
22 December doing some of this very same kind of

1 conversation. But one of the things I was
2 going to ask as my first committee, is how
3 quickly will we get documents relative to the
4 changes that we've suggested today, because as
5 a newbie to this, I've taken notes, but I have
6 been much quieter than I typically am, to just
7 try to take this all in. And I want to speak
8 the truth about what happened, not what I
9 remember in my head.

10 DR. ANGOOD: Yes, in general, we
11 are pretty good with our turnarounds. We have
12 fairly rigid processes in terms of all of our
13 meetings. We get the transcripts back. We
14 review the transcripts. We put meeting
15 summary notes usually within a week to ten
16 days.

17 DR. BURSTIN: And the actual
18 transcript will be posted, as well.

19 DR. ANGOOD: Yes. Other comments,
20 other feedback, things we need to do better
21 for you? It looks like people are hungry, and
22 -- go on.

1 MEMBER MORLEY: I will be talking
2 with -- I work closely with different
3 associations back in New York. We'll be
4 talking to them, as well as hospital medical
5 directors. I want to thank you for getting us,
6 for allowing me and us to participate. This
7 has expanded all of our networks, and I'm
8 particularly happy that you've shared
9 addresses, and so forth, on the information
10 you provided. So, we've already connected in
11 a number of areas, and I'm sure we're going to
12 be connecting on a number more going forward.
13 Thank you.

14 DR. ANGOOD: All right. I think
15 that about wraps it up. Any other comments
16 from folks on the phone before we close out?
17 Hearing none, thank you folks who are on the
18 phone for bearing with us, appreciate all your
19 inputs, and look forward to the ongoing
20 documents. And, as I said to everybody here,
21 thank you so much. This has been exceptional
22 work. This group has come together very

1 quickly, and we appreciate that. So, more to
2 follow, and safe travels home.

3 MEMBER BRENNAN: Thank you.

4 MEMBER LAU: Thank you.

5 DR. ANGOOD: All right, everybody.

6 Bye.

7 (Whereupon, the proceedings went
8 off the record at 12:16 p.m.)

9

10

11

12

13

14

15

16

17

18

19

20

21

22

A				
abandoned 62:13	act 10:19 168:13	adherence 77:5	agree 14:22 19:14	158:11
abandoning 11:5	action 30:4 66:16	ADJOURN 3:22	20:8 26:14 28:4	alternate 20:16
abduction 163:11	115:20 116:11	administer 76:3	29:5,16 31:20	24:3
164:4,5 166:8	125:13 144:9	administered 74:7	46:7 47:6 56:9	alternative 18:11
ability 94:18	actionable 200:19	74:9 86:13 187:16	60:6,22 62:2 66:8	23:5
able 8:18 16:21	actions 30:6 168:20	193:20	84:15 88:21 90:12	Alzheimer's 174:2
37:10,13 67:4	actively 90:21	administering 78:8	92:17 93:5 110:18	ambiguity 151:1
85:10 111:18	activities 65:19	82:6	122:6 126:2 128:7	ambiguous 23:12
114:2 115:11	171:17 172:5	administration	132:8,15 133:4,9	ambivalent 176:1
154:20 164:3	245:19	73:16,20 76:11	136:9 148:14	ambulatory 3:14
173:18 194:2	activity 169:15	89:6 148:6	152:17 153:17	7:11 69:8 143:15
235:1 245:12	171:6 222:4	administrative	173:1 176:10	186:20 187:9
ABO 89:6,11	actual 41:17 112:7	19:9	179:11 211:10	188:5,20,22 191:7
absence 30:4	141:15 180:15	admissible 42:16	213:10 222:9,22	192:12,13,19,19
absolutely 14:12	247:17	admission 109:10	232:10,11 237:15	193:5,7,18 194:13
16:12 36:9	acute 91:14 162:6	109:13,20 110:13	240:11 243:22	195:7,12,15,18
abuse 171:10	195:22 196:10	110:16 111:21	agreed 51:4 53:16	198:10,12,15
abuses 21:17	add 28:13 69:13	admissions 215:20	56:7 57:16 58:14	201:4,20,22
accelerated 243:3	83:14 84:5 89:9	admit 116:20	65:10 152:16	202:15 203:18
accept 15:18	109:4 121:6 125:7	adopt 229:17	agreeing 81:12	204:6,13 205:2,19
111:12,18	145:8 156:7	advance 53:8	AGSF 2:10	206:2,3,11,13
accepted 111:14	164:20 196:17	Advancement	ahead 119:22	210:7,14,15 211:7
accepting 222:1	198:6 212:1	10:19	177:16 210:10	211:12 212:14
accident 175:10	241:20	adverse 8:6 23:12	air 35:8 140:19	216:22 217:3
accompaniment	added 55:16,21	40:7 51:20 54:19	airline 9:7 12:13	219:21 221:1
110:2	58:4 91:11 150:18	55:7,9 68:21	35:3,3,17 36:16	230:11,14 231:7
accompanying	246:1	108:22 131:15	airlines 35:10	American 245:16
56:12	adding 32:4 39:22	149:21 150:1	airway 131:19	245:22
accomplish 206:9	41:8 44:3,6,8 49:1	200:2 231:22	alarming 144:8	amniotic 91:13
account 58:3	67:13 89:11 123:1	advise 189:11	alcohol-based	amount 11:21 39:5
accountability 19:9	addition 78:19	Advisor 3:4,6,19	143:9	89:21 141:11
27:11 28:18 54:22	81:13 110:20	advisors 189:11	alerts 79:13	174:7 179:22
accountable 28:11	121:4 126:22	advisory 3:5 7:4	align 66:4	analogy 35:3
216:11	152:11	182:12 206:2	alleged 169:2	analysis 83:22 92:1
accreditation 193:1	additional 15:8,8,9	affirmation 56:6	allegedly 166:19	132:2 158:3
accuracy 13:5	31:18 76:5 125:2	afternoon 240:13	170:15	analyzed 83:17
accurate 13:4	226:11 227:5	age 163:12	alleges 170:13	and/or 54:16
accusatory 20:11	additions 77:17	agenda 6:16 24:8	allergy 73:21 75:11	anesthesia 131:18
accused 16:6	address 17:16	32:18 66:6 72:19	allow 25:1 39:15	198:16,20
acknowledge 14:13	36:20 80:12	120:8 123:20	97:18 111:2 149:4	anesthesiologist
acquired 1:3 59:15	165:12	177:18 178:2	177:8	44:19
62:8 63:5,12 65:5	addressed 139:7	179:1 181:6	allowed 83:14	Angood 2:11 3:4,6
67:1,5 68:4,5	174:6	aggressively 28:14	188:2	3:19 5:2,2,15,18
109:10	addresses 248:9	ago 33:6,17 103:13	allowing 248:6	6:15 8:16 10:9
acquired/healthc...	addressing 50:7	103:14 117:16	allows 39:1 43:15	11:13 12:16 13:7
67:14	adds 58:22 60:20	168:18 199:6	167:12	15:2 16:2 17:18
	adequate 162:21	214:15	alphabetizing	26:2 52:14 53:13

56:15 57:11,13 59:12 63:1,19 65:16 66:7,21 68:1,15 72:6,10 72:15 87:11,18 88:21 89:15,19 90:12,20 97:21 105:1,16 106:3 110:3 112:19 115:5 120:15 128:8 138:20 140:18 144:10 147:12,18 148:4 148:21 156:5 157:14 159:5 162:9 163:17 167:7 168:5 171:4 176:15 177:4 178:7,13 180:17 181:3 183:16,21 188:10,15 190:3 190:20 191:3 192:16 193:9 194:12 195:6,9 202:11 213:15 214:14 215:6 216:4,17 217:4,9 217:15,20 218:2 218:13,19 219:8 219:12,14,17,20 220:5,20 221:9,20 222:16 223:12 225:17 226:1 227:16 231:3 238:8,17 239:5 240:11 242:3,16 242:20 243:19 246:7 247:10,19 248:14 249:5 angry 20:7 announced 66:15 annual 227:5 228:1 answer 33:14 86:18 98:21 187:20 209:10 227:17 244:17 answers 114:22	antibiotic 74:11 75:11,13 97:3 anticipate 214:1 218:7 anticipated 55:13 153:21 240:20 anticoagulants 108:13 anxiety 10:14 anybody 5:10,13 5:20 61:15 86:3 89:8 93:11 102:18 125:17,18 144:16 155:11 163:9,21 175:12 220:10 244:20 anybody's 12:4 anyway 95:14 144:16 anyways 87:19 apart 130:13 apologize 22:6 43:6 44:21 apology 41:9,12 42:5,11,16 43:14 43:17,19 44:9,13 45:2,10,13 46:3,4 46:19 47:5 Apparently 58:17 appear 110:10 appendix 46:2 applicability 98:5 applicable 129:22 178:17 196:18 234:18 applied 113:19 159:8 applies 167:6 apply 96:5,6 158:21 167:3 176:5 204:16,19 209:19 210:21 230:2 235:2 applying 81:8 appreciate 6:5 15:5 29:15 43:4 70:18 76:14 248:18	249:1 approach 27:4,17 48:9 109:3 153:18 214:5 218:5 231:10 approaching 214:7 appropriate 9:1 38:13 107:9,10 141:2 182:16 appropriately 78:11 approval 183:5 Approvals 183:4 approves 183:10 approximately 94:7 arbitrarily 158:12 arbitrary 130:3 area 15:12 85:11 93:7 145:15 148:7 160:3,4,6 199:7 199:18 221:12 233:7 areas 75:15 105:2 135:20 181:21 200:12,13,17 207:18,19 210:17 210:21 211:3,11 213:13 219:6 223:17,18 232:20 234:11 248:11 argue 93:19 150:6 230:5 argument 173:17 arguments 18:22 arose 236:1 artery 199:16 articulate 59:4 articulated 63:3 Artificial 125:15 ASA 129:17,21 ASC 204:17 aside 122:3 asked 199:3 asking 75:12 83:12 96:22 168:4 197:16,22 209:13	223:8 aspirin 77:10 assault 165:14,16 166:9,11 169:14 170:5,11,14 173:12 174:3,16 assaulted 166:20 170:21 assaulting 174:17 assaults 168:14 assessment 151:3 152:4 associated 19:17 39:5 59:15 63:13 66:2 67:14 73:12 89:5 91:8 101:11 102:12 126:12 127:16 129:15 131:17 142:1 151:12,21 155:9 Association 246:1 associations 248:3 assume 143:18 175:7 197:14 239:2 assuming 175:10 assure 21:1 asterisk 116:14 astonishingly 162:4 atresia 103:7 attached 15:5 17:9 140:13 attempt 61:2 70:22 79:12 101:2,3 attention 15:9 24:21 31:15,17 35:21 50:14 169:9 171:12 attorneys 20:1 attribute 43:8 100:20,21 attribution 99:5 100:11 auditable 55:6 augmented 187:20 authoritative 19:1 245:9	authority 10:18 avenue 139:10 average 94:4 avoid 35:13 130:2 aware 122:3 236:21 awful 9:10,21 A-G-E-N-D-A 3:1 a.m 1:9 4:2 177:12 177:13 <hr/> B <hr/> B 232:21 back 6:21 8:17 24:1 35:2 48:3 58:9 60:16 63:10 66:11 67:4 72:20 82:17 95:7 97:19 100:21 106:16 108:1 112:16 113:13 114:12 149:19 151:4 159:6 161:12 165:8 175:4 177:10,15 177:17 190:4,12 190:17 202:6 208:18 215:12 231:2 234:3 244:18 247:13 248:3 background 109:22 121:10 140:5 162:11 179:9 224:21 backgrounds 33:20 backwards 209:2 bad 12:10 21:18 39:6,15 43:11 62:13 64:15 65:14 79:1 128:13 136:18 144:14 149:14,17 150:11 baggage 77:19 Bagian 124:9 balance 28:6 29:2,9 balanced 28:19 Ballroom 1:9 bang 190:17
---	--	--	--	---

base 105:20	214:20	193:21 194:8	brawl 176:2	broke 116:21
based 19:19 70:8	bet 50:9	209:20 226:5	break 3:10 173:6	broken 77:11
109:4 110:21	beta 77:9	bite 84:22 203:12	176:2,18 177:6,9	brought 34:10
112:6 139:5	better 13:17 23:11	biteable 85:21	177:22	89:20 114:20
182:21 197:1	34:14 41:5 71:1	biting 213:11	breakdown 62:21	BSN 2:4
199:7 204:9,9	104:12 175:6	Blackberry 136:20	breaking 108:16	buckets 161:15
210:7 211:14	204:12 224:4	blame 91:17,22,22	breast 105:10	bugaboo 149:7
229:11 230:6	230:9 240:5	blanket 153:9	Brennan 2:1 5:11	build 235:10
231:5 236:9 239:9	244:10 247:20	154:1	5:11 41:14,19	243:15
baseline 140:4	beyond 3:3 12:21	blending 143:19	46:11 47:10 53:11	building 159:14
basic 167:16	38:15 42:21 46:12	blessedly 90:9	56:8 57:9 62:2	built 241:11
basically 54:15	47:7 178:11	blind 45:21	65:15,17 101:4	bullet 75:22 77:20
88:1 178:17 179:8	181:15 226:11	blisters 144:15	133:10 144:2	86:7,11 88:10
181:18 182:1	bias 240:22	blocker 77:10	152:16 166:5	140:9 194:17
193:4 221:22	big 12:1 50:4 60:9	blood 89:7,7 90:2,2	210:8,11 219:19	195:8 201:10,11
basis 38:22	79:3 116:14 169:4	90:5,5 101:17,20	220:4,19 249:3	bullets 54:16
batteries 169:11	170:6 196:11,14	blow 21:13	brief 150:17	158:14 198:1
battery 170:14	201:21 202:1	blurs 229:9	briefing 60:17	201:2
173:13	229:18 236:6	BMI 94:13,14	bring 39:15 118:7	bully 27:2
bearing 248:18	237:4	BMus 2:4	186:21 190:4	bump 171:15
bears 165:10	bigger 84:21	Board 92:19	222:22 234:20	bunch 45:3 246:11
beast 187:16	109:15 121:5	168:17 169:5	bringing 50:20	burlesque 120:1
beat 48:1	162:17,19 230:3	170:17 183:6,10	90:5 189:3 214:22	burn 130:18 142:1
becoming 84:18	biggest 21:16	boats 83:20	245:10	142:12 143:6,7,8
93:22 121:19	biliary 103:6	bodily 55:20	brings 15:13	143:11 145:14,21
192:2	bilirubin 102:16	172:15	broad 42:1 229:16	145:21 146:2,6,12
bed 153:9 155:10	103:16 104:2	body 11:9 19:1	broadcasts 34:6	146:19,20 147:14
beds 162:20	BINDER 2:1 8:21	55:20	broaden 12:20	147:15,16 148:13
beginning 18:2	11:16 16:3 22:3	borrowing 45:12	79:12 81:19	148:14,14,15,20
36:14 94:15	34:3 41:7,11 49:7	bothers 36:10	132:18 167:20	burned 134:16
165:19 224:11	49:10 70:17 99:15	bottom 84:6 88:11	173:18,19	146:4
238:7	99:18 104:13,19	boundaries 90:15	broadened 70:10	burns 142:14,16,19
begins 99:5	104:21 106:21	boundary 76:21	197:1	142:20,21 143:3
behavior 169:7	107:2 153:17	170:1	broadening 70:2	144:1,6,13 146:8
171:11	172:8 197:13	Bovie 134:17	broader 38:18,21	146:8 147:7,9,22
behavioral 160:3	231:15 241:21	143:10,21	39:1,14 57:21	148:16 151:8,10
160:15 161:4	242:12,18,21	Bovies 130:17,17	62:10 64:3,4,7,9	Burstin 2:12 5:5,5
162:6	biomedical 139:19	bow 7:16	68:20 69:19 70:1	38:6 41:3 53:1
belief 33:10	birds 35:6	box 167:5	70:12 71:11 139:5	61:22 63:16,20
believe 27:15 38:13	birth 198:5	boxes 85:13	175:8 229:6,12	69:15 71:8 72:1
47:15 48:12 72:15	birthing 198:5	boy 208:20	broader-based	103:8 104:9,17,20
95:9 151:11	bit 14:14 20:11	bracketed 194:14	190:11	105:15,18 107:12
170:19 235:18	29:7 32:11 52:1	brainstorm 226:5	broadly 165:15	108:19 112:3
believed 19:18	83:1 120:19 130:8	brainstormed	214:12 239:9	118:1 122:17
benefit 191:21	150:13 154:10	238:4	broad-based	124:21 140:20
199:15 246:2	178:3,7 179:8	brainstorming	234:10 239:14	143:14 149:8
best 35:7 53:15	184:9 188:19	184:8,13 226:12	246:13	151:17 154:6

155:13 162:17 163:13 175:2 180:13,18 183:12 183:18 185:15,19 186:9 189:2 196:16,21 201:14 201:18 206:6 208:16 209:9 210:10 216:20 217:5,13,17,21 218:21 226:8,15 234:5 238:11,19 239:7 247:17 business 36:19 37:19 67:10,12,13 Bye 249:6 byte 25:3 by-case 176:7	174:21 192:5 202:12 captured 9:14 10:3 10:13 35:20 50:14 74:19,21 82:10 83:9,18 138:19 207:19 captures 34:8 capturing 12:4 64:14 65:8 car 93:11 card 18:4 cardio 91:15 cardiologist 128:22 129:14 cardioversion 127:9 128:15 129:9 131:14 care 3:2,12,14 7:3 7:10 20:20 21:2 24:3 34:21 37:4,7 43:10 55:10 65:14 73:2,11 96:14,19 97:8 99:6 101:5 111:16,19 113:5 116:7 117:9,12,18 118:3 129:15 130:6 132:16 133:1,6,13 134:5 134:19 136:7 137:15,16,20 138:1 141:6,14 143:19 150:2 151:22 152:10 153:5,10,17 154:5 154:13 155:14 156:13 157:3,8,11 158:16,19 159:17 162:14,19 163:6 167:18 178:11 181:18 182:3 183:13 185:4,6,10 186:3,20,21 189:14 190:16,21 191:1,7,8,11,17 192:3,4,13,15 193:3,8 194:13,21	195:1,4,21 196:10 198:10 199:12,15 200:15 201:4,11 202:16 203:4,7,9 203:18 205:2,19 206:11,13,15 207:4,14 212:14 213:5,9 214:12 215:13,15,17 216:22 217:3,18 219:21 220:14 221:2,6 222:22 223:16 227:8 228:8 229:5,7 230:4,11,15 231:8 231:9,9,20 232:13 233:7,9 237:5 239:14,21 240:3,8 cared 91:10 101:13 126:13 142:2 151:13 155:10 careful 115:16 132:2 223:13 carefully 21:2 caregivers 152:3 carries 77:18 carve 232:17 case 22:21 79:4 84:16 107:20 146:2,5 160:7 173:21 176:6 cases 30:11 74:6,10 94:15,16 136:12 137:3 153:6 cast 141:13 catastrophe 13:3 97:15 catastrophes 12:22 catastrophic 9:21 12:14 17:5,8 catch 201:6 categories 60:12 79:7 93:2 108:14 132:19 135:2 137:17 148:2 158:10 159:1,3 167:8 171:14	197:14,20 202:14 categorization 63:22 155:2 157:19 categorized 154:13 category 14:6 70:1 78:20,22 81:19 86:21 88:20 94:10 95:3,14 119:17 132:5,13 134:18 135:12 145:8 156:8,18,22 163:5 166:12 172:14 174:20 175:5 191:12 catheter 200:4 caught 79:19 cause 32:8,14 37:1 40:9,11 91:20 92:1,10 134:21 233:11 caused 87:15 199:20 causes 40:15 91:22 108:22 causing 18:21 caution 45:7 caveat 213:18 celebrated 173:21 center 94:17 188:5 188:6 193:19 centers 190:13 192:12,14,15 195:8,15 204:14 207:4 210:16 212:3,5,14,15,20 213:17 214:9 217:7 219:9 220:6 237:11 certain 9:20 18:13 35:1 64:15 65:7 137:2 160:6 161:17 204:17 212:22 certainly 7:8 15:4 15:19 31:16 42:6 50:13 56:16 58:2	66:7 68:15,17 70:15 90:12 95:16 127:5 128:2 135:5 136:11 138:13 162:16 167:14 168:6 181:20 186:22 243:21 cetera 35:9 105:7 108:14 128:13,15 147:15 167:13 216:1 224:6,7 chained 162:20 Chairs 1:11 challenge 228:15 230:10 challenges 228:16 challenging 6:3 29:8 chance 44:20 186:14 245:6 change 6:20 7:21 8:4 52:22 54:8 85:15 97:8,9 110:16 123:18 205:21 223:21 changed 113:14 118:11 119:21 changes 52:18,20 55:15 109:16 243:6 247:4 changing 184:6 channels 193:16 characteristic 134:14 charged 174:3 chase 130:1 check 86:3 176:20 244:3 chemical 147:6,9 147:22 155:21 156:4,12,21 157:10 161:2 chemotherapy 85:8 children 101:19 children's 102:2,7 chiming 129:14 chiropractor 124:3
C				
C 4:1 135:8 232:21 California 115:2 call 33:6 39:9 49:22 53:9 79:14 161:20 185:18 200:18 202:2 234:9 239:9 239:12,13 240:3 240:21 241:8,22 241:22 242:2,19 called 39:12 94:2 185:15 188:3 calling 49:12 68:21 92:21 164:8 165:13 calls 184:16 189:7 241:11 243:16 244:5 camps 203:14 cancer 212:4 canoe 77:18 78:20 captive 237:20 capture 30:17 49:2 53:22 64:1,8,16 64:17,21 76:18 87:13 88:12 127:15 151:8 159:1 161:19				

