

NATIONAL QUALITY FORUM
+ + + + +
SURGERY ENDORSEMENT MAINTENANCE
2010 STEERING COMMITTEE
+ + + + +
TUESDAY
MARCH 1, 2011

+ + + + +
The Steering Committee met at the
Washington Hilton, Lincoln West Room, 1919
Connecticut Avenue, N.W., Washington, D.C., at
9:00 a.m., Arden Morris, Chair, presiding.

PRESENT:

ARDEN MORRIS, Chair, University of Michigan
Health system

JAMES CARPENTER, University of Michigan

ROBERT CIMA, Mayor Clinic

CURTIS COLLINS, University of Michigan
Health System

PETER DILLON, Penn State Hershey Medical
Center

RICHARD DUTTON, Anesthesia Quality Institute

STEVEN FINDLAY, Consumers Union

PAULA GRALING, Inova Fairfax Hospital

VIVIENNE HALPERN, Carl T. Hayden VA Medical
Center

EILEEN KENNEDY, Pepco Holdings

RUTH KLEINPELL, Rush University Medical Center

JOHN MORTON, Stanford University

DENNIS RIVENBURGH, St. Anthony's

TERRY ROGERS, The Foundation for Health Care
Quality

CHRISTOPHER SAIGAL, UCLA Medical Center

NICHOLAS SEARS, MedAssets

ALLAN SIPERSTEIN, Cleveland Clinic

RENAE STAFFORD, University of North Carolina

CONNIE STEED, Greenville Hospital System

CAROL WILHOIT, Blue Cross-Blue Shield of
Illinois

CHRISTINE ZAMBRICKI, American Association of
Nurse Anesthetists

NQF STAFF PRESENT:

HELEN BURSTIN

KRISTIN CHANDLER

ALEXIS FORMAN

MELINDA MURPHY

JESSICA WEBER

ALSO PRESENT:

RICHARD PRAGER, The Society of Thoracic
Surgeons

DALE BRATZLER, Oklahoma Foundation for
Medical Quality

DAVID SHAHIAN, The Society of Thoracic
Surgeons (via telephone)

JANE HAN, The Society of Thoracic
Surgeons (via telephone)

JESSICA RIEHLE, Ingenix (via telephone)

WANDA JOHNSON, Oklahoma Foundation for
Medical Quality (via telephone)

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

AGENDA ITEM	PAGE
Welcome, Recap of Day One4
(Dr. Morris, Dr. Torchiana)	
Consideration of Candidate Measures5
Cardiac-CABG and Prophylaxis:	
Measure 0116.8
Measure 0118.	16
Measure 1479.	23
Measure 0130.	55
Measure 0300.	71
Measure 0217.	144
Measure 0218.	101
NQF Member/Public Comment152
Related and Competing Measures.156
Gaps to be Filled166
NQF Member/Public Comment217
Next Steps/Timeline for Project218
Adjourn222

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

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

9:02 a.m.

CHAIR MORRIS: Good morning.

Welcome to the second day of the Surgical Quality Measures Steering Committee.

I wanted to just briefly recap some important points from yesterday, and also to once again thank our Steering Committee members for being present and for their effort and attention.

First of all, we need to continue to focus on a couple of things that came out at various times during the day yesterday. One of them is with the maintenance measures, in particular, what have we learned since they were initially endorsed? Have we seen evidence of an impact? Have we learned anything else from the fact that they were enacted earlier?

Secondly, we need to focus a little bit more on the impact on disparities. We are focusing on a lot of important things,

1 and that is another important thing that we
2 need to focus on.

3 Thirdly, please be mindful that we
4 are very interested in what the either public
5 reporting plan is or ensuring that public
6 reporting is actually already in existent.

7 Then fourth, we need to continue
8 to speak to the cost and burden on hospitals,
9 especially for the measures that are
10 associated with proprietary databases, and I
11 think that that came up yesterday several
12 times, and it is important to remain mindful
13 of it.

14 We would like to give our
15 developers a few moments to introduce the
16 candidate measures that they have for today,
17 and I see that Dr. Prager is here from STS.
18 The first two measures are yours. Would you
19 like to start?

20 DR. PRAGER: I am happy to start
21 these three measures that are, I think, three
22 measures for today for the STS. Jane Han

1 introduced the concept yesterday on the phone
2 of these measures and when they started and,
3 essentially, I would presume, we will discuss
4 them in the same format, anti-lipids, anti-
5 platelet agents at discharge, and post-
6 operative deep wound infections.

7 CHAIR MORRIS: Thanks. Do we have
8 Ingenix on the telephone? All right. So in
9 that case, the third measure is developed by
10 Ingenix, and we will just -- When they get on
11 the phone, we will just have them start, but
12 we may skip to 0130, if we don't have the
13 phone on when it is time to talk about their
14 measure.

15 First of all, measure -- oh, I'm
16 sorry. Is CMS here? Would you like to
17 introduce your measures as well?

18 DR. BRATZLER: I will make it
19 really clear. I am not CMS. My name is Dale
20 Bratzler. I am with the Oklahoma Foundation
21 for Medical Quality, and we are a contractor
22 to CMS supporting the hospital inpatient core

1 measures.

2 We have three measures that are
3 being considered for reendorsement today. All
4 three are currently in use, publicly reported,
5 and I believe all three, or at least two of
6 them, are a part of the proposed value based
7 purchasing measures for 2013, Fiscal Year
8 2013.

9 The first one is cardiac patients
10 with controlled postoperative serum glucose,
11 again a measure limited to cardiac surgery
12 patients, so affects about 1100 hospitals in
13 the United States currently; and then two
14 measures on VTE prophylaxis.

15 The first one, recommended VTE
16 prophylaxis for surgical patients, and the
17 second one patients who receive appropriate
18 prophylaxis and received it in the appropriate
19 time frame, within 24 hours before or after
20 the end of surgery. Approximately 3500
21 hospitals currently capture data on those two
22 VTE measures. When the discussion happens, I

1 am happy to answer any questions.

2 CHAIR MORRIS: Thank you. The
3 first measure is measure 0116. Dr. Kleinpell?
4 All right, 0116, Dr. Kleinpell, anti-platelet
5 medication at discharge.

6 DR. KLEINPELL: Sure. The measure
7 number 0116, the measure title: Anti-platelet
8 medication at discharge. The measure steward
9 is Society for Thoracic Surgeons.

10 The description of this
11 maintenance measure is percent of patients age
12 18 years and older undergoing isolated CABG
13 who were discharged on anti-platelet
14 medication.

15 This is submitted for maintenance
16 review. It was first released in 2004, last
17 revised in 2010, and it is indicated it is
18 updated annually.

19 In terms of importance, we know
20 that the use of anti-platelet therapy at
21 discharge is currently an accepted standard of
22 care to improve bypass graft patency, as well

1 as promote secondary prevention of coronary
2 artery disease.