choice 23:13 103:20	cleaner 42:3	70:20 71:6,7	242:9,11	141:11 177:2
choices 182:21 188:3	clear 38:10,12 39:10 42:18 48:16	155:20 181:11,17	comfort 35:16	179:19 182:20
choose 67:12 224:6	49:12,15 51:16	181:18 185:20	comfortable 8:8,9	183:1,4,8 187:21
chord 24:17	62:17 63:2,16	186:6 200:12	13:18 49:5 54:10	232:19 239:16,22
Chorus 52:11	68:2 74:5 90:4	211:5 223:16	56:18 66:22 67:6	247:2
chose 54:15 192:18	103:22 107:8,18	CNN 34:6 36:6	67:17 194:6	Committee's 69:2
chosen 246:8	116:19 141:17	Coalition 50:5	226:16 234:18	common 89:22
Chris 4:9 99:17,18	169:13 171:1	code 163:15	coming 50:3	134:15 140:17
121:7 166:12	174:18 182:18	codified 125:5	209:15 236:22	172:12
195:19 232:12	186:9 229:18	codify 150:12	comment 3:17 13:8	communicating
246:14	clearly 54:2 55:6	cognitive 236:12	15:1 26:10 31:8	241:6
Christine 2:2 46:9	56:4,14 85:7	cognizant 49:17	53:3,3,8 64:7 74:2	communication
47:21 98:10 99:16	101:2 171:11	93:1 94:3 128:17	76:15 78:19 98:18	62:22
circle 57:14 58:4	217:2	136:5	106:16,17 108:4	community 9:19
60:9,9,10 151:4	climate 43:8	collapse 178:1	109:15 118:19	102:7 191:21
226:19	clinic 193:22	collapsed 7:1	125:17 138:9	229:10 230:5
circles 105:11	198:18 206:14	colleagues 24:20	140:9 148:13	community-based
circulating 241:2	207:16	collect 204:13	150:18 156:3	185:2 201:6,9
claim 115:18	clinical 73:18	224:14	166:2,4 173:7	202:19 203:1,6
claims 235:22	107:13 113:18	collected 85:13	175:16 176:16	228:21 229:5,15
236:1	114:4	92:11 224:17	183:12 184:3	229:22
clarification 76:16	clinician 121:14	collecting 30:10	192:17 206:11	companies 236:4
87:7 94:21 97:22	232:2 233:9 234:1	126:8 232:13,21	214:15 218:3	company 236:3
103:9 147:6	clinics 194:15	collection 57:20	220:7 222:7 231:5	compared 230:16
180:14 189:3	195:12 197:19	85:2 97:9 224:12	242:19 243:15,15	compelling 34:20
190:4 192:12	198:6,9 207:6	collective 219:3	commented 33:13	231:20
201:15	225:8	color 153:7	124:11	competent 163:22
clarification/feed...	clipping 165:11	Colorado 43:14,18	comments 10:10	163:22
228:19	close 23:19 173:9,9	103:2 168:17	24:16 26:3 56:6	complacency 115:9
clarified 65:4	184:21 226:19	column 76:1 86:7	69:14 70:18 71:11	complain 170:17
clarifies 100:15	240:17 248:16	158:12 165:6	122:7,7 144:1	complaints 169:1
clarify 34:15 61:2	closely 154:2 248:2	166:1 167:4	151:16 158:21	complete 157:4
87:22 176:4	closer 26:7 204:22	columns 158:9,13	163:9 166:10,11	completely 27:7
180:12 195:21	205:2,4	165:12 197:7,9	176:22 178:20	83:17 111:15
203:16 207:10	closet 143:6	combination	179:8 231:21	211:10 212:3
222:21	clues 81:21	138:16 223:19	239:12 244:6	237:15
clarifying 95:13	cluster 63:5 188:18	244:4	247:19 248:15	completeness 140:8
clarity 98:9 167:2	clustering 182:7	come 18:10 25:20	commission 32:8	194:17
class 13:21 224:1	192:18	29:3 34:14,18	76:17,17 77:3	complex 159:14
classic 141:8	clusters 181:22	74:9 80:13 106:16	81:11 144:12	complexity 179:2
classification	182:3,17	112:16 117:9,21	commit 18:14	complicate 150:13
113:14	CMD 2:10	154:14 167:16	commitments	complicated 82:21
classifying 112:5	CMS 2:17 5:17	186:16 201:12	177:21	complicates 83:22
clause 146:17	29:21 63:17 64:6	223:17 248:22	committed 227:14	complications
clean 56:22 90:14	64:13,20 65:11	comes 14:19 24:8	committee 1:4,9	82:16
	67:1,8 69:20 70:4	26:22 50:9 118:7	65:19 89:22 118:4	compounded
		155:20 185:20	118:8 140:22	172:18

comprised 76:6 77:5	confused 99:20	Containment 101:5	69:19 149:17	94:20 95:12,21
compromise 13:15	confusing 12:9 67:15	contains 135:17	150:14	96:3,5,8 98:10
concealing 84:11	confusion 10:15	contaminate	Cost 101:5	99:14 100:14
conceivably 79:1	11:4 65:3 66:5	131:10	Coumadin 85:17	101:8 102:3,5,10
conceive 21:6	67:9 103:18 105:9	contaminated	Council's 101:6	106:4,13,19,22
208:8	connected 140:10	135:17	count 84:9 125:10	107:22 109:7
concept 15:14 20:6	140:11 246:17	content 142:19	216:16	110:1,6,10 111:8
49:4 84:17 179:9	248:10	180:19 183:9	counted 92:11	112:1,22 113:10
185:3	connecting 248:12	contention 222:15	counter 10:12	116:1 117:3
conceptualization	connection 190:18	context 68:20	126:16	118:15 119:13
64:8	connections 137:7	105:19 146:14	country 85:3	121:7 122:4
conceptually	cons 116:7	contexts 81:9	200:10 246:18	123:11 125:9
159:15,21	consensus 179:18	continue 66:16	couple 32:4 53:14	126:10,21 127:2,6
concern 14:18 54:1	180:7 183:3 221:6	67:9 69:16 70:6	55:16 66:11 103:1	127:13,20 128:4
95:17 102:20	221:8	167:20 171:13	103:13 213:12	128:18 132:6
122:22 152:9	consequence 16:9	184:15	coupling 27:7	133:5,8,11,17,20
223:19	55:10 107:6 150:2	continued 116:16	course 12:2 60:1	134:11 135:3,10
concerned 24:2	consequences 45:5	continuum 96:14	134:19	135:13 136:8
81:1 189:22	consider 79:16	99:6 189:14	court 18:18 42:16	137:10,22 138:6
232:18	89:11,11 125:1	191:18	covered 75:22	139:12 140:6
concerns 47:11	151:22 232:8	contributions 36:5	113:6 143:18	141:20 142:6
62:6 79:7 102:4	245:9	control 20:17	156:2 181:10	143:4,22 144:19
102:18 151:19	consideration	210:16 243:10	CO-CHAIR 1:21	145:2,18 147:8,17
163:12,14	99:11 122:20	controllable 164:14	1:22 4:3 5:6,9,12	147:20 148:11
concerted 215:7	137:15 142:21	controversial	5:20 6:11 10:11	150:16 151:6,9
concur 108:18	considerations	103:12 109:18	11:14 20:13 21:8	152:12,18 153:13
115:2 132:4	102:4	convene 201:21	22:2 23:21 25:10	155:7,17 156:16
134:11 137:12	considered 22:21	convened 1:9	26:9,11,13 27:21	157:13 158:4
188:9	95:1 151:2 229:15	conversation 61:20	31:5 32:15 34:1	160:10,19,21
condition 19:3	considering 91:21	69:16 114:9 247:1	35:22 39:17 40:10	161:7,10,22 163:2
22:20 92:5 159:18	198:14	conversations	40:15,20 41:1,6	164:2,16,19 166:3
conditions 1:4	consistency 108:15	60:15	41:10,18,20 42:12	166:7,22 167:14
59:16 62:8 63:13	consistency's	convert 21:20	43:12 46:9,17	168:10 169:13
65:6 67:1 68:5,5	174:13	convince 67:19	47:21 48:18 49:9	170:9 172:6 173:2
159:11 181:9,11	consolidate 70:13	convinced 230:8	51:2,14,15,17	173:8 174:9,22
conduct 124:5	consolidation	coordinate 65:19	52:3,4,6,7,12	175:12,14 176:8
conducted 45:21	29:16 30:3	correct 12:18 196:3	60:21 61:6,15,18	177:5,14 178:8
confer 14:17	consternation	corrected 43:3	62:3,18 64:10	187:3 190:1 192:7
conferences 50:2	18:21	139:11	66:19 70:16 71:22	195:19 196:4
confidence 48:21	constituencies	correction 40:17	72:12,17 73:10	197:11 199:1
confident 187:18	244:16	40:19 41:2,12	74:22 75:20 76:12	200:21 203:15,20
configured 208:8	constituency 50:22	corrections 162:3,3	78:16 79:5 80:3	204:1,4 205:8
configuring 208:9	construed 47:20	162:6 163:3	80:16 81:6 82:12	206:18,22 207:8
confrontations	consumer 94:21	corrective 30:6	83:3,10 84:13	207:20 211:21
171:9	113:1	correctly 207:10	86:2,11 89:1,10	212:9 213:3
confuse 121:20	consumers 49:18	corridor 38:19	89:13,18 90:8,17	214:11,16 215:10
		39:1,14 64:3	91:3 92:14 93:3	217:11 221:4,18

222:6 226:18 228:5,17 233:16 234:4 235:6 238:3 241:19 242:22 244:12 CPHQ 2:22 craft 139:20 craniotomy 129:4 crash 9:7 12:14 35:4 crazy 102:1 158:1 create 15:16 27:20 29:17 30:2 38:18 39:14 65:20 71:1 85:20 120:16 124:8 223:20 239:9,11,19 created 10:14 60:11 70:3 210:17 creating 27:13 28:7 28:9 68:3 69:11 69:18 111:10 139:13,15 151:1 235:3 creation 141:5 credential 191:9 credibility 37:9 54:21 creep 48:5 crew 35:9 CRICO 236:4 237:17 criminal 162:12,13 163:4 166:18 167:10 170:5 171:3,16 172:14 174:3 crisp 41:17 83:22 90:15 98:21 criteria 54:14 93:13 113:18 123:2 125:1 142:9 149:5,6 231:16 critical 36:10 48:17 criticizing 208:14 cropping 200:10 crosses 189:17	cross-reference 47:1 crushed 131:2 CSAC 183:5,10 cuff 137:4 culling 210:18 culpability 174:7 culture 28:7,22 cultures 28:8 curious 102:21 121:10 current 38:4 53:21 107:1 179:21 180:3 currently 55:18 80:4 143:14 217:19 curtain 153:7 154:1 cutoff 95:6 171:1 cuts 75:18 cutting 168:22 208:2 cycle 227:6 228:1 Cynthia 2:3 4:14 17:19 42:12 78:17 79:5 113:10 135:18 161:11 164:2 170:9 192:7 192:8 212:9 222:6 231:13	daunorubicin 85:18 day 6:1,4 7:2,17 10:22 51:19 99:1 100:3 177:18 178:22 208:3 240:18 244:7 days 91:12 98:15 99:8,22 102:17 103:13 114:13 122:12 247:16 day's 6:16 179:1 dead 146:3 deal 19:9 37:1 74:6 94:18 121:14 138:21 146:21 174:14 189:7 200:13 202:1 213:12 dealing 30:22 176:6 dealt 83:18 death 55:19,22 73:12 74:1 79:17 79:18 86:15,16 87:9 88:3,18 89:4 91:7,20 92:10 95:19 100:6 101:10 102:11 114:21 115:2 118:16 119:5,7,10 126:11 127:10,16 128:2 129:3,11,16 130:5 131:2,15 135:4 141:22 144:3 145:6 146:4 146:6,17 151:11 151:20 155:8 173:10 174:8 175:8 deaths 91:13 92:18 95:13 99:7 100:2 129:15 132:1 200:3,3 237:7 debate 50:13 52:5 53:4 105:3,12 115:11 193:5	236:13 Debbie 4:10 Deborah 2:6 151:17 decade 227:12 December 246:22 decide 63:18,21 90:1 234:15 decided 60:6,8 182:1 deciding 119:20 decision 14:10 103:12 deck 178:15 decrease 43:5,6 dedicated 50:6 deep 111:6 112:13 158:2 defend 237:4 defense 17:22 19:6 19:22 defer 22:11 96:21 defibrillation 127:8 127:17 153:1 define 60:12 108:9 109:16 111:17 145:9,17 150:22 160:7 173:19 181:12 defined 8:5 16:14 16:16 40:6 51:19 55:6 56:4 68:10 82:3 102:15 defining 55:3 65:3 65:6 68:14 93:2 97:6 definite 186:3 definitely 6:10 14:5 14:18 60:3 61:19 117:4 135:8 153:11 definites 228:7 definition 7:21 8:5 21:3 38:16,21 41:16 42:2 46:8 47:14 48:4,5 51:7 51:18 52:20 53:17	53:19 55:4,8,17 56:12 64:18 70:2 70:12 79:9 92:13 92:22 98:3 101:16 102:15 116:20 117:10 141:14 149:11,21,22 165:7 167:11 170:5 182:14 186:4 197:2 214:3 242:15 definitions 6:14 48:16 53:2,8 56:10 65:14 70:8 135:1 150:15,19 239:10 degree 146:9 148:13 159:9,12 delay 233:10 deleted 55:16 deletion 121:4 deliberately 130:15 deliberation 126:19 182:8,11 183:22 deliberations 69:2 227:18 delighted 215:2 deliver 99:9 100:7 103:19 deliverables 181:8 delivered 20:17 99:2 135:16 deliveries 103:3 delivers 100:2 delivery 21:5 91:9 91:12 96:14 97:14 98:15 99:9 100:1 100:4 130:6 231:11 delving 90:10 demonstrated 15:17 113:20 department 207:1 207:15 departments 92:6 194:19
	D			
	D 4:1 232:21 dah 170:22,22,22 170:22 damaging 172:18 data 30:10 85:1,13 85:15 104:15,17 129:8 203:2,3 204:13 221:13 224:12,16 230:8 230:16 231:2 232:13,17,21 233:13 235:22 236:22 237:17,18 237:19			

depending 182:10	217:20,21 218:1	10:4 90:1	disciplines 159:13	distinction 107:3
depletion 36:22	220:6,9 234:19,20	differentiated	171:22	156:1 169:16
depression 127:12	237:10	10:16	disclose 32:13	180:14 181:4
depth 113:8	Diane 2:8 4:13 13:7	differentiation	disclosed 42:10	disturbed 77:20
depths 235:13	27:22 52:14 58:11	128:16	disclosure 32:7	disturbing 232:16
derived 61:2	74:3,22 100:19	differently 193:21	40:8,11 41:10,12	dive 184:1
describe 17:15 57:6	109:13 118:18	234:13	42:5 46:19 47:4	divide 201:1 208:4
described 136:12	127:18 145:2	difficult 19:5 29:14	discomfort 8:12	dividing 197:13,18
240:12	149:9 150:16	30:20 50:17 114:9	39:5 71:4	doable 42:14
describes 55:9,12	152:18 173:15	145:4,10,16	discount 90:13	docs 187:11 191:8
55:18 150:1 165:7	174:9 175:15	difficulties 50:18	discovery 46:15	243:21
describing 33:5	231:14	diffusing 83:21	discrete 55:6	doctor's 188:7
deserves 169:8	Diane's 8:17 62:5	dilemma 17:21	discuss 36:4 58:15	212:15 215:16
176:12	122:7 175:3	dilute 84:5	241:5	document 45:3
design 75:7	diced 82:16	direct 124:20 232:3	discussed 48:19	46:6 47:7 53:1
designated 135:15	die 132:20 134:9,20	direction 227:20	89:3 92:8 177:1	60:17 183:9
designation 39:16	134:20,21	directions 228:3	196:11 245:17	241:15,17
despite 36:4	dies 76:2 93:9,11	directors 246:1	discussing 61:4	documentation
detecting 107:6	100:4	248:5	discussion 7:1,9,11	111:10,11,12,21
determine 224:22	difference 61:3	disability 55:20	12:18 14:10,21	documented
determined 227:7	76:16 145:20	73:12 74:1,15	18:18 20:15 25:4	109:20 110:14
227:17	170:4	76:2 79:17,18	38:22 45:4 49:2	documents 243:5,8
determining	differences 73:18	86:16,17 87:9	54:22 58:19 59:1	243:14 247:3
161:17	different 13:21	88:4,18 89:4 91:8	59:13 60:13 61:7	248:20
develop 141:9	14:14 30:16 32:11	101:11 102:12	68:19 70:5 71:12	doing 10:6 30:9
developed 82:15	44:10 56:21 65:2	118:17 119:5,7,11	89:21 91:5 93:17	33:20 66:12,14
129:10	65:13 76:19 80:6	126:12 127:16	101:9 105:12	92:1 97:4,17 98:6
developing 114:13	81:11,12 82:17,18	128:2 130:5 135:4	106:18 114:6	112:19 191:8
117:5 179:21	85:7,9 97:2,2	135:6 142:1 144:4	115:12 116:6,14	195:12 242:10
development	107:7 112:10	145:6,12 146:18	137:14 158:17	244:19,20 246:19
179:19	114:15 117:11	149:12,15 151:12	163:15,19 164:1	246:22
device 36:14	121:14 125:8	155:9 174:13	170:2 179:4,12	dollars 20:1 236:6
devices 131:12	128:5 130:8 132:5	175:8	184:13 190:11	Don 65:17 66:9,10
136:5	134:22 135:1,2	disadvantage 114:5	198:4 221:10	66:11
diagnosed 103:7	136:11,14 137:6	disagree 26:15	222:15 226:4,20	Donald 8:1
diagnosis 70:11	137:16 152:21	31:21 230:2	238:5	donation 90:2
diagram 23:8	157:5 158:16,17	disappeared	discussions 57:2	donor 125:16
56:20 57:7 58:20	158:18 168:6	158:10	58:3 66:9 68:17	door 153:8
58:20 59:9,10	172:1 180:8	disappointed	70:14 71:14	Doron 2:9 4:19,19
61:11,16 68:10	182:17 187:16	202:16	148:22 214:2	32:1 33:4 39:22
dialysis 187:5,14	188:17 189:6,9	disaster 80:15	243:7	40:2,4,13,18,21
187:15,22 188:2,4	191:8,17 195:15	discharge 103:17	disease 77:8 174:2	62:4,11,15 106:13
189:8,10,15	198:1 204:21	104:2 164:13	dismissible 8:12	106:15 108:3
194:16 200:3,9	205:18 208:17	discharged 163:18	dispensing 78:7	111:8,9 116:2
202:9 210:3,6	209:14 212:4	disciplinary 168:19	82:5	117:6,8 126:17,18
211:7 212:19	224:17 248:2	discipline 189:21	disruptive 171:11	134:8 137:10,11
213:17 214:9	differentiate 9:2,3	192:2,3	dissect 85:4	138:4 142:4,7

144:19,20 151:6,7 166:22 167:1 196:5 197:11 198:8 205:8,9 215:10,11 222:20 226:18 227:1 228:14 232:11 242:22 243:1 Doron's 138:8 231:21 244:11 dose 73:14,19 dosing 85:18 dot 167:11,11,11 167:12,12 double 45:21 downside 11:3 downsides 110:18 DPH 92:18 DR 5:2,5,14,15,18 6:15 8:16 10:9 11:13 12:16 13:7 14:16 15:2 16:2 17:18 26:2 31:3,7 38:6 41:3 52:14 53:1,13 56:15 57:11,12,13 59:12 61:22 63:1,16,19 63:20 65:16 66:7 66:21 68:1,15 69:15 71:8 72:1,6 72:10,15 78:2 87:11,18 88:21 89:15,19 90:12,20 92:12,16 97:21 103:8 104:9,17,20 105:1,15,16,18 106:3 107:12 108:19 110:3 112:3,19 115:5 118:1 120:15 122:17 124:21 128:8 132:14 134:1 138:20 140:18,20 143:14 144:10 147:12,18 148:4,21 149:8 151:17 154:6	155:13 156:5 157:14 159:5 162:9,17 163:13 163:17 167:7 168:5 171:4 175:2 176:15 177:4 178:7,13 180:13 180:17,18 181:3 183:12,16,18,21 185:15,19 186:9 188:10,15 189:2 190:3,20 191:3 192:16 193:9 194:9,12 195:6,7 195:9,10 196:16 196:21 201:14,18 202:11 206:6 208:16 209:9 210:10 211:9 213:15 214:14 215:6 216:4,17,20 217:4,5,9,13,15 217:17,20,21 218:2,13,19,21 219:8,12,14,16,17 219:20 220:3,5,18 220:20 221:9,20 222:16 223:12 225:17 226:1,8,15 227:16 230:12 231:3 234:5 237:14 238:8,11 238:17,19 239:5,7 240:11 242:3,16 242:20 243:19 246:7 247:10,17 247:19 248:14 249:5 draft 239:11 drama 12:1 dramatic 24:15 37:4 82:21 drawing 15:8 DRGs 201:4 drive 85:15 125:3 179:12 182:11 184:14 227:20	241:14 driver 179:20 drives 183:8 drop 159:1 dropping 119:18 drown 142:15 drug 73:14,19,21 76:8 79:2 86:22 87:14 88:14 131:19,21 drugs 80:8,14 drug-drug 86:14 dual 92:4 due 89:5 108:10 118:17 119:11 dueling 36:6 49:14 dumping 73:5 DVT 74:13 dying 92:2 dynamic 29:2 dynamics 121:21 D.C 103:19,20	<hr/> E <hr/> E 4:1,1 earlier 47:17 53:20 133:14,19 143:21 175:16 198:4 224:13 242:14 early 44:22 125:22 234:2 easier 76:18 123:6 easily 56:5 222:18 easy 20:22 21:6 101:3 139:10 eaten 131:3 ECT 127:10,22 128:3,14 130:7 131:14 153:1 ED 108:22 Eddie 2:17 5:16,18 Eddy 67:21 68:16 71:8,13,13 edification 104:6 113:1 edition 196:12,14 effect 47:18 204:14	effective 17:13,15 17:17 45:10,12,13 45:15 152:6 236:18 effects 121:13 effort 32:2 199:8 215:7 efforts 31:19 32:3 egg 125:16 egregious 20:21 eight 169:1 either 15:17 22:1 24:6 30:4 46:8 60:20 67:20 191:5 211:3 230:9 elaborate 51:5 elected 116:10 elective 128:22 129:2,8 electric 126:16 electrical 126:12 130:6,14 134:3 147:15 electrically 130:22 electricity 130:18 electrocardio 126:16 electrocardiover... 129:1,9 electroconvulsive 127:4,7,11,18 electronic 244:4 electronically 184:15 241:3 244:2 electrotherapeutic 131:11 element 171:12 elements 171:10 eliminate 124:13 131:17 eliminated 132:3 eliminating 50:7 eloquently 198:19 email 241:12 emails 243:8 embedded 243:10	embedding 83:1 embolism 91:14 140:19 emergency 127:16 194:19 206:13,15 206:18 207:1,14 207:15,15 emerging 207:3 emotion 15:5,6 17:9 emotional 17:2,3,6 100:12 emotionally 18:7,8 emphasize 18:7 employees 168:3 encompass 64:3 68:7 76:8,9 encompasses 57:14 encounters 193:15 193:15 encourage 18:14 42:7 84:4 ended 60:15 74:14 endlessly 208:2 endorsed 104:14 endpoint 146:3 energizing 30:22 engaged 171:9 engineered 136:22 engineering 136:17 136:21 137:8 139:4,19 engineers 136:16 enlightening 172:10 enormous 116:6 enormously 96:19 enteral 140:11 enthusiasm 11:21 entire 53:1 entirely 13:11 29:16 137:12 entities 66:13 136:6 entity 57:18 141:9 185:14 environment 6:3 18:1 20:20 21:10
--	--	--	---	---	---

28:22 43:17	97:8 108:7 124:14	45:1,11,14,16	exact 190:6	160:18 179:10
105:14 122:11,14	124:19 132:9	47:15 49:21 50:7	exactly 48:3 96:17	expansion 3:3
136:4 137:14	148:6 157:1	50:8 51:21 52:18	98:19 108:20	225:13 240:6
143:16 155:15	205:18 207:17	53:22,22 57:15,17	109:1 156:2,4	241:14
158:19 162:7	215:20	57:21 60:9 63:3,4	209:7 212:8 246:7	expect 132:20
164:15 176:13	errors 18:11,17	63:22 64:4 65:3,7	exam 107:14	expectation 167:15
182:17 227:4	73:13 79:8 82:3,5	68:20,21,21,22	162:21	180:1,10 181:1
235:16,21 244:1	84:18,20 124:12	69:20 71:20 72:2	Examiners 168:18	expectations 20:4
environmental	124:13 156:19	72:7,21 73:2,11	170:18	171:17
128:10,11 130:20	168:19 236:12,13	79:19 80:22 81:1	example 20:20	experience 18:1
131:5 132:11,17	236:19	82:10,19 83:16	78:12 115:6 122:8	29:7 31:22 34:4
133:2 134:4	erythema 148:19	87:12 90:8 91:11	143:21 144:22	49:20
137:21 138:2	especially 5:22 6:4	98:22 100:22	149:22 234:9	experienced 224:4
152:2,2,8 153:4	44:8 197:3 231:21	108:6 109:1	examples 74:9	experiencing 18:20
153:10,20,22	ESQ 2:3	113:22 115:7	160:8	expert 7:4 113:5
154:14,18 155:5,6	essence 155:13	123:6 126:9,15	excellent 28:2	116:5 157:11
environments 3:2	essentially 32:5	137:21 144:5,8	exception 146:17	160:3 169:19
7:3,6 69:9 80:7	et 35:9 105:7	149:17 154:15	exceptional 248:21	172:9 182:19
98:5,6 159:11	108:13 128:12,15	155:5 157:18,19	excess 149:2	expertise 94:18
162:13 172:2	147:15 167:13	163:4 166:18	exclude 91:20	202:3 203:13
178:10 179:10,11	216:1 224:6,6	167:10,21 174:8	127:4 128:22	219:6 246:9
181:15,18 182:3	event 9:7 11:19	174:16 198:10	excluded 127:8	experts 115:4
183:13 186:6	12:14 17:6,6,8	200:2 209:1 223:3	131:16	118:6 182:13
188:12,20 214:5	22:22 35:4,10,11	223:9 232:1	excludes 73:17	183:7 186:12
223:16 224:5	38:8 41:17 43:21	234:10,21 235:19	91:12 109:11	194:2,5 201:16
227:5 239:14,21	46:16 47:2 48:6	246:20	126:15	expired 200:7
240:14 243:4	54:17 55:5,12,19	eventually 197:9	exclusion 127:21	explain 36:8 58:21
environment-spe...	56:4 74:5,18	everybody 4:6 54:9	152:20	99:11,19
69:4	78:13 81:15 83:4	56:17 57:4 67:6	exclusions 88:20	explains 47:14
envision 36:6 158:8	87:15 88:11 97:1	166:10 176:11,14	execution 75:6	explanation 86:6
epidemic 94:2	120:5 124:15	177:20 245:3	exercise 240:1	explanatory 42:4
epidemiology	126:5,6 127:15	248:20 249:5	existence 58:8	explicitly 38:12
210:13	129:3 146:12	evidence 45:18	existing 6:22 46:20	46:18
equal 10:14	152:2,11,22	46:1 48:15 103:14	98:1 138:22	explode 154:9
equally 39:6 82:11	155:14 164:7	103:15 104:1	179:21 210:20	exploded 155:15
equipment 128:12	174:12,21 204:17	105:4,20,22	225:14 234:17	exposed 128:11
161:15	events 1:4 7:22 8:7	107:18 109:3	235:2 239:12	extended 21:10
era 168:7	8:15 9:2,4,20	112:18 123:9	242:9	extensive 43:16
Eric 2:10 4:15 21:8	12:10,21 13:21	143:1 223:19	expand 95:18	extent 22:10 27:5
73:3 80:3 93:3	14:3,5,7 15:13,19	236:15,17	96:18 110:19	66:3 75:4 129:10
199:1 200:21	16:4,13 17:16	evidence-based	114:19 143:1	external 141:9
202:11 203:16	19:20 20:3 23:12	210:19,19 211:15	178:11 181:15	180:5,21
213:3 231:5	24:20 27:12 29:13	evidentiary 43:16	192:5 196:17	externals 180:11
Err 24:10	31:9 34:7,17 35:1	evolution 48:14	208:21,22 235:1	extinguishers
error 15:16 18:16	38:9 39:8,11,12	61:1	expanded 214:3	131:8
55:14 73:13 77:3	40:7 42:9,18	evolved 59:16	240:2 248:7	extra 58:4 246:1
77:6,6 85:22 97:7	44:10,12,15,17	evolving 168:7	expanding 108:20	extravasation

148:1	179:22	39:21 63:11 107:9	102:17 140:9	167:18
extreme 22:21	fairly 83:22 232:15	136:10 140:21	178:6 191:11	focusing 113:22
extremely 23:14	247:12	153:2 154:8	192:9 193:18	214:17
49:20	fall 82:7 86:21	187:18 194:6	194:8,11 195:8	fodder 65:9
eyebrows 25:3	95:13 129:4 148:1	212:12 226:8	196:9 201:10	folks 4:4 19:12
e.g 73:13	151:12,21 152:5,7	227:7 228:10	214:7 218:12,13	71:12 106:6
	156:18,22 161:17	234:18 244:16	225:2 231:17	124:10 175:19
	211:2 229:7	feeling 7:15 24:9	247:2	177:15 186:19
F	falling 131:2	32:21,21 125:5	first-degree 148:16	189:10 197:3
FAAN 2:6	falls 13:20 14:20	feels 30:21 41:21	fishy 120:2	198:18 246:8
FACC 2:6	142:17 152:5	41:22 172:16	fit 32:19 39:16	248:16,17
FACHE 2:3	153:3,6 154:3	228:4	68:12 69:22 70:10	follow 70:5 161:21
facial 143:10	218:9	fees 20:1	204:6,12 240:10	249:2
facilities 3:8,12	families 9:21 20:5	felt 13:18 14:6	fits 65:13 68:12	followed 66:9
80:2 96:12 162:4	166:20	119:18 191:12	171:6 185:14	following 19:2
163:1 165:18	family 19:18	193:4	fitting 171:15	54:18 158:7
194:16 195:3	187:10	Fentanyl 85:19	five 157:15 201:3	232:22
200:9,16 210:4	fantasy 158:10,13	fewer 236:5	201:12 202:1,13	follow-up 11:15
211:17 217:1	165:6	fibrillation 127:17	235:18 236:16	175:3 241:7
facility 54:7,20	far 6:13 39:22	field 29:19 67:16	240:10	fondness 36:4
91:10 95:22 97:17	84:21 85:4 92:5	241:17	five-year 66:1	footnote 167:11
101:14 109:11	119:17 149:14	Fifty-four 236:2	fix 25:16,21 30:19	footnotes 245:13
116:17,18 121:12	177:1 179:5	figure 30:19 124:13	33:12,15	footwork 224:16
122:19 126:14	181:19 182:18	145:10	fixable 85:21	Force 103:11
131:6 137:18	189:22 192:17	figured 64:20	fixed 33:16 37:8	107:14
138:11 142:3	193:3 201:2 241:9	183:19	81:21	forceful 24:16
146:20 151:14	FASHP 2:9	figuring 246:5	fixes 81:14,15,15	forest 36:22
155:11 165:1,10	fast 242:6	final 56:2 183:2,8,9	81:17	forever 72:1
165:12,22 172:21	fatal 87:15 140:17	184:7	flesh 52:1	156:14
173:14 174:4,6	fatty 91:14	find 38:1 131:22	fleshed 225:22	forget 162:7,16
185:10 186:2	fault 22:15,18	175:11 178:19	233:2	206:12
190:8 234:19,20	faulty 128:12	203:2 205:11	flexibility 167:12	forgot 8:1,2
FACP 2:10	favor 23:3,15 48:8	238:20	flight 177:21 184:6	forgotten 7:22
FACS 2:11	131:5 139:13	finding 207:4	floated 56:21	formally 8:2 245:8
fact 9:4,6 13:2	favorite 167:9	232:15	floor 152:14 153:8	Format 89:22
19:15 29:9 36:18	216:9,9	fine 28:13 186:7	fluid 91:13	forth 24:1 159:6
38:20 50:5 61:7	feasibility 222:12	189:8 216:17	fly 35:6	190:17 200:17
69:19 77:16	224:10 228:11	finish 6:21 184:5	focus 15:9 30:5	248:9
110:21 112:7	feasible 54:3	218:14	75:6,10 97:22	forum 1:1 10:17
136:22 146:9,12	feed 223:6	finishing 176:16	133:22 155:3,5	26:18 27:2,18
152:8 180:15	feedback 64:6 71:7	fire 130:18 131:8	170:8 202:5 213:6	244:5
230:8	102:9 121:1 244:7	143:6	220:15 221:3	forward 6:6 50:21
FAHA 2:6	244:8 247:20	fires 143:16	230:4,7 231:7,8,9	68:19 71:3 79:11
failure 55:15 76:3,8	feeding 137:3	firm 105:20	240:20,20	98:3 180:3 209:19
78:11 102:13	138:14,15 140:11	firmed 241:13	focused 75:16	248:12,19
113:16	feedings 137:5	first 6:16 9:1 31:6	85:11 119:3 168:8	for-profit 232:15
failures 106:12	feel 25:8 28:2 30:5	41:3 53:2 100:22	focuses 85:11	found 34:19 64:14
fair 89:21 174:7				

118:20 119:17 153:22 Foundation 140:1 four 16:19 82:18 109:9 110:21 111:2,7 112:10 181:22 211:20 216:13 240:9 fourth 220:14 fractures 151:15 fragmented 27:3 frailty 117:20 frame 28:14 159:16 framework 112:4,5 118:5 159:21 frank 12:5 frankly 16:8 17:2 free 18:4 21:19 115:21 156:11 freestanding 191:22 192:22 198:5 frequency 120:4 215:17 frequently 122:13 fresh 202:12 frightens 176:14 front 18:22 37:5 46:6 127:21 fronts 168:9 full 68:20 118:14 169:8 246:13 fun 96:18 function 55:21 fundamental 75:3 fundamentally 154:4 funds 189:4 further 32:2 40:5 51:5 53:18 54:22 70:14 87:22 125:13 179:9 180:12 186:14 241:4,4 furthered 20:5 future 75:15,17 90:19 91:4 142:21	215:15 227:20 237:6 <hr/> G <hr/> G 4:1 gain 11:20 32:4 galvanize 144:8 galvanizing 222:17 game 71:17 187:6 games 150:8 Gandhi 2:2 5:14,14 6:9 14:16,16 31:3 31:7 57:12 78:2 92:12,16 132:14 134:1 194:9 195:7 195:10 211:9 219:16 220:3,18 230:12 237:14 Garcia 2:17 5:16 5:17,19 67:21,22 68:2 71:8 gas 135:16,17 139:1 gases 136:15 gauntlet 34:22 gee 46:3 245:3 general 33:3 121:22 165:7 184:11 247:10 generally 65:10 113:5 generate 105:13 180:2 190:11 242:5 generated 89:21 generates 105:3,11 generating 179:17 182:15 generator 67:9 genesis 87:21 120:19 121:2 125:11 179:16 GENTILI 2:22 Geriatric 245:16 geriatrics 186:19 getting 36:3 39:19 42:8 44:18 46:14	81:7 87:2 93:13 98:4 121:19 123:18 125:10 130:8 134:16 149:19 166:17 171:12 208:11 213:13 222:19 225:13 231:11 233:12 248:5 give 8:22 42:11 79:13 102:8 113:2 118:5 132:19 150:13 161:1 179:8 206:9 241:16 245:12 given 48:18 61:6 74:11 141:18 162:10 230:15 239:10 240:19 gives 35:16 96:20 163:3 220:21 glad 142:6 150:18 global 36:22 158:21 go 4:4,7 32:5 34:22 35:2 42:21 48:10 48:15 51:2 52:20 53:2 63:10 67:18 67:20 69:1 71:3 71:20 81:4 82:9 93:1 97:19 99:2 106:1 108:1 111:22 119:22 121:16 124:2 134:5 139:7 159:5 165:8 167:4 170:17 172:1 175:4 177:16 181:5 183:2,20 206:9,15 207:13 208:12 209:20 210:10 215:18 218:8 221:16 227:11 231:12 233:22 234:2 235:11 238:12,15 238:20 241:18	244:2,3,3,18 245:3 247:22 goal 18:17 71:15 goals 32:2 66:1 71:2 105:7 God 37:14 goes 47:18 52:19 78:6 95:7 100:3 115:20 172:21 182:11 203:18 217:13 223:10 Goeschel 2:2 4:9,9 48:2 98:11,19 99:17,21 121:9 139:22 166:13 195:20 224:9 246:15 going 4:3 6:12,17 7:11 9:22 11:8,20 12:1,11,13 23:5 24:1 29:17 30:15 33:12,15 34:22 36:7 37:6,15,22 39:18 44:6 47:22 48:3,17 50:10 53:3 58:9 68:3 69:17 72:1,3,22 77:17 79:3,11 81:4 82:7 85:3,6,8 85:16 86:2 87:4 90:20 92:21 96:17 97:10 99:6 100:1 100:5,16 104:3 108:11 111:1 112:16 114:18 115:8 119:4 121:22 124:12 130:11 140:15,22 143:20 154:6 157:12 158:2 161:12 162:8 164:11 165:2,5,8 165:11 171:18 172:16 173:6,21 177:16,17,18,22 178:1,5,6,8,10 179:7 181:9 184:5	184:22 193:11,12 194:1,2,6,7 202:6 205:18 208:5,18 209:8,19 210:18 214:19 215:14,15 215:17,18,19 216:8,10 221:13 222:14 224:11,20 225:20 227:6,9,11 227:12 228:13 230:21 231:4 234:5 235:8 237:16,22 242:2 245:3 247:2 248:11,12 good 30:13,14,17 36:5 44:1 45:5,17 46:5 47:8 56:15 61:7 65:9,12 66:18 72:17 78:18 78:19 81:21 97:21 116:13 117:2 120:22 134:7 142:20 144:11,17 149:10 164:9,19 177:6 182:6 183:18 190:3 216:4 222:10 223:18 230:16 231:3 238:9 240:19 244:11 246:5 247:11 goofed 208:15 goofing 237:13 Google 243:4,20 gossiped 245:2 grab 34:11 gradation 150:11 grant 140:1 gravitating 213:16 gray 145:15 great 5:12 27:1 32:12 37:1 42:13 44:14 47:5 61:19 90:10 101:8 173:4 184:2,4 200:13 greater 102:16
---	--	--	--	---

117:19,19	161:14 189:5	hang 244:1	havoc 111:11	hear 86:6 137:3
Greg 3:8	204:9 206:12	hanging 6:5	hazard 130:21	233:18
Gregg 1:10,21 3:12	208:7 220:21	hanky 169:3	hazardous 235:19	heard 21:11 76:15
3:15,18 5:10,15	225:15	happen 9:13 12:12	hazards 131:6	140:12 148:12
10:11 11:13 26:9	groupware 245:11	14:4 15:15 18:12	132:11,12 134:18	234:7
26:13 27:22 28:4	grows 109:7	18:12 20:9,22	210:17	hearing 55:1 77:4
31:20 34:10 46:17	guess 10:12 25:12	21:1 25:1 31:12	head 151:15 161:18	141:21 163:10
48:12 61:18 75:1	53:6 56:5 68:13	35:5 43:11 47:15	244:21 247:9	175:19 220:10
89:15,18 102:5	72:21 74:19 79:10	50:15 53:5 90:11	headed 183:17	248:17
106:4 126:21	84:16 101:15	94:5 104:4 111:4	heading 117:13	hears 4:6
127:13 133:8	138:8 140:14	129:11,11 139:2	headline 25:22	heart 77:8 127:10
139:12 175:14	143:5 154:10	147:16 166:17	headlines 199:21	heating 148:16
Gregg's 29:15	189:12 197:20	174:4 212:22	heads 54:11 57:1	heaven 37:21
grid 158:9 197:7	211:22 216:5	226:13,20 243:12	222:4	heavens 37:15
235:9,10,13	guidance 111:17	happened 42:19,20	headway 44:14	heavily 212:20
239:20 240:22	117:14 127:14	59:7 102:22 247:8	health 3:14 34:20	heck 131:8
ground 21:15	152:21 153:14	happening 21:22	68:5 69:7 92:6	held 29:12 212:13
145:13	210:22	35:13 123:17	101:5 115:10	216:10
grounded 123:9	guideline 43:20	236:7 237:9	160:3,15 168:8,9	Helen 2:4,12 5:5,8
grounds 173:14	77:5,12	happens 62:22	183:19 187:1	5:9 6:1,12 36:1
group 12:20 13:14	guidelines 19:20	106:8 119:1,11	194:13 202:20	61:22 69:13 105:8
23:5 24:5 48:20	210:19,20	129:17 143:8	217:18 222:1,22	107:4 108:17
49:17 52:18 62:10	gurney 37:7	200:14 204:17	224:6,16 226:21	112:2 115:1 122:5
63:11 64:2 102:8	Gurwitz 211:18	212:8 232:5	228:14,21 229:4	125:21 128:6
106:7 112:15	guys 68:18 112:11	237:20	229:21 230:7	133:3,12 147:5,10
113:13 121:2	125:19 141:16	happy 64:12,14	231:8 234:13	153:16 159:5
144:18 154:18	181:1 184:2,3	116:16 165:13	237:5 246:21	160:1,11 168:5
157:17 183:15	186:13 194:7	179:5 191:5,10	healthcare 1:3,4	175:1 178:16
184:1,4 186:17	218:1 237:12	239:3 248:8	9:19 12:8 17:7	179:15 181:3
188:16 190:19	241:3,9	hard 27:3 120:17	20:16,17 21:5,7	184:3 188:8
191:11 193:18		130:1 238:2	25:1 28:20 34:11	206:10 207:9
194:8,11 199:11	H	harm 56:13 145:7,9	35:17 54:1,7,20	210:8 219:13
206:2 207:13	HAC 62:13 63:17	145:11 146:1	59:15,15 62:8	220:2,17 228:2
208:18 209:13	HACs 60:18 61:3,4	152:5,7 205:10	63:5,12,13 65:5	233:6,16 238:9,9
218:4 219:3	Hadler 80:10	227:13 231:18,19	66:2 67:2,4,14	240:12
222:11 224:7	HAI 66:16 246:18	232:1 233:13	68:22 91:10 95:20	Helen's 70:18
225:11 226:8,17	HAIs 57:18 60:10	237:9	95:22 96:12	167:8 207:9
227:19,19 228:4	65:21 68:12 101:1	harmonization	101:13 109:10	hell 46:3
229:13 240:18	half 55:16 240:19	32:3 71:16 163:14	116:18 126:13	help 25:20 26:7
242:4 244:13	244:7	harmonize 66:12	142:3 151:13	37:21 47:11 66:5
245:17 248:22	halfway 72:22	123:5	155:11 163:1,8	70:11 114:19
grouping 192:15	hand 37:2,11,16	harmonizing 40:5	164:22 165:10,14	115:4 117:4
203:9 224:3	165:6 213:19	harmony 70:20	165:17 168:1	139:20 157:12
groupings 57:21	handed 151:18	71:1	172:16,21 173:14	168:19 180:1
186:11 201:16	handle 194:3	Harvard 150:9	178:18 185:11,11	182:14 184:12
225:3	handled 35:8	hat 144:12	205:22 210:13	224:21 231:11
groups 36:7 68:18	hands 52:8 95:19	hate 216:14	229:8	helped 59:4 113:21