3 So the measure is important. It
4 is also currently a CMS PQRI initiative. It
5 is 169. The information that was provided to
6 us was that there still is a performance gap.
7 Despite the fact that it has been around for
8 a while, the information noted in a sample of
9 581 patients was that the performance ranged
10 from 85 percent to 100 percent. No
11 information was given on disparities in care,
12 specifically.

13 We had some discussion in our
14 subgroups about this. One issue that came up
15 was it was unclear as to whether, if aspirin
16 is contraindicated in a patient but they are
17 on Plavix, does that mean the measure would
18 have been met? Really, the only exclusion
19 criteria speaks to if aspirin is
20 contraindicated. So that was one issue that
21 was raised within our subgroup.

22 In terms of scientific

1 acceptability, it is clearly a useful measure
2 for consumers and patients, and the scientific
3 evidence is strong.

4 In terms of usability, the measure
5 provides useful information, but one issue
6 that was identified in our subgroup was that
7 it was noted it is a measure of one of 11
8 component measures of a CABG composite score.
9 So we wondered if there was clarification
10 about how the measure is treated within the
11 composite score. For instance, is it weighted
12 equally with all measures?

13 In terms of feasibility, the
14 measure is easy to implement and track. So,
15 really, that was all that we had with respect
16 to discussion of the measure.

17 CHAIR MORRIS: Thank you. Does
18 anybody have anything to add to that? Issues,
19 comments, questions? Anybody from the work
20 group? Okay. Would developer like a chance
21 to respond to that?

22 DR. PRAGER: David, are you on the

1 phone about the composite? Dr. Shahian or
2 Jane?

3 DR. HAN: Hi, this is Jane Han. I
4 was having difficulty getting in.

5 DR. PRAGER: Okay. So David may
6 be having the same.

7 DR. HAN: I actually told him to
8 join us at 9:25, since that was the time on
9 the agenda, but are we running ahead of
10 schedule?

11 DR. PRAGER: Well, we didn't go
12 through the lengthy review.

13 DR. HAN: I know he will be
14 joining us in about 15 minutes. Sorry about
15 that.

16 DR. PRAGER: There are a couple of
17 questions the STS needs to address, or at
18 least two questions. One is -- and I think we
19 need David for this -- how this is weighted in
20 the composite metric, which was one question
21 that came out of the study group. I am not
22 sure that, actually, I can answer that for

1 you.

2 The second issue about, if not
3 aspirin, if allergic to aspirin, was it a
4 question about Plavix? I'm not sure.

5 DR. KLEINPELL: Right. if the
6 patient is on Plavix, does that consider that
7 the measure is met, because the only exclusion
8 criteria speaks to contraindications for
9 aspirin?

10 DR. PRAGER: Right. My
11 understanding is yes for that.

12 DR. WILHOIT: I think the question
13 there perhaps is whether you count the
14 numerator event first or whether you count the
15 exclusion first, because aspirin sensitivity
16 is listed as an exclusion, but taking an
17 alternative drug is also listed as a numerator
18 event.

19 So I think the question probably
20 is what order you count things in, whether you
21 take the exclusion first or the numerator
22 event first.

1 DR. PRAGER: And that is a good
2 question, and I am not sure I know how we
3 sample that via the database, which we take
4 first, and I understand your question.

5 CHAIR MORRIS: Jane, can you speak
6 to that? Do you guys perform your exclusions
7 first before you gather the numerator and
8 denominator?

9 DR. HAN: I, unfortunately, am not
10 the one who does the analyses. So I would
11 have to check with our data warehouse, unless
12 Dr. Shahian knows the answer to that.

13 DR. PRAGER: We will have to go to
14 DCRI to find that out, unless David knows.

15 DR. HAN: Right.

16 CHAIR MORRIS: Okay. Is there
17 anything else that anybody wants to bring up
18 for this measure? All right.

19 Then just also to note -- Jane, I
20 am not sure if you heard this, but another
21 issue that arose was the question of whether
22 disparities have been measured in the

1 application of this care. I just want to
2 reinforce that. I know that it is not present
3 in the documents from STS, and I am suspecting
4 that, like yesterday, it could be done. It
5 just hasn't been done.

6 DR. PRAGER: Correct.

7 CHAIR MORRIS: So I want to
8 underscore that. If there is nothing else,
9 let's go ahead and move on to the vote.

10 So the first vote: Does the
11 measure meet NQF criteria for importance to
12 measure and report? Twenty-one out of 21 say
13 yes.

14 The second vote: Does the measure
15 meet NQF criteria for scientific acceptability
16 of measure properties? Let me ask you all to
17 press your vote one more time, and press Send.
18 Eighteen say completely; 3 say partially.

19 The third vote: Does the measure
20 meet NQF criteria for usability? Twenty-one
21 out of 21 say completely.

22 Then the next: Does the measure

1 meet NQF criteria for feasibility? Twenty say
2 completely; one says partially.

3 Then lastly: Does the measure
4 meet all of the NQF criteria for endorsement,
5 and the issues that arose were the fact that
6 there is indeed a gap -- so that is on the
7 positive side. There are several other
8 positives, and then sort of open questions are
9 what effect does this particular measure have
10 on disparities; secondly, if aspirin is
11 contraindicated, is Plavix an acceptable
12 alternative; and thirdly, how is this measure
13 treated in the composite score with regard to
14 weighting.

15 Then, let's see now, the fourth
16 issue was -- What was the fourth issue? It
17 was when are the exclusions applied? So it
18 was just a question, really, when are
19 exclusions applied, and a pretty simple
20 question. I think, generally, they are
21 probably applied before capturing the entire
22 numerator and denominator.

1 Anybody want to bring anything
2 else up or anybody want to discuss these
3 issues further before we vote?

4 Okay. Does the measure meet all
5 of the NQF criteria for endorsement? Twenty-
6 one out of 21 say yes.

7 The next measure is Dr. Collins,
8 0118, the anti-lipid treatment discharge. It
9 is being introduced by Dr. Collins.

10 DR. COLLINS: Sure. Good morning.
11 I have both 0118 as well as 1479, which are
12 very similar measures. I don't know if you
13 would like me to present both or just one at
14 a time. I think we have some harmonization,
15 potentially, discussions here.

16 CHAIR MORRIS: What I would like
17 to do is to have you go ahead and present the
18 first one. We will vote on it, and then
19 present the second one. Maybe we should talk
20 at that point about competing harmonization.

21 DR. COLLINS: That sounds good.
22 So 0118 is an existing maintenance measure

1 with the steward as the STS, very similar to
2 the previous measure we just discussed, and it
3 looks at lipid lowering agents following CABG
4 therapy.

5 The simple numerators are patients
6 who received lipid-lowering therapy at
7 discharge, with the denominator patients on
8 CABG. Patients are excluded if anti-lipid
9 therapy is contraindicated or if there was an
10 in-hospital mortality.

11 No comments, I believe, in the
12 proposal on disparities of care. This is an
13 existing measure. The compliance is, I
14 believe, around 98 percent in what was
15 reported, which is very high. So our work
16 group did have some questions on whether this
17 measure was tapped out, being at 98 percent.

18 The importance of this measure, I
19 don't think, will require too much discussion.
20 It definitely still remains a very important
21 measure as far as outcomes data associated
22 with lipid therapy and, really, the work group

1 did not have major comments on science,
2 acceptability, usability or feasibility.

3 CHAIR MORRIS: Any other comments
4 anyone one has about this measure?

5 DR. DUTTON: Sorry. It took a
6 moment for the coffee to start working. But
7 both this one and the last one: Has the STS -
8 - since these are returning measures, has the
9 STS looked at why patients don't get them,
10 when they don't. In other words, have they
11 analyzed the failures:

12 The question would be, are they
13 preventable or not preventable, because if
14 most of the failures are not preventable like
15 patients on tube feedings going to a nursing
16 home or absolute allergic contraindications or
17 something like that, then there is no point in
18 keeping the measure. But if the gap is
19 preventable stuff like, oh, we forgot or they
20 couldn't fill their prescription because they
21 are poor or whatever, then, obviously, we
22 should keep it. Does STS know?

1 DR. PRAGER: At the national level
2 -- in other words, via DCRI and then the
3 national population of patients -- the STS
4 does not know. At the regional level where
5 this is looked at and most of the quality
6 initiatives occur, what has been seen is that
7 there has been increasing utilization of it,
8 either via order sets that demand it or demand
9 the reason that you do not use it; and while
10 98 percent looks great, everywhere is not 98
11 percent.

12 So that is what we have seen. Is
13 there a method to see why it is not, is it
14 definitely contraindicated? Have we drilled
15 down? The answer to that is no.

16 I am happy to anticipate your
17 other question about, if it is at 98 percent,
18 should we keep going? Was that the next one?
19 Yes. We have actually talked about this, and
20 I would understand -- I understand the
21 question totally, and we asked ourselves the
22 same question.

1 What we have seen and what we hope
2 to really accomplish by keeping a measure such
3 as this is to allow other people to come up
4 with a system, so that this becomes part of
5 the mindset of a postoperative medication,
6 one, and it isn't there everywhere because
7 there are regional differences, as we talked
8 about yesterday, in things such as the process
9 measure of alima, and we are concerned about
10 slippage. So we would like to keep this.

11 DR. SHAHIAN: This is Dave. I
12 would say that the vast majority, probably
13 approaching 100 percent of our CABG patients,
14 would fall into one of the categories for
15 which that therapy is recommended by ACT and
16 AHA, based on a fairly large body of evidence
17 regarding secondary prevention.

18 Of course, there is now a lot of
19 evidence in cardiac surgery that it is
20 valuable preoperatively as well, which may end
21 up being something we will bring back to you
22 in the future, but I think we would very much

1 like to continue this measure.

2 CHAIR MORRIS: Any other issues
3 that anybody wants to bring up with regard to
4 this measure? I think that that is a pretty
5 insightful comment, and I guess that, as a
6 group, we would like to really encourage the
7 STS to think about some of these measures.
8 They are really excellent quality measures,
9 but maybe topped out in the near future or
10 just beyond the near future.

11 So understanding why particular
12 treatments are not received would probably be
13 very useful to know if those cases in which
14 treatment is not received were actually
15 preventable or should be changed.

16 If there is nothing else to say,
17 let's go ahead and move on to the vote.

18 Does the measure meet NQF criteria
19 for importance to measure and report? Twenty-
20 one out of 21 says yes.

21 Next vote: Does the measure meet
22 NQF criteria for scientific acceptability of

1 measure properties? Twenty say completely;
2 one says partially.

3 Next: Does the measure meet NQF
4 criteria for usability? Twenty say
5 completely; one says minimally.

6 Does the measure meet NQF criteria
7 for feasibility? Twenty-one out of 21 say
8 completely.

9 Then lastly: Does the measure
10 meet all of the NQF criteria for endorsement?

11 Is there, before we start the
12 vote, anything else that anybody wants to
13 bring up? So to briefly recap, there is a
14 question of whether this is tapped out.

15 We know that there is still some
16 regional variation based on what our
17 representatives from STS have said. They
18 strongly desire to increase the utilization,
19 as has happened so far probably with
20 standardized order sets or other things that
21 make it very simple to order these meds.

22 Then we will be addressing in a

1 few minutes whether this is competing with the
2 next measure.

3 So with that, does the measure
4 meet all of the NQF criteria for endorsement?
5 Let's go ahead and vote. Twenty-one out of 21
6 say yes.

7 The next measure, 1479.

8 DR. COLLINS: Sure. The next
9 measure is, like we have mentioned, very
10 similar to the previous measure, also looking
11 at patients 18 years and older who have had
12 lipid-lowering therapy following CABG, and the
13 steward is a company named Ingenix, which I
14 believe is on the phone for comment as well.

15 This measure uses pharmacy claim
16 database where they look at lipid-lowering
17 therapy either 90 days prior to CABG, seven
18 days following DC after CABG, or a procedural
19 code at discharge.

20 So I think that is the major
21 difference. It is really looking at the
22 pharmacy claim data from what I believe is

1 either a 15 million or a 65 million member
2 database.

3 Exclusions are pretty much similar
4 to the previous measure: Mortality; if there
5 was a readmit within seven days to the
6 hospital, or if patients drop pharmacy
7 coverage or Ingenix coverage, I believe, prior
8 to when the script was filled.

9 The work group thought that it,
10 like the other one, was an important measure.
11 Some of the comments came as far as, if a
12 patient did not fill the script after
13 discharge, would the hospitals then become
14 accountable for that, and some of the
15 inaccuracies maybe with using pharmacy claims
16 versus self-reported measures, as with the
17 STS.

18 I don't believe there were
19 comments on disparities of care, and I was a
20 little unclear as far as cost outside of
21 patients who are under the Ingenix umbrella.

22 I will also point out that one of

1 the issues I think we need to discuss in this
2 is the percent of patients who have CABG. I
3 am sure -- I don't know the numbers, but I am
4 sure it is 40, 50, 60 percent are greater than
5 65 years of age, which I question whether this
6 measure would capture those patients.

7 CHAIR MORRIS: Thank you. Are
8 there any other issues or comments anybody
9 wants to make about this?

10 DR. MORTON: I had a question. Is
11 the only way to get the data through Ingenix?

12 DR. BURSTIN: The measure
13 specifications are freely available. Anybody
14 could run it using claims data.

15 DR. WILHOIT: Having additional
16 measures that can be run with an
17 administrative dataset can be a real
18 advantage. While this is similar to the
19 previous measure, the difference, I think, or
20 a major difference is that for a health plan
21 or for a large provider group that gets
22 feedback on their pharmacy claims or whatever,

1 there is the availability to run the data;
2 whereas, a lot of the STS data is not
3 necessarily available to outside entities.