helpful 53:12 161:13,16 184:11 226:9 238:15 244:5	holds 193:13	114:20 115:19	human 15:16 24:10 146:12	illustrates 146:7
helping 157:16	holes 104:11	185:6 187:9 191:6	humanly 35:12	illustrative 145:20
helps 159:15,21 245:11	home 3:14 20:20 68:4,5 69:7 95:20	191:10,15,19,20	hungry 247:21	imagination 9:15 10:3,13 11:7 12:5 34:8
hemmed 20:18	96:14 97:3,14,19	191:21,22 194:16	Hurst 2:12 5:3	imagine 12:3 183:14
hemming 24:3	99:1 103:3 115:10	196:12 201:8,11	hurt 78:20	immediate 48:4
hemolytic 89:5	117:17,19 118:3	202:7 203:8 213:5	Hyatt 1:10	impact 124:19,20 144:5
hemorrhage 94:11 151:16	144:15 159:17	213:8,14 233:7,22 233:22	hyperbili 107:6	impacts 152:14
Hep 135:8	177:22 183:19	hospices 146:21	hyperbilirubine... 102:14	impersonating 163:7
heparin 85:9,17	185:1,10 187:1	hospital 3:8 7:8 21:3,5 37:6 63:19	hyperbilirubine... 107:19	implementable 222:18
he'll 123:7	191:20 194:13	67:1,8 93:10 99:2	hypoglycemia 101:12,16 108:2,9 156:20	implementation 46:15 111:17 117:14 127:14 152:21 153:14
HHS 63:11 65:18 65:19 67:2,19 181:7,14 214:2 218:7	202:18,20,21	99:10 100:2,6,7	hypoglycemics 108:10	implemented 30:8
Hi 31:3	203:5 215:13,17	100:18,21 101:18	<hr/> I <hr/>	implementing 27:16 176:5 222:12
HICPAC 210:18	217:18 222:1,22	102:7,22 104:22	ICD 64:22	implicitly 130:12
hidden 149:4	223:4 224:6,16	117:1 119:2,12	ICFs 229:14	implies 23:7 25:16 149:12
hide 172:3	226:21 227:8	120:5 122:11,14	ID 210:12	imply 15:22
high 9:10,19 10:5 28:20 95:2,4 129:6 172:15	228:13,21,21	126:1,5,5 147:4	idea 25:5 42:1,13 44:1 64:2 69:18 116:5 136:18 150:12 197:7 219:3,4 237:21 244:11	import 90:10
higher 213:13	229:4,5,10,12,21	157:6,7 162:18	ideally 243:12	importance 11:6 11:12 90:13 143:1 235:21
highest 239:16	229:21 230:5,6	164:14 181:16	ideas 6:19 141:15 180:2 182:16 241:4,13 242:5,8 242:11 244:9 246:12	important 17:10 24:6 31:2 54:20 57:2 60:15 67:7 82:11 84:10 91:1 94:1 105:19 106:12 122:19 142:11,13 146:7 146:10 149:18 154:12 172:22 174:5 181:4 202:4 211:8 219:10 222:2 223:20 228:4 234:8 244:8
highlighted 75:17 169:9	231:7,8,9,20	185:9 188:4 189:1	identifiable 54:3 84:8	impossible 36:16
highly 21:4 48:8 99:13 200:15 212:13	232:13 233:7	191:19 192:21	identification 64:17	imprint 8:18
high-risk 200:5	234:12 237:5 249:2	194:18 197:18,19	identified 56:5 225:3	improper 170:15
hip 116:21	homes 146:21 185:16 229:13 237:10	198:18 203:7	identify 85:11 102:13 142:10 235:18	
historically 227:21	home-based 221:6	206:3,16,20	identifying 69:10	
history 121:2	hooked 135:21 136:1,15 137:1,4 137:5	207:14 212:11	illegal 168:13	
HIV 37:15,17	hooks 33:9	225:11 226:7,9,13	illness 55:11 150:3	
HLA 89:6	hope 50:19 69:19 70:2,7,13 108:8 134:9 143:17	233:12 234:3 248:4	illustrated 117:1	
Hoer 2:3 4:14,14 19:14 42:13 79:6 113:12 135:19 161:12 164:6 170:10 192:10 212:11 222:8 232:10	hopefully 47:22 66:14	hospitals 3:3 30:15 31:17 50:8 66:5 79:22 102:2 103:4 104:16 122:16 153:20 156:11,14 170:11 178:11 196:1,1 204:15 206:8 219:2,4,7 225:15		
hold 28:10 110:7	hoping 226:4	hostile 105:14		
	horizons 95:18	hot 115:10		
	horrendous 139:1 148:10	hours 6:20 148:18		
	horrible 245:4	huge 11:21 138:18 139:6,10 144:12 147:1 176:11 193:1 221:12		
	horrified 18:7,9	hugely 159:14		
	horrors 237:7	huh 238:5		
	hospice 21:20			

improperly 170:22	increase 19:16	initial 38:16 98:17	insurance 237:18	intervention 64:17
improprieties	28:11 33:1,19	140:3 184:13	insure 237:11	65:9 142:11 143:2
168:15	154:21	226:12	intended 45:6	236:14
impropriety 169:2	increasing 215:13	initially 98:13	53:21 74:20 87:13	interventions 84:9
172:17	increasingly 94:1	181:21 192:18	88:11,13 174:20	interview 37:21
improve 100:10	incredible 39:4	initiation 209:21	intense 199:7	interviews 36:6
improvement	incredibly 10:21	initiatives 63:7	intensity 205:15	intracranial 151:16
38:14 125:3	90:9,11 106:11	105:6	intent 40:5 74:17	introduce 97:19
improving 168:8	120:4	injuries 142:14	128:3,9 129:13	introduced 43:15
223:21	incur 135:5	143:3 148:1	131:10 156:6	43:19
inadvertently	incurred 142:2	151:15 235:19	intention 39:13	intuitive 205:1
245:1	indefensible 19:3	injury 55:11 111:6	186:10	investigation 32:7
inappropriate	indicate 239:15	132:11 145:22	intentional 146:13	32:13 41:4
116:11 169:7,15	indicated 239:16	149:15 150:3,5,7	interaction 87:14	invoke 146:16
incapacitated	indicating 103:15	150:11 173:11	218:7	168:16
122:2	158:14	174:12 175:4	interactions 73:22	involve 244:17,18
inch 197:10	indicative 54:19	236:2 237:9	86:14,22 87:5	involved 42:22
incident 135:15	individual 26:6	inpatient 3:8 7:8	88:3,14 171:19	150:5 174:16
include 13:19	30:15 55:4 157:18	188:3,20 194:18	interchangeable	229:3
47:11 54:4 74:10	167:13 203:14	194:19 197:18	228:20	involvement
82:3 88:14 110:19	individually 216:15	198:17 203:7	interest 123:16	174:19
111:5 130:16,16	216:16	204:15 205:4,14	131:16 197:15	involving 73:13,19
147:6,9 161:3	individuals 171:22	206:3,20 225:10	199:8,19 210:14	126:15 169:3
173:18,19 176:2	industry 35:17	226:13 236:5	234:11	in-between 54:16
195:22	36:17 156:13	input 118:9 161:1	interested 24:4	145:16 188:22
included 41:15	inevitably 208:14	182:8,20,22 183:7	25:7 94:15 199:4	in-office 170:15
56:14 82:2 87:16	infant 163:18	246:14	215:2,5	irrelevant 91:22
96:15 127:15	infection 74:12	inputs 180:5 241:3	interesting 121:17	irritating 165:22
160:9,12 161:9	200:11 210:16	246:13 248:19	124:22 162:5	isolated 16:17
175:18 192:13	infections 63:6	INR 78:12	199:9 200:19	142:13
206:19	66:3	inroads 70:21	interface 202:17	issue 28:8 33:2
includes 73:19	influence 220:11	insemination	interject 17:21	36:21 46:20 47:12
91:11 98:20 99:22	influenced 54:6	125:15	39:18 46:12	49:21 75:2 78:4
151:14 206:3	informally 245:7	instance 42:15 92:9	intermediate	92:3 94:1 102:9
207:13 229:6,13	information 11:8	101:19 163:6	188:21	107:20 110:13
229:13	79:11,22 85:4,5	168:13	intermixed 117:13	122:22 124:22
including 71:12	85:14 123:22	instances 20:12	internal 93:16	125:2 131:18,19
142:16 177:21	125:2,11 137:8	135:21 171:16	international 24:19	132:17 134:5
194:14,18 203:20	140:5 199:9,10	institution 18:13	internationally	139:15 146:8
210:15 216:22	200:19,20 214:19	93:16 100:4,5	246:19	147:2 152:9 154:5
incompatible 89:6	233:3 238:15	institutional 99:12	internist 107:17	155:20 162:18,19
89:12,13	248:9	institutions 101:22	internists 187:10	169:6 171:7 172:5
incompetence	informed 245:9	131:4	interpretation	173:1 174:5,15
15:18,22 16:7	infusion 212:3,5	insufficient 51:10	147:13 158:15	176:11 181:9
inconsistent 108:12	217:7	103:15	175:16,20,22	198:12 200:9
incorporated 123:3	inhibitors 86:21	insulin 109:2	interpreted 16:7	201:21 204:8
incorporates 66:2	87:2	insulins 108:10	intervene 124:18	209:13

issues 46:14 50:16 75:3 85:6,7,9,19 90:3,6 94:19 99:3 100:11,11 103:22 106:10 124:5,7 128:10 130:12 137:13 153:19,22 159:19 162:5,22 168:2 169:21 186:13 193:14 195:14,17 198:22 211:17 225:21 228:11 230:18,21	138:12 148:11 149:9 155:17 197:12 199:1 208:19 Johnson 140:1 John's 72:2,8 123:6 149:19 Joint 32:8 144:12 judgment 73:18 jump 6:21 31:4 72:20 213:15 jumping 58:11 218:6 juries 18:22 justification 86:19 justified 123:8	138:16 139:16 141:8 143:7,12 145:12 147:14 148:6 149:13 150:22 153:15 154:9 158:19 159:18 163:3 164:10 169:3,5 172:21 176:6 178:21 185:14 186:19 190:12 191:22 192:1 197:4,15,22 203:9 204:11 205:10,14 214:6 218:5 224:16 225:11 226:2,11 231:2,10 232:11 234:22 237:12 239:21 243:1,4,11,15,22 246:22	150:6 154:11 159:19 160:16,20 169:12,16 170:2,4 171:21 172:2 177:20 185:12,13 186:7 187:6 190:5 195:14 197:6 200:1,13 206:14 208:1 209:12 212:4,6,7,12 213:7 215:3 216:1 216:10 221:10 223:14 225:4,6,7 225:9 227:9,9,12 227:13,13 229:19 230:20 232:19 235:10 236:15 237:12 240:12 243:10 245:4 246:6,6	117:13 147:3 lastly 154:17 latest 22:9 112:6 243:9,14 Lau 2:4 5:8,8 6:10 108:17 110:5,9 115:1 125:20 128:6 133:3,12,18 133:21 134:7 147:5,11 152:17 160:1,14,20 161:5 161:8 188:8 206:10,21 207:7 207:12 219:13 220:2,17 233:5,20 249:4 laugh 97:5 Laughter 58:16 62:20 72:5,9 73:9 209:11 215:9 218:18 law 42:16 103:20 104:7,18 170:19 199:5,20 laws 104:18 lawsuits 19:16 22:13 43:5,7 235:22 lawyer 170:12 lay 34:22 113:6 lead 14:21 15:19 32:2,7 40:8,10 41:8,11 181:5 205:18 leading 65:18 78:13 123:18 174:8 Leah 2:1 8:8,20 10:9 11:14 15:3 16:2 22:2 32:16 34:1 47:10 49:9 70:16 72:11 99:14 106:14,19 153:16 172:7 196:4 197:11 231:13 232:10 241:19 Leah's 24:16
item 32:18 218:19 220:14 items 19:2 58:2 121:3 184:18 196:11,14 216:13 iteration 179:20 iterations 183:2 it'll 72:7 188:18 216:5 228:15 241:16 245:21 IV 77:2 135:21 140:11,13 223:6 IVs 135:22 137:5 i.e 140:11 173:13	<hr/> K <hr/> Kathryn 2:5 27:22 93:4 96:8 Kathy 4:18 keen 66:12 keep 26:16 41:16 42:2 83:13 90:14 92:21 99:11 108:8 164:10 168:14 177:19 200:10 231:4 keeping 23:4,15 109:6 Kennedy 114:7 kept 48:3 kernicterus 102:12 104:3 kill 73:4 killed 131:2 146:10 173:22 kind 6:2 12:7 13:20 14:9 18:4 24:1 25:3 29:12 48:1 59:16 64:12 75:16 76:19 77:6 84:3,7 84:12 88:19 102:8 104:10,11 106:1 108:20 118:20 120:11 125:8 129:16 132:9	kinds 16:17 65:7 82:10 110:12 111:10 119:8 170:1 223:6 234:6 236:19 kitchen 97:4 knocks 44:19 know 5:22 6:2,20 9:8 11:18 13:1,10 14:11 22:5 23:3 24:14,18 27:9 30:21 43:22 46:2 52:17 60:4,20 74:17,20 78:3 82:9,14 84:2 86:17 89:7 90:16 92:6,17,20 93:6 100:8,19 102:21 103:18 105:14,16 106:3,6 108:6,22 112:11 114:5 116:3,15,17 118:22 119:8 120:13,16 129:7 129:16 131:3,6 136:17 148:20,22	knowing 61:12 knowledge 22:10 22:11 79:12 190:7 known 73:21,22 86:15,22 87:15	<hr/> L <hr/> labeled 182:4 labeling 214:21 labor 91:8 lacerations 142:18 lack 103:22 108:15 234:1 landed 179:5 language 32:9 34:14,18 38:12 40:1 41:15 42:4 47:12 53:18 54:8 56:13 73:17 78:9 91:11 126:14 139:9 144:14 151:14 160:15 203:17 largely 61:9 75:6 larger 55:4 57:13 60:18 68:11,14 90:6 110:17
<hr/> J <hr/> J 5:11 jacuzzis 73:6 jail 18:4 January 66:1 jargon 201:7 Jennifer 2:12 5:3 Jerry 211:18 Jersey 42:15 43:14 113:14 jettison 219:4 Jim 124:9 job 173:4 John 2:5 5:1 15:2 32:15 39:2 71:19 84:13,14 88:1,6 93:3 100:19 108:4 121:8 122:4 123:11 136:8				

Leapfrog 16:4 29:20 32:9 36:5 104:13,14	134:3 164:3 likelihood 22:7 79:21	214:4 215:12 216:2,6,7,21 217:10 220:9 221:7 223:15 224:19 225:14 226:2,6 230:19 238:4 239:20 245:5	109:3 112:8 154:15 183:18 186:11,15 190:18 201:16	235:22 looks 60:2 64:20 77:19,21 91:17 120:6 177:15 188:4,6 247:21
learn 115:8 146:11 149:19	limb 17:5 limit 101:21 239:17	listed 93:22 109:1 216:13 217:8 239:21	logically 36:15 186:16 240:2	lose 13:12 142:20
learned 209:18	limitation 75:9 93:8,9 148:15	listen 202:10	long 6:4 31:10 83:9 116:17 146:15 159:19 190:15 207:12	losing 81:17 loss 55:19,20 losses 236:3,7 lost 21:14 24:12 223:9 243:7
leave 23:12 51:3,18 106:1 133:6 151:18 165:17 185:6 196:12,13	limitations 129:21 limited 144:3 151:15 191:16	listing 158:12 188:12	longer 10:7 19:13 36:3 61:4 98:16 169:21 188:19	lot 11:2 25:2 30:14 33:7,18 36:11 42:17 50:14 53:4 59:3 60:14 61:8,9 64:18 70:22 73:7 76:18 77:12 79:8 80:10,12 82:17 85:8 87:4 103:19 105:3,12,12 114:11 115:3 120:15 132:18,22 136:14 144:8 148:21 161:1 162:10,12 171:12 186:17 195:13,16 195:16 202:22 211:16 221:6,10 221:19 222:4 229:2,6 232:1 233:3,8,9 245:1
leaving 23:20 48:21 64:12 67:18 142:19	limiting 45:13,15 211:19	litigated 44:18	long-term 3:12 7:10 118:3 156:13 157:3,8 185:4,10 186:2 189:14 190:21 191:1,7,11 191:17 194:21 195:1,4,21,22 196:1 200:15 203:4,7 214:12 216:11 217:18 220:14 221:2 228:8 230:4 231:9	lots 44:22 101:19 199:19 207:17 221:21 230:20 246:17
left 57:3 59:17 73:3 149:10 156:14 158:12 165:5 166:1	Lindsey 2:13 5:3	litigation 19:10 44:16,20 45:10,13 45:15 47:19	look 6:6 28:5 36:21 37:13,17 46:4 59:5 69:20 70:8 80:5,8,14 91:4 98:16 112:13,17 115:7 123:14 142:12 153:3 157:17,19 161:14 165:9 168:21 193:17 216:20 221:13 222:10,11 224:3 244:2 248:19	love 37:18 111:18 137:7 low 95:18 129:21 lower 65:2 101:19 lowering 34:15 low-risk 91:9 95:1 95:15 98:22 99:8
leg 77:11	line 26:12 37:5 135:15 136:3 139:16 140:12,13 140:13 145:11 149:1 171:1 177:3 223:6	little 7:16 14:14 20:10 29:7 32:10 37:18 41:21 42:2 42:8 57:17 77:20 83:1 103:4 109:18 120:19 130:8 142:12 143:20 145:14 150:7 165:9 185:7 188:19 194:8 209:20 211:14 216:12 226:5,19 232:2 244:1	log 82:16,18 154:2 162:12 181:16	LTACs 195:22
legacy 91:17	lines 26:10 87:19 135:22 136:3 137:2,19 138:10 139:1 140:10 229:10	live 15:12,13 17:22 19:11,12 217:8	looking 58:12 68:6 84:17 98:8 124:7 136:16 146:11 149:21 159:3,17 168:2 193:14 229:18 233:12	lump 139:14 154:20 169:10 lumper 154:19 lumping 167:8
legal 18:19 22:4 164:4	link 47:8	litigious 17:22		
legalistic 150:8	linkage 47:6	lived 121:11		
legislature 33:14	list 6:22 8:14 13:19 15:20 18:2,11 19:2 26:21 27:11 30:9 39:2 52:18 62:14 65:12 69:21 70:8 71:19 72:2,8 72:20,22 83:15 84:6,17 87:21 88:9 90:18 97:13 97:20 98:1,6 106:5 109:7 120:20 121:4 122:10,15 123:6 123:15 124:7 125:8 126:1 154:9 154:22 165:8 173:5 179:17,22 180:3 184:11 185:20 204:9,16 204:19 209:3,15 212:1 213:22	liver 91:14		
legs 168:22 177:9		living 37:6		
lessons 209:17		load 83:20		
lethal 87:1		located 1:10		
let's 51:2 73:16 91:10 95:10 102:14 109:8 124:13 126:14 142:20 162:7 177:7 181:17 209:1 216:20 218:4,8 224:2		location 207:17		
level 12:15 14:18 65:2,2 79:9 99:13 105:10 145:9 164:7 170:18 171:3 172:15 210:3 212:4 231:17 237:8		locked 160:6 161:6		
levels 102:16		locus 96:19 97:7		
licensed 163:8 225:7,8		log 243:13		
licensing 204:20		logic 186:22		
life 102:17 114:6,13		logical 18:6,22 44:4		
light 112:17 130:9				

168:12 183:14 lunch 231:11	MAO 86:21 87:2 Martha 2:6 4:16 12:16 80:17 148:12 164:16 188:16 196:4 212:10 218:4 220:6,11 228:5 235:6 Martha's 202:6 213:18 218:3 Massachusetts 31:11,20 massage 121:19 massive 84:21 228:11 maternal 91:7 92:10,18 94:4,6,8 95:9 100:6 maternal/child 98:14 matrix 159:7,10,14 240:21 matter 11:1 18:15 57:15 84:10 90:14 155:3 193:11 198:1 216:5 237:11 matters 16:10 197:21 mature 37:22 matured 213:9 MBA 2:22 McDONAGH 2:5 4:18,18 28:1 96:10 MD 1:21 2:1,2,5,6 2:8,9,10,10,11,12 3:4,6,8,12,15,18 3:19 mean 9:5,15 16:19 23:10 31:9 35:5 37:20 39:20 42:18 44:3 46:13 50:8 59:20 66:21 70:21 78:22 81:7,10 94:22 96:4 99:3 100:12,13 108:21	116:8,9 117:21 120:10 121:14,21 127:5 128:1 129:8 129:14 134:2,16 135:5 138:14 142:16 153:9,18 156:1,8 161:16 162:22 164:3,7 166:16 167:21 169:14 177:7 184:3,20 189:7 204:22 209:22 211:15 215:14 218:22 221:5,12 223:10 224:13,15 225:6 227:3 229:3 229:11 230:20 234:6 236:14 241:22 meaning 75:6 meaningful 178:4 means 9:12 25:13 25:15 49:4 55:5 60:4 86:10 99:12 165:4,15 178:1 185:13 meant 81:8 136:1 measurable 54:3 measure 96:7 104:14 141:9 143:15 measurement 31:1 measures 26:4 29:17,22 79:13 103:10 141:8 159:10 180:6,8,20 180:22 measuring 118:6 mechanism 15:7 27:14 30:17 85:20 146:6 mechanisms 15:21 30:14 33:1 244:15 Medicaid 229:9 medical 128:14 129:5,15 150:9 168:18,19 170:17	229:8 245:22 248:4 Medicare 191:20 medication 73:13 73:20 74:6,8 76:6 78:6 79:8 80:7,20 82:20 84:18,20 85:12,22 108:7 129:19 132:9 148:7 156:18 157:1 medications 86:13 161:4 216:1 223:5 medicine 37:6 76:4 76:11 92:19 156:21 meet 149:5 meeting 1:3 6:7 8:2 24:19 33:5 66:11 136:18 149:6 247:14 meetings 6:3,4 37:3 247:13 member 2:1,1,2,3,4 2:5,5,6,6,8,8,9,9 2:10,10,22 4:9,10 4:11,13,14,15,16 4:17,18,19,21 5:1 5:8,11 6:9,10 8:11 8:21 11:16 12:17 13:9 15:4 16:3 17:20 19:14 20:14 21:9 22:3 23:16 23:22 25:12 28:1 29:5 32:1,17 34:3 36:2 40:4,13,16 40:18,21 41:7,11 41:14,19,21 42:13 43:13 45:9,17 46:7,11 47:10 48:2 49:7,10 52:16 53:11 56:8 57:9 58:12,17 59:19 60:5,22 62:2,4,9,11,12,15 62:21 64:11 65:15 65:17 70:17 74:4	75:21 76:13 78:18 79:6 80:4,18 81:10,22 82:13 83:6,11 84:15 86:5,20 87:6,12 88:5,7,8,16 91:16 93:5 95:4,17 96:1 96:4,6,10,16 98:11,19 99:15,17 99:18,21 100:16 101:1,4,15 102:19 103:6 104:5,13,19 104:21 106:15,21 107:2 108:3,17 109:5,14 110:5,9 110:12 111:9 113:4,12 114:3,17 115:1,15 116:3 117:8,16 118:19 119:15 121:9 122:6 123:13 125:20 126:3,18 127:3 128:1,6,20 129:12,18 130:4 130:10 131:13 132:4,7 133:3,10 133:12,18,21 134:7,8,12 135:7 135:11,19 136:9 137:11 138:4,8 139:22 140:7 142:4,8 143:5 144:2,20 145:3,19 147:1,3,5,11,21 148:12 150:17 151:7 152:16,17 152:19 153:17 155:1,19 156:3,10 156:17 157:2 158:6 160:1,14,20 161:5,8,12 162:2 164:6,17,21 166:5 166:13 167:1,17 168:11 169:18 170:10 172:8 173:12,16,20 174:10 175:21
--------------------------------------	---	--	--	---

176:9 184:17 185:17,21 186:1 187:4 188:8,14 189:13 190:14,22 191:4,14 192:10 193:7,10 195:4,20 196:6,20 197:6,13 198:8 199:2 200:22 201:17 202:15 203:19,22 204:3,5,7 205:9 205:20 206:4,10 206:21 207:2,7,12 208:1 209:4,6,12 210:8,11 211:22 212:11,18 213:4 213:10 214:18 215:8,11 216:14 216:18 217:16 218:11,16 219:13 219:19 220:2,4,17 220:19 221:11,15 221:17 222:8,20 224:9 225:1,19 226:10 227:1 228:6 230:1 231:15 232:10 233:5,20 235:8,12 236:8,10 237:16 238:1 241:21 242:12,18,21 243:1 244:22 245:15 246:15 248:1 249:3,4 members 36:7 174:17,17 176:3 176:18,21 177:3 245:18 membership 52:19 52:21 242:1 246:4 mention 8:1 163:2 179:15 mentioned 33:5 39:2 125:21,21 160:9 meperidine 86:20 87:3	mess 122:1 message 245:13 messaging 241:17 met 245:15 method 82:2,14 methodologies 243:5 methods 152:7 metric 161:21 Meyer 1:10,21 3:8 3:12,15,18 10:11 26:9,13 46:17 51:15 52:3,6 61:18 74:22 89:10 89:18 90:8,17 102:5 106:4 126:21 127:6,20 128:4 133:8 139:12 152:12 175:14 MHROD 2:4 MHS 2:12 mic 98:18 166:2 173:7 Michael 2:10 4:11 8:10 17:18 19:15 34:2 35:22 43:12 47:17 48:11 58:10 60:6 64:10 76:12 78:17 81:4,12 83:10 91:15 96:9 113:11 116:1 128:19 132:13 145:18 158:5 162:1 164:20 168:10 173:14 187:3 196:7 207:21 235:7 239:19 244:20 Michael's 45:12 49:11 172:9 197:7 235:9 243:14 microphone 221:22 middle 21:15 76:1 86:7 145:13 175:5 Mike 58:11 84:16 93:5 95:8 119:14	123:19 231:14 Mike's 122:7 218:5 mild 120:8 milligrams 102:16 million 20:1 mind 17:13 24:2 72:3 83:13 119:21 122:9 123:7 155:20 160:2 165:19 171:5 194:10 mindful 71:4 minimal 141:12 minimalist 48:9 minimize 123:5 152:5 mining 221:13 Minnesota 29:8 109:17 173:21 minor 18:15 144:7 minute 207:6 minutes 157:15 misadministering 223:5 misadministration 215:22 misadventures 131:11 134:14 misbehaving 171:8 misconnect 136:3 misconnections 137:20 139:6 misdeemeanors 168:15 miseries 237:7 mishaps 139:16 misinfusions 215:22 mislabeled 137:19 138:10 misreading 120:7 missed 208:13 misses 12:22 13:3 80:6 81:14 missing 149:3 153:16 misspoke 62:16	mistake 36:13 mistakes 12:12 mistubing 215:22 mitigate 236:18 mixes 153:11 mode 83:12 model 96:21 165:20 modern 34:10 modification 121:5 modifications 225:14 modifying 40:1 203:17 molecules 37:18 mollified 238:17 moment 58:10 69:21 234:14 moments 214:15 momentum 24:11 money 44:21 206:15 monitor 78:11 monitoring 78:5,8 78:15 82:4,6 83:5 monkey 187:13 242:7 monovision 238:13 month 50:3 169:1 241:8 months 103:14 191:16 morbidly 94:22 Morley 2:5 5:1,1 15:4 32:17 84:15 86:20 88:7 93:5 95:4 97:16 101:1 102:19 109:6 122:6 123:13 131:13 136:9 148:12 155:19 199:2 209:6,12 248:1 morning 86:9 177:1 179:1 184:5 226:4 mortalities 94:5,6,8	95:9 mortality 200:5 mousetrap 18:20 move 14:10 28:20 37:10,20 48:13 50:19 67:10 88:20 89:3 91:5 101:9 109:8 117:2 118:16 126:4 133:6,7,13 135:14 141:21,22 151:10 155:8 158:18 159:21 163:11 170:7 180:3 228:3 moved 122:15 125:22 191:10 204:2 217:21,22 217:22 218:1 227:22 243:19 moving 68:18 91:19 98:3 151:10 151:22 163:5 166:9 227:4 MPA 1:22 2:2,8 3:9 3:13,15,19 MPH 2:2,3,8 MSc 1:21 3:12,15 3:18 multiple 42:22 multi-system 113:16 mumblings 221:22 music 109:22 110:7 Musical 110:1 musings 178:21 myopathy 91:15 <hr/> N <hr/> N 4:1 NACHRI 102:7 Nadzam 2:6 4:10 4:10 name 4:6 22:20 34:6 named 109:2 narcotic 108:13 narrow 135:20
--	--	--	--	---

national 1:1 10:17 10:18 65:20 105:6 210:2 246:21	219:1,6 224:21 225:2 229:17 232:6 234:14 235:11 241:18 246:6 247:20	39:16 43:18 47:11 47:13,14,15 49:4 49:21 50:7,7,11 51:6 52:1 69:20 72:7 74:5 106:8 108:6 117:17,22 118:21 146:13 150:21	50:22 82:15 nots 240:15 November 1:6 nowadays 185:2 No's 52:12 NQF 5:3 16:15 29:20 30:9 34:18 38:7 42:9 52:19 64:5 66:12 87:20 104:6,14 112:4 141:10 167:18,22 168:7 180:16 215:2,4 222:17 224:10 243:10 245:4,19 NQF's 39:10 63:22 71:1 92:7 228:2	observe 157:5 obstetricians 94:3 95:5 obvious 192:11 obviously 15:15 43:9 64:6 71:11 94:9 117:11 156:6 169:16 179:7 192:20 241:12 246:16
nationally 43:7 124:10	needed 8:13 58:2 63:18,21 69:5 76:9 226:13	new 26:21 34:5,16 37:21 42:15 43:13 49:13 60:11 66:14 69:11 73:17 87:20 94:6,7 98:3,12 112:18 113:14 121:18 141:13,18 151:14 156:8 168:7 182:14 188:17 199:5 209:22 228:3 235:3 239:13 240:7,7 243:20 248:3	NQF 5:3 16:15 29:20 30:9 34:18 38:7 42:9 52:19 64:5 66:12 87:20 104:6,14 112:4 141:10 167:18,22 168:7 180:16 215:2,4 222:17 224:10 243:10 245:4,19 NQF's 39:10 63:22 71:1 92:7 228:2	obviously 15:15 43:9 64:6 71:11 94:9 117:11 156:6 169:16 179:7 192:20 241:12 246:16
natural 29:2	needle 134:15 135:8	newbie 247:5	number 19:16 76:6 112:7 136:2,11 137:6 171:22 200:6 211:1 217:12 241:11 248:11,12	occupational 189:19
nature 54:4 97:8 187:14	needs 28:15,22 43:3 75:16 81:21 84:6 123:8 125:13 138:19 157:17 204:1 246:3	newborns 163:20	numbers 100:12 236:6	occur 8:7,15 9:5,6 9:8 13:1,2 15:21 16:18,21 18:16 21:18 22:14,17,17 23:6,10 32:6 35:1 40:8 48:22 51:21 58:8 63:3,8 91:12 106:12 167:10 192:21 198:10,11 202:21 204:17 215:16,21 235:20 243:6
near 12:22 13:2 57:15 80:6 81:14 83:16 114:21 238:14	negative 55:9 150:1	newer 118:13	nurse 159:17 163:7	occurred 20:3 23:18 43:2 99:8 146:12
neat 215:4,7	neither 122:20 145:7	newsletters 245:21 245:22	nurses 229:4	occurrence 54:5 55:7
neater 85:14	Neonate 102:17	newspapers 34:7	nursing 3:11 7:10 68:4 111:16,19 118:3 137:20 185:11,13,16 186:1,18 190:8,12 190:15 191:20 194:20 195:2 200:16 211:16	Occurrences 76:1
necessarily 15:22 39:16 42:14,21 57:22 58:1 69:5 81:15 104:3 107:13,17,18 110:15 111:20 154:21 157:22 181:13 223:13 229:11 234:15,20 235:3 239:17	neonates 102:14 103:17	newspapers 34:7 newsworthy 10:7	N.W 1:10 N/A 167:4	occurring 79:21 115:9 122:13 215:15 223:3
necessary 36:10 38:2	nerve 199:2	nice 7:16 37:11 80:5 163:3	non-existent 213:7	occurs 55:14 95:19 97:1 101:12 124:15 146:20 173:13 183:6
need 7:7 8:19 24:14 24:15 26:6,14 28:3 30:5 39:21 43:10 53:6 58:7 58:19 63:10 67:20 72:19 75:12 82:22 92:17 99:11 104:12 105:4 107:7 115:4 117:4 117:14 118:10 120:18 121:17 128:16 133:15,21 137:17 141:1 145:12 149:16,20 150:7 157:18 161:1,8 162:15 175:4 176:4 177:6 181:14 182:1 187:20 192:11 199:14 208:20,21 214:6 215:13	nervous 45:22 119:16 235:14	nine 33:16	non-serious 45:11 45:14	odor 120:8
needed 8:13 58:2 63:18,21 69:5 76:9 226:13	net 124:9 141:13	nodding 54:11 244:20	non-slip 131:7	offense 172:14
needle 134:15 135:8	nets 130:3	nomencature 205:21	nos 52:13	offer 40:1 44:21 200:17 228:12,17 231:5
needs 28:15,22 43:3 75:16 81:21 84:6 123:8 125:13 138:19 157:17 204:1 246:3	networks 245:2 246:10,17 248:7	non-existent 213:7	note 46:22 88:22 102:11 142:22 160:10,13	offered 39:22
negative 55:9 150:1	neutral 91:22	non-serious 45:11 45:14	notes 151:18 160:22 247:5,15	office 187:9 188:7 199:6,17 210:6 219:18 228:10
neither 122:20 145:7	never 9:1,5,6,7,12 9:12,12,14 10:2,8 11:1,4 12:6,7,11 12:13 13:6,14,18 14:2,19 15:6,13 15:14 16:4,6,9,10 16:13,18,21 17:1 17:10,12 18:16 19:12,20 20:6,19 21:1,12,14 22:12 22:14,22 23:4,15 24:20 25:13,15 26:1,16 27:19 31:9,14 32:22 34:7,12,17 35:1,4 35:4,10,11 36:12 36:13,18,19 38:2 38:8,14 39:5,8,12	notice 30:1 50:10		

235:15,20 236:8	134:12 137:10	openness 28:9	original 87:21 98:2	P
offices 194:15	141:21 146:15	operated 193:21	98:14 100:18	P 4:1 5:11
198:12 203:21	153:16 155:7,16	operating 148:17	128:9 156:5	package 28:17
209:5 210:15	157:13 158:4	operator 8:1	179:15 215:12	packet 188:11,15
211:11 212:15	160:10,19,21	176:19 177:2	originally 48:22	pad 148:17
213:18 214:9	161:7,10,11,22	opinion 71:6 168:4	origination 38:9	page 6:18 53:15
216:22 219:21	163:10 164:16,19	168:6 243:2	OSHA 131:8,8,9	57:4 188:14,15
221:1 222:9 225:4	164:20 166:7,10	opinions 24:5	osteopathic 121:12	232:12 238:9
236:7,9 237:5,10	166:11 172:6	224:8 238:10	124:3	paid 187:15 193:19
237:19	173:2 175:12	245:8	ought 10:20 18:9	palliative 185:6
office-based 199:22	177:4,5,7,9,14	opportunities	18:12 27:10,15	192:3,4 201:11
200:7 210:1	178:8,11 182:17	136:3	65:21 102:6 130:2	202:7 203:8 213:5
213:16 214:8	188:10 191:3	opportunity 27:1	136:4 170:3,7,7	213:9,14
217:4,5 219:8	193:9 196:3 198:9	33:19 47:6 154:9	208:10	panel 114:19 116:6
220:22 236:19	203:5 207:20	200:18 223:2,9	outbreaks 211:1	157:12 169:19
official 102:8	214:16 217:14	227:15 241:16	outcome 9:10	172:9 189:10
oftentimes 157:7	218:20,21 219:14	opposed 69:11 74:8	131:15	201:22 219:2
185:5	219:17 220:5,10	76:10 90:5 119:10	outcomes 128:13	panels 3:5 7:4,4
oh 11:22 34:15	220:20 231:3	121:6 128:13	148:10	182:12 219:5
37:14 46:5 84:2	234:4 235:12	132:17 133:1	outlined 228:15	240:6
90:12 99:18 110:9	238:7 239:4	148:7 164:12	240:16	panky 169:3
119:20 173:8	242:12	170:6 197:15	outlines 178:17	paper 197:10
190:5 197:10	old 144:12	205:16 210:6	outpatient 187:9	paradoxical 87:17
Ohio 50:4,6	older 73:4	236:12	193:22 194:15	88:12
okay 5:9 25:15	omission 76:17,19	opposite 21:13	197:19 198:9,18	paralyzed 121:19
27:21 31:7 37:15	78:10 81:13 82:4	23:10 54:11	207:5 217:1,7	paranoia 91:18
39:17 41:20 49:9	82:5 83:5	options 132:22	221:1 228:7 236:3	Pardon 106:21
51:2,7,17 52:3,6,7	once 120:16 139:2	oral 108:10	outside 57:7 113:17	parens 203:17
52:12,13 56:17	215:16	order 76:22 77:1	122:10,13,16	parent 164:13
61:6 62:3,11,15	ones 44:17 45:6	82:15	167:22 180:5	parental 150:4
62:16,18 63:11	76:18,19 84:1	ordered 77:1 163:6	211:3	Park 1:9,10
66:19 71:22 72:12	102:21 109:1	ordering 78:7	overall 11:6 182:7	parking 221:19
72:17 73:10,16	129:21 131:15,18	organ 90:2,8	overdose 131:19,21	part 7:2 8:3,20
74:2 78:16 82:12	148:2 165:9 180:1	113:16	overlap 162:5	12:19 21:22 30:8
83:8 84:15 86:4	188:17 192:22	organization 28:21	195:17 215:21	55:8,20 70:22
89:1,14 91:3,7,15	199:3 217:18	37:10 80:21,21	overlapping 163:16	71:1 80:19 81:9
95:16 96:22 99:19	226:6 238:12	167:20	187:12	87:20 90:21 96:18
99:21 100:14	239:15 240:1	organizational	overlaps 181:20	100:17 101:16,17
101:8,9 102:3,10	ongoing 7:17 75:1	81:14	192:1	105:5 122:12
102:11 104:20	248:19	organizationally	overly 162:15	129:6 140:16,21
107:22 108:1	onset 101:12	203:11	overnight 73:8	145:4 147:19
109:8,13 110:9,11	open 8:2 77:15,16	organizations 28:9	overseen 21:2	150:4,9 157:16
123:11 125:9,14	78:4 121:4 183:22	79:15	oversight 216:3	180:6 181:6 190:5
125:18 126:10,17	242:10,13 246:12	organized 21:4	232:2	192:21 204:7
127:2 128:18	opening 26:3 59:18	184:19 187:15	oxygen 135:15,21	211:4 226:3
130:10 132:6	77:4 132:22	organs 89:12,14	135:22 137:1	242:18 246:8,18
133:11,20 134:7	164:22 192:17	oriented 217:7	138:13,15 140:13	partial 118:13