4 So I think in many respects it is
5 a very different measure, even though it is
6 looking at the same thing, because of the
7 different data source or the different
8 availability of information. However, that
9 being said -- and I think the second thing
10 that is different is the difference between
11 prescribing a drug and filling a prescription.

12 The STS measure that we just
13 looked at had a mean of in the high nineties
14 or mid-nineties. This one, the rate was 32
15 percent, 32.8 percent. Well, either one is
16 wrong or the other is wrong or we have got a
17 huge issue.

18 If 95 percent of people are really
19 being prescribed drugs and only 33 percent of
20 people are filling the drugs, then we are
21 fooling ourselves to look at the STS measure.

22 On the other hand, this 35 percent

1 really seems unrealistically low, and that
2 makes me wonder if there are problems with the
3 measure. So I think that adding measures that
4 can be run using administrative data is
5 important, but it seems like there must be a
6 disconnect here.

7 Coming back also to the issue of
8 whether the data could be run for patients age
9 65 and older, there are many retirees who are
10 still covered under their employers' or former
11 employers' health benefit plan, and a lot of
12 people who are continuing to work after that
13 age, and it is usually clearly identified in
14 the administrative dataset whether somebody
15 has pharmacy benefits and, if they don't have
16 pharmacy benefits, I believe they are excluded
17 from the measure.

18 So I think that particular issue
19 isn't of particular concern.

20 DR. SAIGAL: Can I comment? I
21 agree. I see two points. One, Carol's point
22 about the low rate of filling -- I do a lot of

1 work with claims. There is a lot of noise
2 when I look at those claims data.

3 I was wondering if there is any
4 validation studies done on this measure
5 looking at whether patients actually who
6 didn't get a pharmacy fill in their claims
7 database got a prescription, if we can do any
8 clinical correlation with that on a small
9 scale, and also how do they deal with
10 exclusions that are clinical in nature like on
11 reactions to Lipitor, something like that, in
12 a claims database.

13 DR. CIMA: Also to follow up on
14 Carol's point, when we have looked at this in
15 our institution about what people right after
16 surgery, not filling their prescriptions right
17 away, oftentimes there's confounders into
18 that.

19 So like I just got out of the
20 hospital, and my husband is also on Lipitor,
21 same prescription; I started taking his. I am
22 not going to fill it until I feel better.

1 There's all sorts of weird issues.

2 The other thing, the fundamental
3 issue and my main concern with this is
4 attribution. Who is going to be responsible
5 for this? So who is going to get the -- When
6 you do public reporting on this, what is it
7 going to say? Is it going to say hospital A
8 only performed at a certain level on this,
9 when they had no control on whether or not
10 that patient fills that prescription?

11 I have real serious concerns about
12 the quality of the data as far as the amount
13 of lives covered, and to Carol's point, why
14 was there only 30-some-odd percent of patients
15 saying they had this? Is that really the gap?

16 You know, even if we take the STS
17 as a rosy picture, this would be saying that
18 we are doing a terrible job. So my main
19 concern is attribution. How are you going to
20 attribute who is responsible for owning this
21 and saying we can make it better? Is there
22 really a quality improvement initiative that

1 a hospital can do if patients aren't filling
2 the prescriptions?

3 There are all these other ways
4 around handling administrative pharmacy data,
5 and there is a lot of noise in it. I think we
6 have a cleaner measure with the STS one. This
7 one doesn't really add a lot of value as far
8 as quality improvement, and it is going to
9 make public reporting somewhat of a nightmare
10 for institutions to try and handle.

11 MS. STEED: It is actually not
12 clear how they are going to use it for public
13 reporting.

14 DR. HALPERN: I also do wonder
15 about the age issue, because they do say this
16 database represents a predominantly commercial
17 population less than 65 years old. So what
18 percentage of their patients are 65 years and
19 older that they are actually analyzing, since
20 again, like somebody else pointed out, people
21 who get CABGs are generally over 65?

22 DR. MORTON: I had a technical

1 question about would this measure only work if
2 you have a pharmacy benefit? If that is the
3 case, I don't know how often people don't have
4 a pharmacy benefit for this particular
5 surgery.

6 DR. WILHOIT: In a commercial
7 health plan setting, it depends on the health
8 plan. However, depending -- For us, depending
9 on the product, it ranges from about 40
10 percent of members with a pharmacy benefit to
11 about 85 percent, depending on the particular
12 kind of product.

13 Not having a pharmacy benefit is
14 an exclusion from the measure. So that, you
15 know, it is accounted for. The other thing --
16 and I can't speak for Ingenix, and if they are
17 on the phone, they may be able to respond, but
18 in terms of the database and whether the
19 people were under 65, I think that was the
20 database in which they did the analysis, but
21 the measure, I think, would be intended for
22 use in other databases as well.

1 CHAIR MORRIS: Dr. Dutton, did you
2 have something to add?

3 DR. DUTTON: Well, I was going to
4 say, if you have to have a pharmacy benefit to
5 be included in the measure, isn't there an
6 inherent socioeconomic bias in the data
7 already that is going to make it very hard to
8 use this data for looking at disparities.

9 DR. WILHOIT: The other side of
10 that is, if one is, for example, a health plan
11 or one is an integrated delivery system and
12 you are trying to look at your own data, you
13 know, the administrative data is what you
14 have, and that is what you can work with.

15 The other advantage of using
16 pharmacy claims -- I know from our experience,
17 we have pharmacy data pretty complete within
18 a month; whereas, claims data for other kinds
19 of services is three, four, five, six, eight
20 months, depending on what you are looking at,
21 and STS is a whole lot longer than that.

22 So one of the real up sides in

1 terms of things like identifying gaps in
2 care, improving gaps in care, is that this can
3 be assessed on a very timely basis. So that
4 is a real positive as well.

5 DR. MORTON: I guess my only
6 concern is, if pharmacy benefits are an
7 exclusion, you are going to leave out anywhere
8 between 15 to 60 percent of people that are
9 undergoing the procedure potentially.

10 CHAIR MORRIS: So a lot of
11 different issues arise with that. Does anybody
12 have anything else before we give Ingenix an
13 opportunity to say a few words, and also I
14 would like to just let the folks on the line
15 know that they certainly can have a little bit
16 of extra time, since they were unable to
17 introduce their measure, because our phone
18 lines were not open.

19 Any other issues before Ingenix
20 responds? One more?

21 MS. ZAMBRICKI: I would just like
22 to speak for the fact that this is a big

1 concern when I read it, this difference, and
2 we are not sure exactly what it means. But I
3 would hope that, whatever the decision is,
4 that somehow this continues to be measured and
5 some attention be paid to it.