participate 248:6	190:17 199:21	perfectly 107:8,10	5:22 6:2,5 31:4,6	pieces 203:12
particular 19:19	200:4,5,7	120:22 194:4	51:14 52:9,13	pile 85:14
22:20 26:20 77:6	patient-centered	period 23:13 93:12	53:19 54:14 57:5	pilot 35:7 137:4
81:4 84:16 105:2	154:16	167:10	61:16 71:9 78:3	pin 137:2
172:13 190:9	PATRICK 2:1	permanent 140:16	86:3 110:4,7	pink 163:15
particularly 23:6	patterns 184:6	person 6:7 94:4	125:19 132:15	pipeline 214:1
36:20 49:3 51:6	pay 206:14	114:4 116:21	133:4,13 160:2	Pittsburgh 80:9
94:14 101:16	payment 71:12	121:18 124:16	163:10 166:4	pizza 208:2,4
102:1 148:2	190:9 201:5	163:19 187:8	175:13 176:22	place 136:18
211:11 232:4	PDCA 33:21	189:4	178:19 184:16	149:14 170:8
248:8	pediatric 85:6,18	personal 148:5	194:10,11 202:2	176:12 182:12
parties 215:4	101:18	229:7 246:12	211:10 219:12	194:8 195:11
pass 21:19 115:22	pediatricians	personally 205:13	220:1,10,16	placed 35:19
156:11	187:11	person's 113:6	221:21 230:13	places 11:19 97:2
passed 199:5,20,22	pending 112:21	perspective 39:10	233:6 237:15	103:18,19 211:8
passionate 49:21	Pennsylvania	126:7 155:2	241:7,11 243:16	plaintiff 18:5
path 48:15	101:4	201:19 204:20	244:5 248:16,18	plaintiffs 18:3
pathway 134:21	people 9:17 11:17	210:12 211:7	phones 176:19	plan 65:20,22
146:1,4,9	12:3 13:10 17:4	212:12	phrase 8:13 13:11	66:16 75:8 181:7
patient 3:4,6,20	18:14,21 19:8	perspectives	18:5	241:11
21:20 22:6 24:13	25:8 28:11 29:19	154:11	physical 155:21	plane 35:7 65:3
37:7 41:9,13 47:3	30:1,18 37:3,7	pessimistic 25:9	156:7 157:6	planned 126:15
73:11,21 74:12,15	39:21 42:7 48:20	Peter 2:11 3:4,6,19	162:21 173:12	plans 177:21
75:12 76:2 89:4	49:5,5 51:11,12	5:2 6:12 46:11	174:16 205:5	platform 243:20
101:10,13 105:6	61:8 73:4 77:8	56:8 65:15 67:21	physician 111:12	platforms 243:21
115:18 117:17	83:8 86:1 107:15	72:12 86:19 89:15	128:21 163:7	play 136:20 150:8
118:16 124:14,20	107:16 110:17	115:5 144:11	169:22 170:16	234:22
126:11,19 127:15	111:2 112:10	147:12 148:14	194:15 198:11	played 150:9
129:22 133:14,19	114:12 121:20	161:13 177:17	209:4 211:8,11	players 42:22
134:21 135:16	122:1 129:17	178:5,12	213:18 214:9	playing 187:6
141:22 146:19	136:19 177:8	pharmacist 163:8	216:22 219:18,21	plays 152:3
151:11,20 152:5	179:16 186:16	pharmacological	221:1 222:9 225:4	please 12:18 56:19
152:14 155:8	189:4 202:1,13	155:22	225:6 228:9	141:15 176:20
159:18 163:11	206:14 207:13	Phase 217:16,17	physicians 111:14	222:21
165:14,16 170:13	208:4 223:18	PhD 2:5,6	111:20 168:20	plenty 213:12
170:16,16,21	229:20 235:14	Phil 4:21	203:21 210:15	plough 208:10
172:16 173:11	239:16 245:8,13	Philip 2:9 4:21	222:12	ploughing 173:4
174:19 231:18	246:11 247:21	20:13,14 23:21,22	pick 72:19 177:17	203:3
232:4,4 233:22	people's 24:21	60:21,22 75:20,21	196:11 208:14	plow 73:1
234:2	31:15	80:17 81:22 82:13	picked 209:17	plug 65:13 230:13
patients 9:22 20:5	perceiving 49:18	83:6 86:4,5 88:5,8	piece 21:12 23:19	235:9
42:10 43:10 73:14	percent 22:8 93:6	128:18,20 129:18	31:16 111:10	plugged 138:14,15
79:20 80:14 87:1	236:2,11	132:6,7 140:6,7	156:7 184:10	138:17 153:15
94:12 117:19	perception 123:10	147:20,21 156:16	189:15 192:4	plugging 138:12
131:13 133:22	perfect 59:10 96:21	156:17 167:17	193:4 199:10	plunge 72:18
160:5,16 166:15	101:6 182:6	philosophy 91:18	201:8 215:19	plus 33:22 109:1
167:19 171:19	192:17	phone 4:6,8 5:7,21	238:15	PM&R 189:19

pockets 237:1	populations 171:20	125:4	preventable 8:6	problematic 43:3
point 8:17 11:6	portfolio 26:20	pregnancy 91:9,14	19:18 20:10 29:11	112:8 165:1
16:11 17:11,14	ports 136:1	95:2,19 99:1	35:6,15 40:6	problems 33:12
26:8 29:15 31:17	position 19:5 66:15	prejudicial 19:10	47:16 51:20 54:18	37:8 101:21 237:8
34:10 47:22 48:2	positioned 27:18	prep 143:9	55:11 92:13,22	procedural 195:14
49:11,11,16 51:7	positions 39:20	preparation 73:15	93:15 94:11,12	195:18 212:15
56:16 61:21 66:18	positive 15:7,10	178:14	113:21 116:8,9	236:12
69:6 75:22 76:5	219:22 220:15	prepare 232:22	132:10 136:13,13	procedure 82:1
86:7,11 93:19	possibilities 218:22	prepared 45:7	152:6	129:2,5 228:8
96:1,2,11 105:7	possibility 81:17	55:13 237:3	preventative 79:13	procedures 54:7
107:21 108:16,18	possible 7:14 37:2	prescribe 22:15,18	prevented 115:14	82:20 159:12
112:3,12 121:3,9	42:21 71:15 83:12	76:8	116:12	195:13 198:14,20
122:18 123:1,4,19	140:14 146:5	prescribed 76:3,22	Preventive 103:10	200:6,8 205:17,17
130:11 139:11	possibly 172:18	prescribing 76:7	pre-meeting	235:20 236:9
140:9,21 144:11	post 34:6 91:12	78:7 82:4,5	188:11	procedure-based
145:21,22 148:9	98:15 100:3	present 1:18 2:15	pre-op 74:10	217:3
149:19 151:5	posted 247:18	2:20 110:13	primarily 212:5	proceedings 177:11
154:7 175:3	potential 44:15	111:21	primary 186:21	249:7
180:13 181:12	74:1 81:17 86:15	presented 19:4	191:7 216:6 220:9	process 7:18 59:3
188:13 201:14	87:10 119:19	presiding 1:11	prime 233:4	64:13 76:10 78:6
202:6 207:9,10	125:22 135:22	press 33:9,11	prior 103:16	80:8,11 97:10
216:5 222:14	223:20 226:5	pressing 122:1	177:21	119:12 121:20
239:1 240:4	231:18,19 234:11	pressure 13:20	priorities 240:15	124:7,17 129:7
pointed 77:21	235:15	14:8,20 16:12,12	prioritize 196:22	137:16 140:20
107:14	potentially 82:22	16:16,17,19 19:17	prioritizing 223:14	152:15 179:19
pointing 43:1 190:7	87:1 92:18 93:15	21:17 109:9	priority 213:13	180:7,11 183:1,3
points 28:2 38:7	93:18,19 133:5,7	110:20,22 112:5	214:5	208:12 241:10
47:17,18 88:10	134:2 239:15	113:3,15,16 114:8	prisoners 162:20	245:18
149:10	power 106:9	114:15 115:10,17	private 230:22	processes 77:13
police 164:8,12	powerful 10:22	117:10,18,21	probably 7:6 20:1	98:7 117:12,12
170:20	25:4 27:8 34:19	118:5	26:2 44:11 47:7	137:21 179:14
policies 16:14 54:6	35:12	presumably 191:16	68:3 82:18 106:12	247:12
policy 16:5 49:22	practice 46:20 47:4	presume 54:9	112:11 134:18	product 90:5 184:7
political 119:19	75:5 124:6 150:10	presumes 191:17	135:2 140:15	productive 243:17
120:8 122:22	172:1 230:14	pretty 77:21 90:4	147:22 151:4	products 89:7 90:2
politically 203:10	practices 26:4,22	112:17 118:11	169:8 172:17	professional 124:5
politics 123:10	27:17 46:18 75:19	139:3 144:7	174:18 191:6	173:22 174:1
poll 213:20 216:12	112:20 159:9	149:14,14 167:16	192:11 211:13	245:1
218:9	180:7,16 210:14	182:2,6 212:20	231:1 238:21	professionals 54:2
ponder 45:8	210:20 211:2,8	220:7 229:18	239:8 240:8	profile 162:15
poor 162:14 213:8	228:1 230:21	230:16 238:5	problem 8:10	profit 232:14
pops 115:3	practicing 37:5	240:17 247:11	42:17 44:1 45:22	program 43:17
popular 37:1 220:9	precise 142:10	prevent 9:11 13:3	54:19 59:20,22	193:2 210:1
populate 159:20	precisely 159:3	16:21 114:1 124:1	76:13 97:5 107:12	progress 37:19
240:1	predicted 88:15	124:2,4,14,18	120:14 136:22	progresses 111:5
population 190:10	preempt 44:15	154:3 155:4 197:8	152:13 169:4	progression 109:11
237:21	prefer 41:16 42:2	236:19	214:21 237:4	112:9

project 46:13 159:20	publicity 37:11	putting 23:20 28:16 31:18 45:2 45:22 47:13 53:7 178:14 223:5 226:21 241:14	183:11	238:22
prolific 157:9	publicly 10:21 11:10 27:13 99:7 100:1	P.J 5:12 41:18 56:9 56:16 62:2 65:17 66:8 89:16 144:10 166:3 210:9 219:19,20 220:4 220:19	quickly 247:3 249:1	reaching 124:14
promote 66:6 149:2	published 19:1 24:11 65:22	quagmire 237:6	quieter 247:6	reacting 214:14
prompted 171:5	publishing 68:11	quality 1:1 10:17 26:18 27:2,18 71:13 168:1,8 223:21 245:16	quite 12:5 72:10 103:12 116:19 193:21 222:2 238:14	reaction 89:5 97:3
propagated 18:3	pull 27:4,6 189:6,9 201:9 202:1 210:21 240:7	quarter 215:16	quo 225:11	read 40:5 86:7 136:11
prophylaxis 74:13	pulled 136:6 189:12	question 52:15,17 53:6 68:13,16 75:12 82:1 94:20 96:20 98:12 112:22 114:21 119:16 147:8 149:16 150:6 152:20 154:10 155:19 166:14,21 167:18 168:4 183:19 186:4,15 187:18 191:4 193:8 199:3 208:17,18 209:13 219:1 221:4 224:10 225:6,10 226:16 233:4 241:21 244:12 246:16	quoting 235:17	reading 194:10
proposal 181:7 183:22	pulling 131:5	questionable 187:2 187:5	<hr/> R <hr/>	readmission 233:11
propose 83:13 84:1 130:19 188:1 216:15	pulmonary 91:13	questions 80:12 98:20 176:22 183:11 224:13	R 4:1	reads 55:9,18
proposing 138:5	pulpit 27:2	quick 52:15,17 62:5 103:8 108:4 113:2 121:9	Radford 2:6 4:16 4:16 12:17 40:16 80:18 81:10 104:5 129:12 130:4 132:4 164:17 188:14 196:6,20 197:6 204:5 206:4 212:18 218:11 228:6 235:8 236:8	ready 202:5,7 221:16 239:8
pros 116:7	pulse 244:2		radiation 151:8 188:5	reaffirm 67:17
prostate 199:17	punch 40:22		radically 118:11	real 101:20 119:16 150:10 162:22 180:14 212:7
protocol 107:5	punitive 28:21		rails 155:10	realize 77:7 172:10
provide 33:20 190:16	purchaser 50:4		rain 36:22	realized 181:19
provided 74:14 162:19 163:6 167:19 205:7 248:10	purchasers 11:22 49:18,20 50:1,5		raise 45:3 121:17 166:20	really 9:17,22 10:7 16:18 17:16 18:10 21:15 24:17,21,22 25:2,3,19 27:2 28:6,10,16,19 30:2,13,17,20 31:12,18 32:8,10 37:4,17 38:15 39:3 43:2 44:1 49:12 51:22 59:2 59:5,8 60:4,20 74:5 97:6 105:13 106:2 107:14 111:14 112:13 113:2 114:8 115:3 115:16 119:18 120:2,10 129:10 131:4 141:3 149:10,13 150:21 152:10 153:19 154:3,8 155:3 160:8 170:8 171:5 172:8 181:2 182:2 192:5 193:10 198:21 201:3 202:3,4,5 204:10 205:12 206:4 208:20,21 209:14 219:1 223:8
provider 95:20 119:3 163:9 165:14,17	purpose 8:20 97:13 116:19		raised 25:2 49:16 119:15 149:9 225:21	
providers 34:21 54:2 134:19 166:15,19 169:4 171:7,18	purposes 26:6 70:4 71:18 98:2		raises 124:21 172:22	
provides 125:2	pursue 140:4		ramifications 22:4 119:20	
providing 171:18 233:9	purview 172:4		ran 226:2	
prudent 59:8	push 27:3 114:11 32:10 46:2 48:1 64:6 77:11 78:9 78:14,19,21 79:12 79:16 83:19 90:18 95:2 110:7 115:19 116:14 122:2 140:18 144:12 156:8 171:13 180:11 182:12 185:12 190:14 195:11 198:16 204:8 205:1 212:12,16,19 213:22 222:3 230:3,13 235:9 242:2,18 247:14		range 229:18	
psych 160:3,5,16 161:3 196:1	put 10:7 12:11		rare 90:9 106:11 120:4 143:17	
psychological 56:13	puts 19:4		rate 18:13 22:7 73:15	
PTT 78:12			ratified 179:18	
public 3:17 9:15 11:7,18,22 27:15 30:9 35:14,16,21 38:13 49:17 54:1 54:21,21 99:4 100:9,10 121:22 122:3 162:18 176:19,21			ratifies 183:6,10	

225:22 241:13 243:6 245:13 realm 58:6 reason 13:14 19:7 44:10 45:19 59:21 61:5 91:19 117:18 120:22 128:21,22 168:16 181:5 191:15 197:16,21 234:8 246:4 reasonable 73:18 93:12 195:11 reasons 18:6 22:16 44:5 93:13 116:12 120:2 199:20 228:14 reassure 235:14 recognition 169:5 recognize 58:5 59:7 113:15 recognized 109:12 109:19 110:15 124:10 131:21,22 recognizing 182:5 recommend 103:16 141:4,5 recommendation 232:20 recommended 222:13 recommending 11:9 140:22 recommit 24:7 recommitting 25:6 record 4:4 8:9 48:10 140:8,16 177:12 249:8 redefining 67:3 redness 150:7 reduce 22:6 66:5 124:11 215:19 reducing 45:10 152:7 reduction 65:21 refer 124:4 referred 94:17 referring 86:12	107:4,5 refers 56:3 95:22 102:17 refined 38:3 refinement 93:8 reflection 179:2 regard 111:11 156:10 regarding 7:2 regardless 92:10 106:10 107:9 regards 157:10 174:7 192:3 region 85:3 Registration 92:19 regulated 200:12 200:15 211:4 212:21 220:8 regulation 157:4 211:3 regulations 156:12 224:17 rehab 7:10 186:19 189:17,18 190:2 190:12 195:22 202:20 rehabilitation 3:11 185:8 190:13 194:21 reimbursed 229:9 reinforce 26:7 reinforcing 39:20 reinvigorate 26:19 relate 82:19,19 156:20 168:2 related 47:4 56:13 85:5,7 107:20 119:5,7 130:5 153:7 194:18 200:11 211:2 234:12 relationship 232:3 relationships 246:2 relative 122:10 247:3 relatively 87:20 201:5	relevance 158:15 relevant 96:20 99:13 184:11 reliability 28:20 relocating 188:1 remain 123:2 remediate 236:18 remedies 38:1 84:8 135:1 193:15 remedy 43:20 51:11 97:9 remember 73:6 163:20 247:9 reminding 59:20 176:17 remove 50:19 61:13 111:2 121:6 126:6 133:15,17 133:21 removed 52:2 96:12 removing 17:4 61:11,16 105:13 122:22 renal 199:16 rendered 199:12 227:10 reorg 186:7,10 repackage 26:19 repeat 160:11 rephrase 88:17 replete 157:3 replicated 16:6 50:1 report 32:12 33:22 46:22 49:1 51:22 58:21 61:11,17 81:20 85:17,17 93:17,20 97:10,11 100:1 103:14 105:22 112:15,21 123:18 170:12,20 204:18 224:14 232:22 reportability 31:16 reportable 1:4 7:22 8:15 11:18 12:2,3	12:21 22:22 27:12 38:9 39:11 44:9 44:12 45:16 47:2 48:6 57:17 58:1 63:4 65:8 72:21 87:8 92:6 113:17 114:11 127:12 129:3 149:18 170:3 209:1 223:3 246:20 reported 10:20 11:10 28:16 88:6 91:20 92:11 95:10 99:7 100:5 118:22 134:10 135:9 153:4 171:2 reporting 13:2 27:13,16 30:10 31:1,13 33:3,7,8,9 33:12,14,16,21 38:14,19 46:16 54:4 64:13 66:10 66:13 80:19,22 81:19 92:4 95:16 99:4 100:10 101:6 115:7 117:6 144:4 149:2 150:14 161:14 164:9 193:16 197:22 199:6 205:11 212:7,21 223:8 232:6 237:18 reports 126:8 193:17 200:1,2 represent 50:22 representing 210:12 215:1 represents 182:6 request 181:14 242:13 require 141:8 145:15 148:3 198:15,20,21 required 28:15 170:19 requirement 31:13 requires 199:6	rescue 80:8,14 research 43:4 75:15 resemble 58:13 resides 203:13 resolution 44:22 resolve 61:9 69:18 resonance 17:2 resonant 25:5 resources 15:8 182:1 respect 113:22 222:9 232:13 respond 9:18 responding 17:7 175:15 response 136:17 137:8 responses 100:12 responsible 180:19 180:21 responsive 24:17 rest 24:5 69:1 82:14 84:7 124:6 173:5 187:22 218:3 240:13 restarting 127:9 restrain 160:18 restrained 160:7 restraints 155:10 155:21,22,22 156:4,12,22 157:6 157:10 161:2 rests 37:10 result 55:19,22 74:16 76:3 86:16 87:9 88:3,17 200:7 resulted 79:18 resulting 173:12 results 55:10 132:10 150:2 154:4 resumed 177:12 retain 24:7 retired 141:1 retirement 141:4
--	---	--	---	---

review 6:12,17 66:20 72:14 115:2 227:5 246:4 247:14	249:5 right-hand 165:12 rigid 247:12 rigorous 20:18 180:10	routinely 103:16 rows 165:3 rubric 92:7,8 ruins 44:4 rule 108:1 109:8 125:11	Sally 1:10,22 3:9 3:13,15,19 5:6 58:10 59:13 230:1 231:12	205:9 215:11 222:20 227:1 243:1
reviewed 94:13	Riley 2:8 4:17,17 25:12 100:16	rules 138:1	Salon 1:9	science 37:12 48:14 213:7,8 214:19 221:14 222:2 223:1 236:20
reviewing 6:22 94:5 179:21	101:15 138:8 143:5 156:3 176:9	run 93:10 100:18 115:9 169:22 180:9 187:15 206:13	satisfactory 226:22	scientifically 36:15
revised 214:4 242:15	193:7 211:22 218:16 237:16	run 93:10 100:18 115:9 169:22 180:9 187:15 206:13	satisfied 238:5	scientists 37:22
revision 243:14	ripe 208:22	running 120:21 167:19 242:6	save 100:8 202:8	scope 12:20 46:13 47:7 48:5 109:16 167:22
revisit 127:22	rise 79:9 171:2	Rydrych 2:8 4:13 4:13 13:9 29:5 41:21 45:9 46:7 52:16 60:5 62:9 62:12,21 74:4 87:6 88:16 109:14 110:12 113:4 114:3 118:19 126:3 127:3 128:1 145:3 150:17 152:19 155:1 174:10 175:21 204:7 205:20 213:10 221:15 225:1,19 226:10	saw 52:8 76:22	screen 51:4
rework 178:2	rises 170:18		saying 14:6 17:8 22:13 26:1 39:5 44:3 47:2 63:14 65:11 88:2 95:8 100:8 108:5 114:12 116:15 126:7 138:3 146:16 161:13 185:19 198:13 206:20 209:22 224:2	screening 105:10 107:5,10,16
re-emerging 207:3	rising 237:8		says 8:5 12:9 22:19 22:22 46:2 87:12 98:13 99:22 122:15 170:21	scrutiny 84:7
re-engaged 231:12	risk 54:5 55:21 56:1 79:13 81:16 95:3,5,19 115:9 120:21 129:6,22 130:17 144:21 149:12,13 150:18 150:22 151:2,2,3 169:22		scabbed 113:8	se 223:14
re-establish 26:14	RMF 236:4 237:17 237:21		scabbing 113:7	search 40:8,11,16 41:1,12
rhetoric 18:19 44:4	RN 2:2,4,6		scalded 142:15	seclusion 160:17 161:6
rhetorical 36:14	Robert 140:1		scalding 142:16 147:17,18	second 6:1 23:13 34:12 35:3 38:17 53:20 75:22 100:20 122:20 148:13 152:13,20 156:8 177:18 178:22 179:1,20 194:17 198:3 218:15 222:21 223:22 224:1 227:2
RHIA 2:22	robust 43:14		scale 90:6	secondary 164:11 213:22 216:7 217:9,14 221:20 226:21 246:10
rid 13:13 54:15 55:7 120:17 146:17 150:4	robustness 179:3		Schneider 2:9,9 4:19,20,21,22 20:14 23:22 32:1 40:4,13,18,21 60:22 62:4,11,15 75:21 81:22 82:13 83:6 86:5 88:5,8 106:15 108:3 111:9 117:8 126:18 128:20 129:18 132:7 134:8 137:11 138:4 140:7 142:4 144:20 147:21 151:7 156:17 167:1,17 198:8	secondly 39:13 76:4
right 8:21 11:5 13:16 14:12 21:17 24:15 26:15 34:13 40:12 53:13 56:19 60:15 63:20 71:5 75:8,9 77:2 87:10 87:11 88:19 89:3 94:6 95:22 96:3 97:12,16,22 98:19 101:7 102:10,20 106:20 107:1,21 114:22 115:21 118:15 126:10 127:19 134:20 135:10 147:9 151:10,11 155:17 157:21,22 158:13 161:3 164:4 165:18 166:9 173:9,21 196:20 201:7 203:1,21 204:4,11 215:8 218:12 220:13 224:20 225:19 226:1 234:14,15 237:1 248:14	role 3:5 7:3 12:19 140:21 152:3 178:9	s 4:1 36:7	schedule 177:19	seconds 8:22
	roll 224:4	sad 72:4		second-degree 148:20
	rolls 66:17	safe 26:22 27:16 46:18,20 47:4 75:4,19 112:20 176:12 180:7,15 228:1 249:2		section 108:7 140:9 163:4
	roof 227:11	safety 3:4,6,20 24:8 24:14 26:19 28:7 29:1 36:19 37:19 54:20 75:9 84:20 105:6 124:8 130:3 130:21 131:6 144:6 146:7 167:16 168:9 193:14 195:17		sections 85:21
	room 52:9 57:1 131:1 148:17 166:15 176:2 177:16 179:17 194:7 206:18 207:15 219:22 220:16	sake 140:8 174:14		sedation 108:13
	roommate 174:1			see 4:7 6:6 7:5 11:8 12:15 21:22 39:18
	root 32:7,13 40:9 40:11 92:1			
	rounding 179:14			
	route 73:16			

42:3,5 43:18	21:14 24:7,13	144:4 145:6,11,22	201:20 202:4	174:12 175:3
56:10 58:19 61:5	25:5,20 27:6,13	146:18 149:11	203:5,8 204:10	195:13 210:13
65:12 71:21 73:16	27:20 28:11 29:6	151:12 155:9	205:22 206:16	significantly 54:6
75:17 77:7,10,10	29:18 30:2 31:8	175:8 208:22	214:12 229:17	154:21
82:2 85:10 86:3	57:3 68:16 69:7	223:8 230:21	230:4 231:8 240:7	silly 36:15
91:11,19 93:16	72:11 83:7 88:19	231:22	settle 130:19,20	similar 63:8 69:9
102:14 109:8	98:2 106:11	seriously 29:13	sexual 165:13,16	89:17 137:13
111:18 113:8	108:21 120:11	service 205:15	166:9,11 168:14	similarly 53:15
117:17,21,22	154:15 191:13	206:5,19 233:10	168:15 169:1,2,7	simplify 167:9
124:17 126:14	197:3 206:17	233:21 234:2	169:14,15 170:5	simply 19:2 22:18
132:2 136:14	222:16 238:6	246:21	171:8 172:17	76:10 142:22
137:7 138:17	sensitive 119:19	services 103:11	shaking 57:1	197:16 199:11
153:19 157:7	169:6	185:2 194:19	share 79:11 112:14	simultaneously
160:8 165:10	sensitivity 81:3	201:6,9 202:19	199:10	98:7
174:4,8 177:9	sent 53:20 243:8	204:11,11 205:3,7	shared 191:6 248:8	single 44:12 119:9
183:15 187:8	sentence 130:20	205:12,15 208:21	sharing 30:11,12	124:16
191:10 201:4	sentiment 19:8	227:10 228:22	80:1	sins 81:11,13
202:13 203:10	46:1 48:20	229:7,15,16,22	shed 164:3	siree 97:14
208:2 210:2,3,5	sentimentally	230:6,7 232:14	shies 10:5	site 185:9 189:20
212:5 214:20	45:19	233:15	shift 72:7	230:22 231:1
227:18 233:6	separate 83:4,17	set 9:10 10:6 12:7,8	shock 117:20	245:11
240:3 242:9,11	108:14 117:5	16:20 22:19 50:14	126:12,16 134:3	sites 141:14 190:2
243:6,13,14	137:13 139:14,15	53:21 57:2 60:18	shocked 128:11	197:2,4 208:19
seeing 54:10 55:1	168:16 185:13	64:4 117:11 145:5	130:8,22	230:11,14,15,17
199:16 201:3	189:15 207:16	172:4 187:12	shopping 83:15	230:22 235:1
208:12 210:6	213:5 225:15	189:10 191:6	short 32:22 130:22	240:2
222:4	separately 83:18	193:2 203:2,3	174:10 227:16	site-specific 189:21
seek 90:22	225:8	235:3 241:7,16	shortage 233:8	sits 64:5
seen 16:15 19:15	serious 1:4 7:22 8:6	sets 56:18 63:6	show 22:5 58:6,21	sitting 90:4 129:4
31:22 43:5,6	8:14 12:21 13:3	setting 7:8 9:14,19	238:1 245:20,21	179:17
106:1 135:20	22:22 23:12 27:12	21:3,5 24:13	showed 120:20	situation 61:10
136:11 138:9,13	38:9 39:11 40:6	35:15 101:21	shower 153:7 154:1	114:15 140:17
138:18 153:21	44:9,12,14,17	118:2 119:2 126:1	showing 60:19	160:5
154:3	45:1,16 47:1 48:5	130:2 172:17	shows 246:3	situations 21:19
sees 219:9	50:19 51:20 54:18	181:16 185:11	shutting 114:14	74:18 86:12
segue 163:3	55:15,18 56:11	188:21 189:1	sick 100:3	204:21
seldom 211:5	57:16,22 63:4	192:20 199:13,18	side 10:14 11:20	six 103:14 191:16
select 178:10	72:20 73:12 74:1	205:3,6 226:7	14:3 15:11 17:4	236:16 241:8
SELECTING 3:2	74:15 76:2 78:13	229:11 231:22	21:13 24:1 25:17	size 154:22
selection 73:19	86:15,17 87:9	240:21	31:2 63:22 71:12	skill 187:12 191:6
selective 144:21	88:18 89:4 91:8	settings 3:14 7:11	71:14 120:18	skilled 186:1 190:8
seminars 169:22	101:11 102:12	20:16 21:7 24:4	159:10 190:9	190:15 195:2
170:1	112:17 118:16	111:13 167:3	sides 234:22	200:16 211:16
send 144:15 239:20	119:5,7,10,21	178:18 185:4	signal 136:19	skills 187:19
Senior 3:4,6,19	121:13 126:11	186:3 192:21	significant 7:20 8:4	skin 148:19
sense 8:19 10:16	128:2 130:5 135:4	193:3 194:16	19:16 39:4 88:2,4	skirts 76:20
12:20 13:13 21:4	135:5 142:1 144:4	195:5,21 196:18	144:5 173:11	slide 53:20 54:12

54:13 55:3 56:19 62:19 178:14,15 178:15 202:13 slides 53:14 56:18 slightly 208:17 slippery 153:8,9,22 slips 142:17 small 58:5 87:3 106:7 109:15 140:1 229:14 smaller 198:19,21 205:17 smart 179:16 187:22 246:11 smoother 209:20 sneaking 84:11 SNF 190:8 214:10 215:1 SNFs 190:20 191:2 213:19 214:13,20 214:22 220:15 221:2 230:5 231:10 social 245:2 societies 124:3 139:19 society 210:12 245:16 softer 20:11 solicit 180:4 242:8 solicitation 139:8 242:10,13 solicitations 90:22 solicited 245:8 solution 25:13 136:21 158:22 solutions 155:6 solved 59:22 somebody 15:15 93:9,18 113:1 117:2 123:20 124:5 143:9,10 145:13 148:16 170:13 223:4 somebody's 59:6 214:15 somewhat 175:22	soon 158:18 245:10 sophisticated 38:4 sore 114:13 sores 21:17 sorry 17:5 26:11 42:19 45:9 51:15 52:14 59:13 70:10 92:16 99:15,16 157:14 166:5 176:15 193:6 213:15 218:5 221:21 233:19 243:19 sort 26:4 42:8 43:19,20 58:4,4 88:1 93:20 95:10 102:1 108:11 112:6,20 113:7,7 118:2 138:20 145:7 154:18 159:7,15 165:6 168:19 171:5 179:8,9,13 180:9 181:11 182:15 185:1 187:17 188:21 193:4 197:17 212:3,5 213:19 219:2 221:9 225:20 227:20 231:6 238:22 240:15 sorts 15:9 sound 25:3 89:16 sounds 39:20 48:19 61:8 117:3 132:15 163:15 231:20 source 142:2 181:2 sources 245:12 so-called 57:14 183:4 188:12 space 64:9 244:1 speak 21:21 22:3 34:3 198:19 247:7 speaking 152:1 speaks 47:12 spec 98:12 special 9:4 35:19	169:8 specialists 111:16 111:19 specialized 219:6 specialties 195:18 specialty 120:6 specific 16:17 80:22 81:1 102:9 118:2 138:22 164:5 181:13 190:9 201:20 234:21 244:15 specifically 118:7 143:3 151:20 160:12 specification 86:18 specificity 81:2 108:5 specifics 113:13 specifying 69:11 spectacular 238:14 spectrum 81:3 169:8 speech 189:19 spend 7:7 60:7 240:13 spent 60:14 sperm 125:16 spinal 118:17 119:1 119:9 121:11 spine 122:1 spines 120:6 splint 77:12 split 23:18 splitter 79:4 81:5 84:19 132:13 143:12 splitting 134:2 153:2 splitty 134:13 spoken 34:5 36:13 95:6 212:2 spread 165:3 SRE 53:17 54:14 92:13,21 107:11 138:22 141:4,5,19 171:14 179:22	226:6 239:20 SREs 6:22 10:4 26:4,21 53:9,21 60:10,18 61:3 62:7 64:5,8,16 67:3,11 68:9,12 69:1,7,8 70:1,12 91:1 109:4 139:8 141:10 144:14 159:8 173:5 179:16 180:8,16 181:2 182:14,16 184:10,14 197:2 206:8 208:20,21 214:3 224:22 228:2 234:17 235:2,3 239:9,12 239:12,13 240:7 241:15 242:9,15 SREs/HACS 3:8,11 3:14 SRE's 108:20 staff 2:11,12,12,13 5:4 126:20 133:15 133:16,19,22 134:9,13 135:5 142:4,5,7 146:19 164:18 165:15 168:3 173:11 174:17,17 176:3 224:10 staffed 187:15 193:20 staff-on-staff 175:17 176:10 stage 16:19 37:12 37:12,19 109:9,11 109:12,12,19 110:20 111:3,6 234:7 235:4 staged 111:1,1,1,3 stages 112:7,10 staging 118:12 stairways 131:2 stamp 32:10 Stan 25:10 100:15 101:14 138:6	143:4 155:18 176:8,16 192:8 211:21 Stancel 2:8 4:17 stand 35:11 standard 9:11,14 9:20 10:5 12:7 16:20 22:19 34:16 35:16 50:15 83:2 standards 24:13 183:4 212:13 standing 142:7 standpoint 170:10 stands 61:12 203:6 stars 158:14 start 43:1 77:17 94:16 98:4,6 109:13,14 112:10 177:17 181:12 184:6 209:1,15,17 232:20 234:2 235:10 239:3,4 started 59:13 60:16 62:6 156:19 157:21 210:2 220:21 223:15,18 224:2 227:19 232:12 237:2 starter 61:20 starting 30:19 31:18 76:7 80:5 163:5 179:1 188:13 208:11 209:3 233:15,21 starts 80:12 state 14:1 31:11 33:13 42:15 80:1 85:2 92:6 94:6,7,8 104:18,18 164:9 197:3 225:5 236:21 237:19 stated 139:17 207:11 statement 11:11,17 28:18 60:17 62:5 87:17 88:10,13 150:19 222:17
--	--	---	--	--

statements 28:4,14 29:4	strikes 88:12 102:6 123:14	substance 171:10	81:6 82:9 83:7,19	SUSAN 2:22
states 10:20 11:10 27:12 30:7,13,16 103:1 104:7 154:11 167:13 175:19 224:14	striking 24:17	substances 135:18	89:16 95:5 98:21	suspect 233:2
State-Based 66:10 66:13	strong 19:8 28:3,18 29:4 32:21,21 33:11 36:8 219:14 219:22 220:11,15 238:10	substituted 52:2	102:19 104:10	suspected 105:21 111:6
state-by-state 176:7	stronger 11:11 107:21 232:6	sub-bullets 195:1	106:8 112:14	switch 130:9 134:3
state-to-state 224:18	strongly 23:3,14 28:3 136:10 139:13 227:8 237:4	sub-category 162:14	114:21 120:20	sword 82:7
statins 77:9	struck 60:13 199:2 224:13	succinct 48:16	123:21 124:12	sympathy 168:12
status 225:11	structural 139:4	suctioning 136:2	131:9 138:9 153:1	synopse 239:6
statute 43:14	structurally 137:15	suffers 76:2	156:2 157:20	system 12:8 17:7 25:2 33:7 34:21 35:17 55:14 62:22 64:21 101:7 114:14 119:4 137:2 145:5 201:5 212:21
stay 134:3	structures 80:20	sufficient 51:8	160:13 166:8	systems 27:17 54:20 154:3 161:18 192:22
Steering 1:4,9 6:7 65:18 69:2 89:22 118:4,8 140:22 182:20 183:1,8	struggling 59:14 96:22 138:21 181:8	sugar 101:17	167:5 171:14	
stents 199:16	studies 22:5	sugars 101:20	172:21 175:18	T
step 43:21 64:18 121:5 124:17 214:7	study 46:3,3 150:10	suggest 58:6 95:6 113:20 139:17 156:1	186:18,20 194:12	table 10:8 97:4,12 148:17,18 158:8 217:19 231:13
steps 3:18 76:7 80:11 238:22	stuff 59:4 65:8 83:14,21 84:11 92:2 97:19 129:17 149:3 189:22 208:10,11,15 211:16,18 222:19 240:16 245:5	suggested 132:13 133:14,18 247:4	198:2 207:9,18	tackled 155:20
Steve 80:10	stylistic 44:5	suggesting 145:8 203:16 231:6	216:21 217:8	tact 133:7
steward 180:15,21	SU 194:7	suggestion 40:2 144:17 172:9 194:22 233:7,17	218:3 226:10	take 13:11 27:2 39:21 43:10 61:10 88:1 112:16 116:11 117:18 125:13 161:14 164:12 173:6 176:17 177:9 180:2 182:14 188:18 213:19 215:12 218:4 247:7
stick 181:17 182:2 188:19	subcategory 93:21	suggestions 234:12 244:6	234:14 240:9 248:11	taken 29:13 32:9 51:13 58:2 61:14 77:1 136:7 148:9 157:11 219:11 247:5
sticking 44:2	subgroup 57:18,19	suggests 134:22	248:11	takes 220:13
sticks 134:15 150:14	subgroups 58:5	suits 240:22	surely 92:9	talk 14:1 65:1 79:10 94:16 119:4 150:21 168:1 174:12 178:5,9 225:13 245:7
story 34:9,13 129:4 186:2	subject 134:13	summary 247:15	surface 80:13	
strange 206:1	subjectivity 149:6	SUMMATION 3:18	surgeon 162:11	
strategies 139:5 152:4	submissions 180:10	superficial 112:14	surgery 11:20 14:4 17:4 25:17 129:16 143:15 148:3 192:12,19 193:8 198:13,15 199:7 199:17,22 201:20 204:6 210:1,7,7 211:7,12 212:14 213:17 214:8 217:3,4,6 219:9 220:22	
strategists 38:1	submit 141:9,15 183:2	superfluous 61:21	surgery/ambulat... 213:17 214:8 219:9 220:22	
strategy 17:13 106:10 159:7	submitted 141:12	support 33:2,20 39:8 44:6 50:15 52:9 61:19 62:1 108:4 116:5 236:17	surgical 82:16,20 148:3 188:5 193:19 195:8,15 201:22 204:13 210:16 217:6	
straw 216:12 218:9	submitting 181:7	supported 38:8	220:22	
Street 1:10	subscribe 46:5	supporting 48:11 61:16	surgery/ambulat... 213:17 214:8 219:9 220:22	
stretch 177:9	subsequently 209:20	supportive 245:20	surprised 103:3,5	
stricken 38:11	subset 60:18 62:8,9	supposed 7:1 74:11 77:8	surprises 103:4	
strike 124:6 232:6		sure 5:19 6:9,18 10:1 29:11 31:5 32:19 43:8 53:15 63:2 64:15 66:22 67:5 70:20 71:3	surprising 105:22 200:6,8	
			survey 104:15 242:7	
			surveyors 211:6	
			survived 35:9	

talked 24:18,20 29:6,19 56:16 69:21 70:9 71:6 71:19 98:15 141:6 144:20 231:1 242:10,14	Task 103:11 107:14 taught 59:3 taxonomy 168:18 teach 216:19 238:13 teachable 238:18 238:19 teams 159:13 tease 82:22 156:19 teased 130:13 teasing 220:12 240:13 technical 3:5 7:3 114:18 157:11 182:11,13 189:10 189:11 201:22 206:2 219:1,5 240:6 technically 140:14 Technology 10:19 tedious 169:21 teeny 145:14 Tejal 2:2 5:14,22 14:16 15:2 31:3 78:2 92:14,16 132:14 194:9 198:13 211:9 219:16 220:3,18 230:12 237:14 telephone 1:21 2:1 2:2,4,7 television 121:18 tell 34:4 57:16 107:13 144:16 169:20 189:11 202:2,3 208:3 209:9 236:16 telling 10:20 49:19 ten 157:15 196:19 235:19 247:15 tend 126:2 147:14 197:4 204:21 240:11 tends 201:8 tension 29:3 205:5 tentative 236:17	term 14:2 15:6 16:4 16:9 19:11 20:11 20:19 24:15 31:9 31:14 39:8 52:1 56:1,2 62:13 63:12,13,17,17 66:2 67:3,8,18 68:6,11,14 69:5 70:14 78:14 92:12 92:22 113:6 159:20 160:17 164:4,5 167:9 169:14 175:6 190:16 214:3 terminal 115:19 116:7,21,22 terms 6:16 7:19 16:11 28:8 36:8 45:4 47:19 48:16 55:4 68:4 69:12 75:11 88:2 89:22 90:22 92:20 93:21 105:3 108:19 118:11 138:11,12 148:15 171:8,19 177:19 178:20 182:22 184:4 190:10 200:16 209:21 210:16 214:2 222:18 228:20 229:10 230:17,20 235:21 237:20 239:14 241:5,14 246:19 247:12 terrible 43:21 terribly 19:10 terrific 240:18 testimony 33:13 106:6 testing 103:16 106:10 text 41:15 42:3 46:22 47:12 49:1 51:5,22 56:11,12 thank 5:18,21 6:8,9 8:3 10:9 57:10	62:3 161:11 188:16 200:20 207:21 209:7 219:17 220:5 234:4 246:16 248:5,13,17,21 249:3,4 thanks 11:13 15:2 27:21 34:18 56:17 66:18 78:16 89:19 178:13 181:3 188:10 193:9 219:20 220:20 242:21 theft 169:11 theoretical 45:19 therapeutic 119:11 therapeutically 130:15 therapies 127:18 129:19 therapy 82:6 118:18 119:1,6,8 119:9 121:11 127:4,7,11 128:3 189:19 thereof 55:21 56:1 87:10 144:22 149:12,13 150:19 150:22 151:3 thickness 118:14 thing 11:5 22:15 25:19 36:18 37:14 38:17 44:9 48:13 49:14 59:8 67:5 74:4 79:1 89:10 94:2 108:21 112:20 116:15 117:2 121:18 123:13 130:21 131:6 134:3 138:17,18 143:7 150:20 162:1 164:19 172:7 198:3 212:1 214:22 222:10 232:8 234:16	237:3 245:4 things 12:22 13:6 13:19 14:8 15:10 15:21 17:3 18:8 20:9,21 23:1,9 24:22 25:14,18 27:5 29:10,22 30:20 31:19 33:4 33:16 39:3,7,15 43:11,15 44:13,22 62:13 63:8 64:15 64:18 65:14 72:7 78:21 82:19 83:15 88:9 97:2,12,15 98:14 99:4 104:11 113:15 118:6,12 118:14 119:18 120:16 122:9 123:15,16,17 124:9 125:5 131:20 136:7,13 138:12 139:2 143:2,12 149:4 154:19 156:20 158:18 159:16 161:17 165:21 166:16 168:22 178:2 187:7,12 189:18 199:16 202:18,22 203:1 210:4,7 212:2,16 212:22 223:7 230:19 232:16 236:16 239:11 247:1,20 think 6:11 7:14 8:12,14,16,22 10:15,21 11:3,4 11:14 12:2,7,9,9 12:10 13:4,17 14:17 15:18 16:8 16:13,18 17:7,17 22:8,13 23:11,17 24:11 25:10,19,22 26:16,17,20 27:1 27:8,18 28:1,15 28:16 29:1,3,6,19
--	---	---	---	--