6 I think the attribution issue is
7 an important one, but as a global public
8 health issue, I think this is really an
9 important question.

10 CHAIR MORRIS: Okay. So just to
11 recap, a lot of different things came up. One
12 question is what percent of patients over the
13 age of 65 years old would actually be captured
14 using this system? How will this be used for
15 public reporting is unknown, as I understand
16 it. There are issues with attribution or
17 accountability at the hospital level, who is
18 accountable, particularly if patients elect
19 not to get their prescriptions filled.

20 There is no information about
21 disparities, and it seems unlikely that using
22 this measure we would be able to obtain a lot

1 of information about disparities, because
2 those without a pharmacy benefit would not be
3 captured.

4 There is a question about the cost
5 burden to hospitals, which was unclear, and a
6 couple of related questions. Using
7 administrative claims, how does Ingenix deal
8 with the noise in this? How do they address
9 exclusions using this measure, and why is the
10 measure uptake -- why does it appear so
11 different from measure uptake in the previous
12 measure?

13 One of the questions with regard
14 to that was the fact that, if patients already
15 have a prescription for statins or lipid-
16 lowering medication at home, would they not be
17 captured by this measure? So this specifies
18 taking a lipid-lowering medication at
19 admission or within seven days of discharge.
20 It is possible that they may have statins at
21 home that, for some reason, are not captured,
22 and that may be why there is such a low rate.

1 Dr. Halpern?

2 DR. HALPERN: I have also noticed
3 that one of their -- Included in the measure
4 is 90 days preop. So I am wondering if that
5 is the difference in the percentage, because
6 maybe people don't have it prior to coming to
7 the hospital, which is an important issue
8 also; because as somebody mentioned, if it is
9 prior to surgery, both cardiac and vascular
10 seem to help with overall morbidity and
11 mortality from the surgeries.

12 CHAIR MORRIS: Okay. Would our
13 Ingenix representative like to respond to
14 that?

15 DR. RIEHLE: This is Jessica from
16 Ingenix. Can you hear me?

17 CHAIR MORRIS: Yes.

18 DR. RIEHLE: Do you want me
19 specifically to respond to using Lipitor or
20 lipid-lowering medication at home prior or do
21 you want me just to go through the list that
22 you read off?

1 CHAIR MORRIS: I would like for
2 you to go through the list.

3 DR. RIEHLE: Okay. So there was a
4 concern raised about the percentage of
5 patients 65 and older. Our database
6 specifically that we use to test the measure
7 does not have very many people who are over
8 65. However, there is nothing inherent to the
9 measure itself that ruled out patients who are
10 older than 65, and a lot of our customers have
11 data for patients over 65.

12 So the measure still applies to
13 that population. Unfortunately, with our
14 database we weren't able to test it in that
15 population, but there is nothing that would
16 exclude older patients.

17 In terms of public reporting, this
18 measure is being used for public reporting,
19 mostly at the physician level for provider
20 measurement.

21 In terms of attribution, you know,
22 we don't have specifications as to how the

1 measure is attributed. The people that use
2 our measure -- that is something that they
3 define.

4 We also share the concern about
5 patients who don't fill their medications,
6 which is why we included in the numerator a G
7 code, which is a code that a physician can use
8 to say that they prescribed the medication,
9 and it is not at all dependent on whether or
10 not the patient fills the medication.

11 In terms of exclusions for people
12 who might have an intolerance to the
13 medication, unfortunately, that is really hard
14 to do with claims data. There really isn't a
15 great way to code the fact that somebody may
16 have a history of intolerance to the
17 medication.

18 For the Lipitor prescription at
19 home, again the numerator does include
20 patients who filled a lipid-lowering
21 medication during the 90 days prior to the
22 CABG admission. So people who may have the

1 medication at home -- you know, if they are
2 taking their wife's prescription,
3 unfortunately, there is no good way to capture
4 that using claims.

5 CHAIR MORRIS: Can you clarify
6 your thoughts regarding why that measure
7 uptake appears so different from the STS
8 measure uptake?

9 DR. RIEHLE: In terms of the
10 compliance, the 32 percent versus the 90-
11 whatever percent?

12 CHAIR MORRIS: Yes.

13 DR. RIEHLE: You know, I am not
14 sure. I suspect that -- I mean, I would be
15 very, very surprised if the compliance was as
16 high as 90-something percent. We would like
17 to go and actually do a comparison eventually
18 of our data versus electronic charts or even
19 paper charts. That is something that we would
20 like to do soon, but we have never done that.
21 I am not sure why you see such a discrepancy,
22 to be honest.

1 DR. SAIGAL: Can I ask a question?
2 Could you not also use a G code to eliminate
3 people that are intolerant to these
4 medications, if you are using the physician
5 reported one?

6 DR. RIEHLE: I am not sure if
7 there is a G code. There might be a CPT-2
8 code. There probably is some sort of a code,
9 and we could definitely look into that.

10 DR. WILHOIT: There is a code
11 listed in the denominator exclusions on page
12 7 under QA-10. There is a G code, 8586, which
13 is anti-lipid treatment contraindicated/not
14 indicated.

15 DR. RIEHLE: Oh, okay. So it is
16 there.

17 CHAIR MORRIS: It doesn't mean
18 that the providers will know that that is
19 there.

20 DR. RIEHLE: Yes.

21 CHAIR MORRIS: Are there any other
22 issues anybody wants to bring up before we

1 vote?

2 DR. STAFFORD: Yes, I have a
3 question. Did I understand you correction
4 that public reporting would be at the
5 physician level?

6 DR. RIEHLE: You know, I mean, it
7 could be used in a variety of different ways,
8 but that is primarily how it is being used now
9 in terms of public reporting, would be at the
10 physician level.

11 DR. STAFFORD: So I would -- This
12 gets back to attribution and attribution bias.
13 There is a huge problem with that,
14 particularly in academic centers where a
15 prescription for a medication might get
16 written by the resident, and so if you are
17 looking at attendings, then it wouldn't show
18 up as having been written by the attending.
19 I think that could be a huge problem.

20 DR. HALPERN: Not only that, if
21 the doctors are responsible for the ones
22 putting in the codes, if it is a resident

1 putting in the -- A resident won't be putting
2 in those codes.

3 DR. DUTTON: I will pile on that
4 also. We are trying to encourage team
5 practice and accountable care and bundling of
6 episodes and so on. Attributing data like
7 this to individual physicians is just horrible
8 for that, because you don't necessarily know
9 who the responsible doctor is, and in an
10 appropriate system it might be an internist
11 who is managing that patient's medications
12 through a surgical episode.

13 CHAIR MORRIS: I believe that the
14 accountability problem here also resides in
15 the other measure. If this is to be published
16 at the hospital level or publicly reported at
17 the hospital level, that would match,
18 presumably, the other measure from STS.

19 If it is to be reported at the
20 physician level or whoever it is that is
21 measuring it decides to report it at the
22 physician level, then obviously that group is

1 really concerned about that.

2 DR. CIMA: But even at the
3 hospital level, there are things out of your
4 control -- you know, what plan they have,
5 whether their plan is covered. It poses a
6 risk to the hospital, even it is on the
7 dismissal summary.

8 We should ask people to do what
9 they can do, not to ask them to be responsible
10 for the world. I think this attribution issue
11 is a major issue, and institutions have to be
12 sensitive to it, and we have to be sensitive
13 to that also.

14 DR. SEARS: Yes, I guess we are
15 all piling on about the attribution issue. I
16 think one thing, we pass a measure like this,
17 hospitals will rethink what they do.

18 They may have to actually give the
19 prescriptions to the patients so that, when
20 they go home, they know that the prescription
21 has been filled, and then they have satisfied
22 their obligation to the measure, and in a DRG

1 world where 65-70 percent of these patients
2 are probably Medicare, they are not going to
3 be able to get any collection for the drug
4 that they are going to have to give out.

5 DR. SAIGAL: I just have one last
6 comment. I do think that the issue of the
7 difference in the rates between this measure
8 and the STS measure needs to be looked at
9 before this measure gets put through, because
10 I think a small validation approach to what
11 they are doing would be really helpful and
12 help me believe that this is going to be
13 useful in public reporting.

14 DR. WILHOIT: And I totally agree
15 with that. For me, that is the biggest issue
16 here. I think adding some administrative
17 measures is really positive. I think there's
18 a lot of things that are positive about this,
19 but at the moment, for me it lacks face
20 validity. Thirty-five percent just seems --
21 just doesn't fit the sniff test.

22 That makes me wonder if there is

1 some of the logic that isn't quite correct.
2 So for me, it needs some further evaluation
3 and, if the rate really is this low and we are
4 kidding ourselves with the 95 percent, then
5 that is really worth knowing, and that is very
6 important; because if we want good outcomes,
7 we need to make sure care is actually
8 delivered. But I think it needs testing to
9 try to understand that and make sure it is not
10 a logic error.

11 CHAIR MORRIS: Helen?

12 DR. BURSTIN: Just two comments,
13 one of which is: There is actually very clear
14 and known literature of the low rate of
15 compliance with statins post-discharge. I
16 mean very low rates. Thirty percent is
17 actually what people tend to say for people
18 actually on statins beyond six months.

19 So it is actually hard to know
20 which is actually correct. Ninety-eight
21 percent is probably true in terms of saying,
22 yes, please be on a statin at discharge. It

1 is very different to say a patient actually
2 went, took the prescription, and filled it.

3 So they really are measuring very
4 different concepts, and we need to better
5 understand it. My preference personally is to
6 go to the one where we actually know the
7 patient has got the drug in their hand or,
8 even better, skip that entirely and just look
9 at LDLs, which is really the end test here of
10 are you on a statin? Are you taking it, and
11 is your LDL in control? Neither of these kind
12 of really get at what I think is truly the end
13 game here.

14 Just lastly, just because this
15 comes up on every single Steering Committee,
16 this issue of accountability and attribution
17 is just a really difficult one. The reality
18 is we need to pick the measures that we think
19 are best to serve the needs of the public, to
20 get to the right assessment of quality.

21 We are really trying to move
22 toward models of shared accountability. It is

1 not just the clinician. It is not just the
2 hospital. It is not just the pharmacy who
3 fills it at the end of the day. But the only
4 way to do that is to pick whatever the best
5 measure is, and the attribution issues, I
6 think, are just going to -- will always make
7 us take a step back from potentially measures
8 that would really drive improvement.

9 We would potentially not have done
10 readmissions. We would not have done -- There
11 is a whole series of things we have been able
12 to make improvements, because we kind of took
13 the step toward the tougher measures. So I am
14 off my soapbox. Thank you.

15 CHAIR MORRIS: Okay. I think it
16 is time for us to move to a vote.

17 DR. SHAHIAN: Excuse me. This is
18 Dave Shahian. Is it permissible for me to
19 make a comment as somebody involved with the
20 other measure?

21 CHAIR MORRIS: Sure. Go ahead.

22 DR. SHAHIAN: It strikes me that

1 this is really a completely different measure
2 in many respects. Well, one of the most
3 important that I see is that the measure would
4 be satisfied, as I read it, if one were on a
5 lipid-lowering medication at the time of CABG
6 admission.

7 Now that, clearly, is out of the
8 control completely -- I know we just talked
9 about this a second ago, but it is totally out
10 of the control of the surgeon, and the surgeon
11 could -- Our measure is trying to determine
12 whether surgeons and their team, including
13 cardiologists, are giving a statin
14 prescription or a lipid-lowering prescription
15 at the time of discharge.

16 This measure would be satisfied, I
17 think, if a patient simply came into the
18 hospital on a lipid-lowering medication. Am
19 I correct about that?

20 DR. RIEHLE: Yes.

21 DR. SHAHIAN: So that strikes me
22 as a completely different measure. I am not

1 saying whether I favor it or not, but I think
2 it is a much, much different measure in many
3 respects.

4 CHAIR MORRIS: Thank you. Are
5 there any other comments? Dr. Collins, can
6 you speak to the discussion among the work
7 group regarding whether you felt that this was
8 a competing measure or whether it was
9 substantially different from the previous
10 measure?

11 DR. COLLINS: I believe the work
12 group thought that they were competing
13 measures, and the question, like I mentioned
14 before, of harmonization or we were a little
15 unclear, if we had to pick a winner, of what
16 our course was there. But we thought they
17 were competing and not completely separate.

18 MS. MURPHY: And the requirement
19 that you had before you is to evaluate this
20 measure with its specifications, and the
21 discussion about harmonization/competing can
22 follow later.

1 CHAIR MORRIS: Thanks for
2 clarifying that. Let's move on to the vote.

3 Does the measure meet NQF criteria
4 for importance to measure and report? This
5 speaks particularly to impact, performance
6 gap, and evidence. I will ask everybody to
7 press their buttons one more time, and hit
8 Send. Twelve say yes; nine say no. So we
9 will go ahead and proceed.

10 Does the measure meet NQF criteria
11 for scientific acceptability of measure
12 properties? One says completely. Seven say
13 partially. Twelve say minimally, and one says
14 not at all.

15 Does the measure meet NQF criteria
16 for usability? Three say completely, six
17 partially, nine minimally, and three say not
18 at all.

19 Does the measure meet NQF criteria
20 for feasibility? I will ask everybody to hit
21 their button once more, and hit Send again.
22 One last time, and if you notice that you are

1 consistently potentially the last voter,
2 please see me at the break. We will change
3 your battery or something like that, the
4 battery in your voting item, not your personal
5 battery. Five say completely. Eight say
6 partially, seven minimally, and one says not
7 at all.