30:3 31:11,14,21 32:17,20 33:8 34:1,10 35:20 36:12 37:9,20 38:17,18,19,21 39:7 41:4,14 42:6 43:9 44:4 45:7,18 45:20 46:21 47:5 47:8,21 48:16 50:18 51:8,9 53:4 53:7,9,11 56:9,10 57:9 58:22 59:4,8 60:1,5,7,8 61:1,20 62:12 64:1,4,13 65:1,21 66:3 67:3 67:7,15 68:9 69:15,16,17,18,21 70:1,5,6,6,12,21 71:2,15 73:3,7 75:1,2,2,14 76:5 76:15 77:18 78:5 80:16 81:16 82:11 82:22 83:3 84:4 84:19 87:5,16 88:16 92:2,9,22 93:6,7,14 96:8,13 96:19 97:11,21 99:5,10 102:20 103:21 104:11,12 105:8,13,18,20 106:5,6,9 107:3,4 107:7,8 108:15 110:8 111:21 112:15 113:17 114:9,17 115:3,15 116:16 118:10 120:2,18 121:15 121:21 122:21 123:3,7 125:6,7 125:12 126:4 128:4,8,16 129:12 130:4,7 131:17 132:5,8,8,12,15 132:21,22 133:14 133:15 135:20 136:4,12,14,15 137:12,16 138:18	139:14,20 140:12 140:16 141:2,3,12 142:9 143:11 144:10,17,18 145:4 146:5 147:14 149:8,9,20 152:8 153:3 154:4 154:7 155:7 156:5 158:20,22 160:4 161:2 162:14 164:9 165:15,16 165:20 167:15 168:14 169:6 170:7 171:6 172:20,22 173:6 175:4,5,6,9,15,21 176:3,9 177:4,16 179:2,4,6 181:4 184:20,21 185:1,3 185:4,7,8 186:11 186:12,17 187:10 187:19 189:5,8,16 192:8 194:1 195:10,13,16 196:7,21 197:20 198:9,16 199:19 200:17 201:15,18 202:6 203:5 204:7 204:22 205:10,13 206:6,12 207:17 207:20,21 208:7 208:22 211:6,18 213:11,21 214:18 215:4 216:2 217:1 218:7,21 219:5 221:8,15 222:13 223:1,9,12,14,18 225:1 226:22 227:16 230:14,16 230:18 231:16 232:7 233:4,13 234:7,13,21,22 235:4,11 236:16 236:20 237:1 238:21,22 239:8 239:10,19 240:1,3 240:4,5,8,16,19	241:4,13,19 244:8 244:10 248:14 thinking 68:8 78:11 112:6 118:13 142:9 165:3 194:5 197:1 201:1 206:7 209:16 229:2,20 229:20 232:9 238:20 240:17 241:9 244:14 thinks 152:1 183:15 third 54:13 194:20 228:13 236:14 thoroughly 89:3 thought 6:18 7:19 58:13 59:2,7 91:18 96:11,17 103:2 134:1 162:10 164:11 187:1 214:11,16 218:1 233:17 239:7 thoughts 48:4 49:3 52:5 143:22 154:22 155:12 thread 243:6 threat 21:12 three 54:16 108:22 109:9,12 110:20 111:2,6 112:9 178:17 181:8 182:3,4,9 188:2 188:17 196:9 197:14 201:3,13 208:4 211:19 220:21 223:17 235:16 240:9 three-year 227:6 227:21 throw 115:17 126:19 150:20 211:13,20 243:17 thrown 21:21 thumbnail 113:2 Thursday 1:6	ticket 196:11,14 tied 7:15 tier 218:12,13,15 222:21 223:11 224:1 225:2 226:21 227:3 231:17 tiering 214:4 232:9 Tighe 2:13 5:3 tight 7:16 27:7 time 7:7 11:6 15:12 26:5 27:15 31:10 32:20 37:16,17 50:2 55:17 58:8 60:7,14 63:9 69:6 69:12 73:15 85:5 93:9,12 98:16 139:2,11 141:3 145:1 147:13 159:15 169:19 177:8,19 178:1 184:5 191:15,17 198:21 202:8 209:16 218:19 233:10 238:21 240:5 242:6 timeliness 233:14 233:20 times 34:5 37:21 43:22 49:13 86:8 107:13 166:19 tissue 111:6 112:13 title 194:14 today 7:14 15:13 32:19 53:21 59:10 59:18 69:18 71:10 96:18 178:4 184:8 224:14 225:18 226:3 247:4 today's 72:18 told 154:19 tolerance 10:1 tonsillectomy 97:3 tool 107:10 tools 161:19 tooth 44:19 top 108:22 181:11	235:18 topic 44:10 89:19 91:1 105:2 116:4 139:5,6,10 179:3 tort 170:6 total 15:17 totality 28:5 totally 116:4,13 touch 65:22 touched 170:22 touching 170:15 tough 143:20 towel 21:21 115:18 toxic 135:18 trach 117:9 136:1 137:4 track 94:15 104:7 104:21 109:6 157:21 164:10 tracking 104:1 training 162:18 transcript 247:18 transcripts 247:13 247:14 Transfer 10:19 transmission 200:11 transparency 246:13 trauma 162:11 travels 249:2 treads 131:7 treat 102:13 treating 204:14 treatment 126:15 128:14 132:10,12 134:14 145:15 176:13 188:6 treatments 132:19 134:10 treatment-related 134:5 tremendously 113:21 trend 115:17 trial 45:21 tribute 34:20
---	--	--	--	--

tried 19:21 38:18 56:22 100:7	109:11,12,19 111:3 112:9	134:11 135:3,10 135:13 136:8	206:5 215:20	unfortunately 9:13 15:11 33:8 104:1
triggering 22:12	130:12 137:13,17	137:10,22 138:6	typically 126:4	130:16 143:17
trivializes 18:9	138:1 168:21	140:6 141:20	134:20 141:10	236:11
trouble 65:11	174:10 176:3	142:6 143:4,22	247:6	unintended 45:5 55:10 150:2
true 23:10 25:8 45:20 123:2	196:9 197:20	144:19 145:2,18	U	unintentional 146:19,20
truly 189:6,8	198:1 199:5,8	147:8,17,20	ulcer 16:19 113:3	unique 201:5,8
truncate 179:7	217:12,16,17	148:11 150:16	115:10 117:10	unit 198:13
trust 35:19	223:11 228:7	151:6,9 152:18	118:5	United 102:22
truth 247:8	240:8	153:13 155:7,17	ulcers 13:20 14:8	units 187:14
try 57:6 100:20,21	Tyler 1:10,22 3:9	156:16 157:13	14:20 16:12,12,16	universally 92:5
123:4 124:2	3:13,15,19 4:3 5:6	158:4 160:10,19	16:17 19:17 109:9	universe 114:20
177:19 185:1	5:6,9,12,20 6:11	160:21 161:7,10	110:20,22 112:6	142:12 185:7
186:10 189:9	11:14 20:13 21:8	161:22 163:2	113:15,17 114:6,7	189:9 202:17
218:14 223:20	22:2 23:21 25:10	164:2,16,19 166:3	114:8,16 115:17	213:6 215:1,3
244:17 247:7	26:11 27:21 31:5	166:7,22 167:14	115:21 117:18,22	225:9
trying 14:13 26:3	32:15 34:1 35:22	168:10 169:13	ultimately 181:10	unmask 172:3
26:18 27:4 28:19	39:17 40:10,15,20	170:9 172:6 173:2	umbrella 68:7	unnecessary 233:11
29:1 49:1,14	41:1,6,10,18,20	173:8 174:9,22	191:1 230:3	unpreventable 115:13
63:18,21 70:4	42:12 43:12 46:9	175:12 176:8	unambiguous 8:6	unregulation 207:6
90:1,14 106:7	47:21 48:18 49:9	177:5,14 178:8	40:7 51:20 54:17	unstageable 110:19
112:13 124:1	51:2,14,17 52:4,7	187:3 190:1 192:7	56:3	110:22 113:3
182:2 188:19	52:12 60:21 61:6	195:19 196:4	unchanged 55:5,12	untoward 115:20
190:10 196:8	61:15 62:3,18	197:11 199:1	56:3	121:13
201:15 204:8	64:10 66:19 70:16	200:21 203:15,20	uncomfortable	update 227:22
205:11 208:19	71:22 72:12,17	204:1,4 205:8	14:6 36:3 70:19	228:1
210:20 211:14	73:10 75:20 76:12	206:18,22 207:8	uncontrollable	updated 29:22 73:4
213:12,20 214:1	78:16 79:5 80:3	207:20 211:21	20:7	112:5
218:6	80:16 81:6 82:12	212:9 213:3	undergo 131:14	updating 6:13
tube 137:3,5	83:3,10 84:13	214:11,16 215:10	understand 9:18	29:17
138:15,16 139:6	86:2,11 89:1,13	217:11 221:4,18	12:12 35:18 43:2	upsides 110:18
223:6	91:3 92:14 93:3	222:6 226:18	50:11,16,16,17	urgency 8:19 11:11
tubes 140:11	94:20 95:12,21	228:5,17 233:16	68:16 81:7 86:8,9	13:13 24:8 25:6
tubing 137:19	96:3,5,8 98:10	234:4 235:6 238:3	87:14,19 104:12	25:20 26:15 27:14
tune 19:22	99:14 100:14	241:19 242:22	105:19 116:19	27:20 28:12 29:6
turn 58:9	101:8 102:3,10	244:12	157:16 223:2	29:18 30:3 31:8
turnarounds	106:13,19,22	type 67:2 80:21	understanding	31:11 33:2,19
247:11	107:22 109:7	119:6 132:16	38:5 111:15	36:21 37:2,3,5
turning 161:18	110:1,6,10 111:8	159:20 174:21	121:15 123:17	72:11 237:9
TV 131:1	112:1,22 113:10	205:6,6 206:13	224:19	urgent 24:10 37:8
Twenty 117:16	116:1 117:3	207:14,14,16	understands 35:14	192:15 193:3
twice 19:21	118:15 119:13	210:7	understood 18:3	207:4 212:14
two 8:22 37:12 38:7	121:7 122:4	types 29:12 57:21	50:20 172:12	urgy 192:14
39:7 59:21,22	123:11 125:9	63:8 74:18 90:3	under-reporting	
61:10 86:13 88:10	126:10 127:2,13	94:18 131:20	144:13	
94:4,12 97:1,2	128:18 132:6	137:6 162:12	undesirable 167:21	
	133:5,11,17,20	184:10 205:18	unfortunate 20:4	

use 13:6 14:2,12
38:2 61:1 64:21
69:3 76:6 100:9
144:21 145:1
152:4 155:9
156:21 161:3
165:21 167:8
182:19 185:5
197:16 215:13
228:19 231:16
243:3

useful 59:2 60:2,3
85:22 196:22
208:9,11 235:15
239:1

uses 36:17 104:14

usual 141:7

usually 14:2 78:5
81:18 100:17,18
108:9 184:19
247:15

utilize 118:4
243:20

utilizing 179:13

U.S 24:22 103:10

V

vaccine 37:14
vaguely 70:19
valid 123:4
valuable 90:11
245:14
value 125:7 159:2
variety 80:6 196:15
various 49:3 93:2
vast 230:14
Venn 23:8 56:20
57:6 59:9,10,21
60:1 68:10
ventricular 127:17
venue 228:9
venues 79:21
158:16 159:4
165:4 228:8,10
verdicts 19:22
vernacular 185:5
versed 187:8

version 26:22 59:6
59:6 126:17 180:3
243:9

versioning 243:9

versions 56:22

versus 23:20 80:21
90:2 105:4 112:13
114:1 118:13
132:11 145:14
149:3 154:14
155:21

vexing 75:2

Victoroff 2:10 4:11

4:12 8:11 17:20
36:2 43:13 45:17

58:12,17 59:19
64:11 76:13 78:18

83:11 87:12 91:16
96:16 103:6 109:5

116:3 119:15
130:10 134:12

135:7,11 142:8
145:19 147:3

158:6 162:2
164:21 168:11

169:18 173:16
187:4 191:4

193:10 208:1
209:4 216:14,18

217:16 235:12
236:10 238:1

244:22
view 17:14 36:9

148:5 224:7
violence 175:17

virtual 243:3

vision 27:10

visited 211:5

visiting 229:4

visitors 166:16,20
167:15

visits 215:16,17

visually 60:19

vociferous 106:7

voice 186:21

vote 23:5,17,19

39:22 48:21 49:6

51:3,3,11,13
52:19,20 53:5
61:11,14 112:4
212:16,19 216:15
219:7,11 228:9

votes 216:16

218:16
voting 51:9,12,18
52:8,21 218:11

vulnerability

172:15 231:19
vulnerable 172:20

232:5

W

walking 93:10

wall 138:11

want 7:8,13 9:11
13:11 20:8 21:15
21:22 24:12 28:10

32:11,12,13 35:2
38:6,10 43:18

46:2,8,21 48:13
49:6,10,15 51:12

57:6 58:14 59:10
63:1 66:22 67:5

69:13 70:17,19
71:3 74:2 77:16

78:3,9,14,19
79:14 83:19,20

84:4,5 86:3 89:9
90:6,16 93:6,15

95:8 108:21
115:11 117:8

122:17 123:4
130:1,4 149:1,1,3

149:16 151:8
156:7 158:1,8

161:20 163:10
165:20 166:7

173:17 174:14,18
175:2 178:19

179:13 183:14
184:8 186:18,20

188:16 190:10
192:5,8 193:12

198:2,4,6 201:2

202:5 203:11
205:21 206:11
207:8,18 208:5
209:6,14 220:10
228:17 229:19
231:4 235:14
239:3 240:7 247:7
248:5

wanted 5:21 11:15
13:9 14:17,22

31:7 48:10 67:16
72:14 116:1 175:7

180:12 182:7
206:7 226:19

227:18
wanting 29:11

36:20 227:8
wants 46:9 92:19

109:13 241:20
warming 36:22

Washington 1:10
34:5

wasn't 51:16 59:1
74:12 87:20

103:20 105:15
225:19 226:10

wave 196:9 213:2,2
222:4 224:2,5,12

waves 196:9
waving 37:2,11,16

way 16:8 17:11,15
18:15 25:7,14

26:15,17,18 27:19
28:12 30:21 34:19

38:20 41:4 47:3,8
50:21 64:12,14,21

69:10 71:17,20
72:3,6 77:3 78:6

80:5 90:3 97:10
111:22 125:8

136:19 146:15
147:22 150:14

153:8 154:13
156:6 169:10

178:4 184:19,21
187:14 191:5

204:15 208:17

209:14 228:22
229:1 235:16
236:21 244:3

ways 13:21 17:17
77:4 82:17 118:13

121:14 124:13
195:16 224:3

234:6 236:18
weave 26:3

website 243:11
week 98:8 105:11

238:16 247:15
weeks 33:6 66:11

184:15 241:8
weigh 86:4,19

163:10
weight 42:8,11

105:4
weighting 212:19

welcome 64:6
70:15 139:21

went 59:3 82:17
168:17 177:11

249:7
weren't 105:17

West 212:6
we'll 4:7 6:21,22

7:5 53:9 54:9
67:19 68:17 69:2

69:3 70:6 71:14
91:5 98:4,7 101:9

118:7,15 121:1
125:9 141:13

144:15 146:21
160:12 163:11

174:8 175:11
182:12 184:15

189:6,9 201:21
202:1 208:14

218:14 231:4
235:10 238:1

239:11 240:3,10
241:2,5,6 244:3

246:21 248:3
we're 6:17,18 8:2

12:10 17:2 18:20
24:22 27:4 28:5

28:19 29:1 34:15 34:16 37:13,15 39:19,20 41:22 44:13 46:14 47:22 51:17 52:8 59:18 60:11 61:4 62:16 63:2,14 65:4,7 66:22 67:4,17 68:3 69:17 71:3 72:22 73:11 77:16 83:13 87:3 92:1 92:21 94:14 96:16 97:4,10,17 99:3 100:1 108:11 112:16,19 118:1 119:19 120:21 124:12 125:6 126:11 130:7 138:5 140:15 142:9 148:8 153:15 157:20 158:2,11 165:2,5 165:11 166:8,14 166:17,17 168:6 173:10 177:16,18 177:22 178:1,10 178:14,22 184:4 187:6 188:19 189:3 193:11 196:2,8 197:17,21 199:15 201:15 204:8,10,14 205:2 205:10,16,21 206:1 211:14 212:13 213:11 215:19 218:6,11 221:16 223:7,7 228:12 229:18 231:10 232:15 239:8 242:6 245:3 246:18 248:11 we've 16:3,6,14,16 20:2 21:11 22:19 28:6,12,13 29:8 29:19 30:7 38:18 43:6 48:18 53:16 57:11,13 58:10	59:11 63:3,4,5 73:7 82:15 94:1,4 109:15 114:6 118:21 135:20 136:10 138:13,18 144:6 145:5 149:13 152:10 153:6,10,21 156:19 173:3 179:5 180:4 182:4 186:18 189:4 199:4,9 219:21 223:16,17 225:20 230:3 231:1 232:12 234:7 238:22 241:10 245:17,18 247:4 248:10 wheelchairs 73:5 white 57:14 wild 158:1 212:6,6 wildly 16:5 willing 34:21 wiring 128:12,12 wish 212:1 woman 100:2 women 92:2 99:8 99:22 wonder 32:3 80:18 144:2 205:20 231:15 wondered 164:18 wonderful 116:4 wondering 20:15 78:9,14 127:3 224:18 Wood 140:1 word 7:21 9:1,3 10:2,8 12:6,6,11 13:16 14:12 17:1 17:10,12 24:15 25:12 26:16 33:1 33:9,11 34:12,16 34:17 35:19 36:9 36:12,17 38:2,8 38:15 50:10,19 102:20 116:17	146:1 162:2 165:22 201:7 worded 28:12 156:6 wording 19:19 79:16 words 32:5 44:7 55:16,21 144:21 wordy 41:22 work 7:13 19:12 28:5 30:15 32:2 47:9 71:16,18 75:4,5 80:10 101:22 140:3 141:10,15,18 167:22 181:7 182:2 186:14 201:1 208:9 209:2 224:20,21 226:11 234:7 235:5,15 240:10,18 243:2 244:4,10 246:18 246:20 248:2,22 worked 181:21 244:9 workforce 229:2 working 30:12 140:2 210:18 works 25:21 70:3 153:8 155:4 203:10,11 236:21 workspace 243:3 243:11,13 world 57:7 84:19 84:20 189:16 worms 78:4 worried 13:12 21:10 194:3 196:7 worry 197:5 208:6 worsening 105:9 worth 175:9 203:3 worthwhile 230:10 wouldn't 12:4 44:11 45:11,14 75:21 119:6 126:6 134:9 167:5 169:10 180:22	213:6 wound 111:16,18 113:4,9 229:4 wrap 48:1 wrapped 7:16 173:3 wraps 248:15 wrestler 173:22 174:1 Wright 65:18 write 180:22 234:9 writing 141:16 wrong 11:19 12:19 14:3 17:4,5 25:17 73:14,14,14,14,15 73:15,15 74:8 75:10 78:1 125:16 125:16 135:17 138:17 140:10 163:19 164:13 168:22 184:18 208:13 <hr/> X <hr/> X 100:2 <hr/> Y <hr/> Y 100:5 yanks 120:6 year 50:6 85:1,13 94:8 103:10 123:22 163:21 168:22 200:1 233:1 years 33:17 39:9 66:18 103:1 117:16 168:18 199:6,8 yellow 107:19 yesterday 6:13,19 7:20 8:18 9:17 12:18 14:11 23:17 23:19 29:7 38:22 39:2,14 48:10 51:5 56:7 57:3,16 58:14 59:1,7 60:13 61:20 65:4 66:15 69:22 70:9	71:9 72:13,20 93:14 154:19 163:15 178:16 225:17 226:2 yesterday's 58:18 68:19 York 34:5 37:21 49:13 94:6,7 199:5 210:1 248:3 <hr/> Z <hr/> zapped 134:16 zero 10:1 zone 188:22 <hr/> 0 <hr/> 02 157:21 03 157:22 <hr/> 1 <hr/> 10 181:18 186:5 188:12 190:2 197:9 209:15 223:15 10:05 177:7 10:54 177:12 100 93:6 11:05 177:8 11:11 177:13 11:15 178:22 12:16 249:8 1201 1:10 15 99:8 234:12 16 229:14 17 197:10 176 3:17 177 3:10 178 3:5 18-month 241:10 19 1:6 <hr/> 2 <hr/> 2 7:2 20 181:11 2000 38:15 2002 227:1 2006 227:2 2009 1:6 66:1 227:2
--	--	---	---	---

2010 210:6	6B 163:11
2011 210:5	6D 173:10
2012 227:3	60 94:13 95:5
238 3:18	101:18,21
24 6:20	600 200:1
24th 1:10	
25 94:7 168:18	<hr/> 7 <hr/>
27 30:7	70 94:14 95:5
28 102:17 178:15	
<hr/> 3 <hr/>	<hr/> 8 <hr/>
3A 163:18	8:00 1:9
30 99:1,7 100:3	8:08 4:2
102:16 200:1	80 109:6
39 123:7	87 188:14,15
<hr/> 4 <hr/>	
4A 73:2,11	
4B 89:4	
4C 91:7	
4D 101:10 106:16	
108:8	
4E 102:11 106:20	
4F 109:9	
4G 118:16 122:12	
4H 122:11,12	
125:15	
40 39:3 71:19 72:4	
72:8 83:15 97:16	
97:16 123:6	
42 91:12 98:15	
99:22	
<hr/> 5 <hr/>	
5 129:17	
5A 126:11	
5B 135:14	
5C 141:22	
5D 151:11	
5E 155:8	
50 95:6	
50-50 191:6	
54 236:11	
55 22:8 95:7 236:11	
<hr/> 6 <hr/>	
6 3:3 163:5	
6A 163:5	