8 Then the last vote is: Does the
9 measure meet all the NQF criteria for
10 endorsement, and I would like to recap some of
11 the major issues that were brought up.

12 There was a lot of question about
13 the validity of this data compared to the --
14 or of this measure uptake compared to the
15 measure uptake for the STS measure, and a lot
16 of concern about the big gap there with
17 questions about which one could potentially be
18 more accurate or whether they are really
19 measuring different things.

20 We heard from Ingenix that at some
21 point they may have a plan to validate their
22 claims method by comparing to chart derived

1 data. That sounded, to me, a little bit
2 fuzzy, as had been discussed, but that a plan
3 doesn't exist at this time.

4 There were issues regarding
5 capture of -- adequate capture of patients,
6 particularly those who don't have pharmacy
7 coverage, and whether or not we would be able
8 to learn anything about disparities in care
9 using this measure.

10 There were issues about
11 attribution accountability at the hospital
12 level, at the physician level, holding folks
13 accountable or institutions accountable that
14 really had no control over this outcome.

15 There were questions about how
16 exclusions were dealt with. A lot of times
17 Ingenix said that the exclusions couldn't
18 actually be addressed using claims data, but
19 it sounds as though there are some claims that
20 indicate when patients are unsuitable for use
21 of lipid-lowering medication, or it sounds
22 like that claims are not known by many

1 providers potentially.

2 There is a question about how to
3 deal with the noise that is inherent in claims
4 data, and to my mind, that wasn't truly
5 addressed, but it may not be possible to
6 completely deal with the noise in claims data.
7 On the plus side, claims data is pretty easy
8 and cheap to acquire.

9 There were issues about cost
10 burden to hospital. That pretty much
11 summarizes it for me. Does anybody else want
12 to bring anything up with regard to this
13 measure?

14 DR. SIPERSTEIN: I just want to
15 comment. I think the goals of this measure are
16 very laudable in that it looks at the next
17 step after we write our prescriptions. It
18 starts to look at the whole issue of patient
19 compliance, and it is, obviously, part of
20 physicians' responsibility to educate their
21 patients to the importance of filling their
22 prescription and taking their medication.

1 I am just not convinced that the
2 measure as written really serves that goal.
3 We get a hint of that when we do our
4 medication reconciliation when a patient comes
5 back a week later. It is not a perfect system,
6 but I would encourage the authors to continue
7 to work on some similar measure, because I
8 think this is an important thing to look at.

9 CHAIR MORRIS: Thank you for
10 making that comment. That also speaks to Dr.
11 Burstin's comment about what is the real
12 outcome that we are going for here. Are we
13 going for the outcome of just prescribing the
14 medication or recording that one has been
15 prescribed or are we going for the outcome of
16 patients actually taking the medication or the
17 end game, which is better health or lower LDL?

18 So I think those are important to
19 keep in mind with all of the measures.

20 DR. STAFFORD: Along with that
21 point, Dr. Dutton mentioned the potential for
22 socioeconomic bias, and those are exactly the

1 people that we probably could help the most,
2 and they are being excluded from this
3 database. So if they have trouble getting
4 them filled, there is no way we are ever going
5 to capture that with this database.

6 CHAIR MORRIS: Thanks. So let's
7 move on to the last vote. Does the measure
8 meet all of the NQF criteria for endorsement?

9 We have one yes, 19 no, and one
10 abstaining.

11 We will move on to the next
12 measure, which is Measure 0130, deep sternal
13 wound infection rate by Ms. Steed --
14 introduced by Ms. Steed.

15 MS. STEED: Yes. This measure is
16 an established measure already, and it is the
17 percentage of patients age 18 and older
18 undergoing isolated CABG who within 30 days
19 postoperatively develop deep sternal wound
20 infection involving muscle, bone and/or
21 mediastinal, requiring operative intervention.

22 It has a pretty clear numerator

1 and denominator statement, and in the
2 discussion with the group there was really no
3 significant conversation about this measure
4 via the importance of scientific, usability or
5 feasibility except for one comment.

6 That is, at the present time I
7 understand that are two organizations, the CDC
8 and the American Academy of Surgeons, who have
9 proposed surgical site infection definitions
10 to NQF, and I understand that they are in the
11 harmonization phase. They have not harmonized
12 those definitions, but when those get
13 approved, then this particular measure will
14 have an issue related to harmonization.

15 I don't know what the American
16 College of Surgeons' definition is, but I know
17 what CDC's definition is, and this particular
18 definition differs in that it looks at the
19 infection developing within 30 days of
20 hospitalization or the surgery, to where CDC's
21 goes up to 12 months postoperatively, and that
22 is the biggest difference.

1 DR. BURSTIN: The CDC measure goes
2 longer out only if there is an implant.

3 MS. STEED: If there is an
4 implant. You are right, if there is an
5 implant, and they consider sternal wires
6 implants. I hate to say it, but that is the
7 truth.

8 DR. BURSTIN: It is actually 180
9 days, but still that is a good point. I don't
10 know the answer of whether that --

11 MS. STEED: Yes, sternal wires are
12 considered implants by CDC, which is one of
13 the controversies between, I am sure, the
14 American College of Surgeons and the CDC.

15 DR. SIPERSTEIN: My understanding
16 of reading that infection measure is that
17 sternal wires would not count. They are
18 talking about joints, valves, but not wires,
19 which are variants of sutures.

20 MS. STEED: Being someone that has
21 to conduct the surveillance for CDC and being
22 involved in public reporting, and I am in the

1 state of South Carolina, when we get validated
2 they do consider -- CDC considers sternal
3 wires as an implantable, which is one of the
4 biggest controversies that surgeons have with
5 their definition.

6 So just know that that is the
7 case, and I am sure that is part of the
8 harmonization that is going on between the
9 American College of Surgeons and the CDC, but
10 I do not know where that stands. I am not
11 involved in it, but I felt it important to
12 bring it up.

13 DR. BURSTIN: It is actually a
14 good point. I believe part of the
15 harmonization effort to date has been to at
16 least take staples out of the definition, but
17 I don't know about wires. Staples was
18 actually considered.

19 MS. STEED: I know it was -- guide
20 wires -- Put staples in there, and you have to
21 follow a guide wire for 12 months.

22 CHAIR MORRIS: Any other issues

1 anybody wants to bring up? Okay. Would the
2 STS like to respond?

3 DR. PRAGER: Yes. We recognize
4 the differences with the aspects of the CDC
5 definition. I am not sure, frankly, we were
6 aware that wires are implants, but they
7 apparently are.

8 At this point, as we have said
9 over the last day and a half, we do not have
10 measures that go out to a year at this point
11 in time, which is what the CDC does with
12 implants. Ideally, you would love to know
13 these pieces of information, but the practical
14 side of this at this point is that it is not
15 being done.

16 DR. SHAHIAN: This is Dave. I
17 would just add that we spent a lot of time on
18 this particular one this year, and the
19 specification upgrade. There were a few minor
20 differences between our measure and the CDC
21 definition, and we did, in fact, make those
22 changes in order to make it completely

1 consistent, except for the 30-day versus one
2 year, which is simply impractical for us to
3 implement at this point. But in all other
4 respects, the measure is now consistent with
5 the CDC definition.

6 In fact, although there are
7 very, very small number of smoldering sternal
8 infections that occur late, I would say that
9 the vast, vast majority occur within that 30-
10 day window.

11 CHAIR MORRIS: Thank you. I am
12 actually curious about that small number of
13 smoldering infections. In colorectal surgery,
14 we know that with a colonopy anastomosis,
15 about 12 percent of them occur -- become
16 apparent after 30 days. We know this based on
17 pretty good registry data.

18 So measuring anything up to a 30-
19 day window always leads you to wonder what is
20 happening after 30 days. Do we have any hard
21 numbers at all regarding what happens with
22 sternal wound infections?

1 DR. PRAGER: I am not sure David
2 or I -- I don't want to speak for him -- have
3 hard numbers. There have been a couple of
4 anecdotal case reports in the literature of
5 patients occurring -- having mediastinal
6 infections late, and I don't mean day 31. I
7 mean three months, five months, six months,
8 and frankly, we have all seen it.

9 Where that is, though,
10 percentagewise, I frankly do not know. David,
11 do you have anything to add?

12 DR. SHAHIAN: As you say, there
13 are a very few reports about this, and I don't
14 have them at the tip of my fingers, but the
15 number is really quite small.

16 DR. DUTTON: Just a science
17 question for the cardiac surgeons. Are these
18 ever managed with percutaneous drainage or
19 nonoperative treatment? I know open
20 exploration is the recommended approach, but
21 do you think you miss some in the numerator,
22 because the patient is very sick or for some

1 other reason that are managed nonoperatively?

2 DR. PRAGER: That is a good
3 question. I would expand it a little bit to
4 say that, if a wound vac is now placed, which
5 is now being done not infrequently, that is
6 considered an operation, and we are capturing
7 that. At least, in the new specifications, we
8 will.

9 There are opportunities for
10 percutaneous drainage via interventional
11 radiology usually. Our experience with that
12 has been that has occurred even after the
13 exploration, less likely to take the place of
14 an operation, but I wouldn't say that my
15 statement is 100 percent.

16 DR. SHAHIAN: I would say that,
17 unlike an intra-abdominal abscess that may
18 occur after colon surgery, for example, which
19 can be -- if there is no active leak, can be
20 treated with drainage and antibiotics, I don't
21 think I have ever seen a true sternal
22 infection/mediastinitis effectively treated

1 without reopening the sternum and doing
2 something.

3 Now you may reopen and put -- Some
4 people have put drainage and irrigation tubes
5 and used various agents to irrigate the
6 mediastinum. People use vacs. people use
7 flaps, but to treat it completely
8 percutaneously -- never seen it in 30-plus
9 years.

10 MS. STEED: Another comment I
11 wanted to make is that CMS is going to be
12 utilizing CDC surgical site data at some point
13 for public reporting and reimbursement. In
14 doing so, CDC's definition doesn't only
15 include deep surgical site infections. It
16 includes superficial, incisional and organ
17 space. So, therefore, the surgical site
18 infection rates that will be reported via CMS,
19 via the CDC, will be higher than the rates
20 reported by this particular metric.

21 DR. SHAHIAN: We also capture the
22 superficial separately.

1 DR. WILHOIT: One thing I wondered
2 in looking at the measure is how useful it is,
3 other than as part of the composite.
4 According to the materials, the rate is about
5 a half a percent, which means that you would
6 have to do about 200 cases to have one
7 infection on average.

8 You know, from the data we saw
9 yesterday, a lot of facilities or practices
10 are not above that 200 mark. When you look at
11 the distribution of results, they show that
12 out of 640 groups that were assessed, there
13 were 54 outliers, so a little less than 10
14 percent outliers. Of those 54 outliers, 53
15 were low.

16 When you look at the distribution,
17 there were a lot of zeros or near-zeros,
18 probably because of the adjustment
19 methodology, and there was only one high
20 outlier.

21 So is this even useful? You can
22 identify the people who have a rate of zero

1 and come out low. Well, that is this year,
2 just -- which, because of the small numbers,
3 may be chance, but there is very few high
4 outliers identified. So is this even useful?

5 DR. SHAHIAN: Well, there,
6 historically, and even today, I'd say, is a
7 five -- probably at least a fivefold, if not
8 greater, variation in the prevalence across
9 institutions. There are institutions that
10 have reported anywhere from zero to .3 percent
11 deep sternal infection rates over a period of
12 many years. There are institutions that have
13 reported rates of two to three percent.

14 So there is variability, and I
15 think this is one of those measures where
16 there are some very well described
17 interventions that can reduce the incidence of
18 sternal wound infections. So I think there is
19 a real opportunity for improvement, and there
20 is a link to process measures that have
21 demonstrated efficacy.

22 CHAIR MORRIS: Dr. Prager, do you

1 have anything to add to that?

2 DR. PRAGER: No.

3 MS. STEED: I think that there is
4 significant morbidity and mortality associated
5 with this particular metric, which is the
6 reason why I think it is important.

7 DR. PRAGER: Yes. This is a
8 catastrophic complication, and if you put it
9 in the world of cardiac surgery with certain
10 groups doing many immunosuppressed patients,
11 more people looking to do two internal mammary
12 arteries, I think we need this.

13 CHAIR MORRIS: Okay. Any other
14 comments? We will go ahead and vote.

15 Does the measure meet NQF criteria
16 for importance to measure and report? Twenty-
17 one out of 21 say yes.

18 Does the measure meet NQF criteria
19 for scientific acceptability of measure
20 properties? Twenty say completely; one says
21 partially.

22 Does the measure meet NQF criteria

1 for usability? Nineteen say completely; two
2 partially.

3 Does the measure meet NQF criteria
4 for feasibility? Nineteen say completely; two
5 say partially.

6 So just to recap our discussion,
7 we talked about potentially competing
8 measures. We talked about the difference in
9 the CDC definition versus the -- or some CDC
10 definitions versus the STS definition. We
11 learned that STS has worked to harmonize as
12 much as they can the definitions, although
13 they are still slightly different.

14 We learned that, although sternal
15 wound infections don't occur that often, they
16 primarily occur before the 30-day window, and
17 that they are devastating when they do occur.

18 Anybody want to add anything to
19 that? Okay, does the measure meet all of the
20 NQF criteria for endorsement? Twenty say yes;
21 one says no. Great.

22 Dr. Shahian, are you still on the

1 line?

2 DR. SHAHIAN: I am.

3 CHAIR MORRIS: We have a couple of
4 questions from previously with regard to
5 measure 0116. Let's see now. Who was it that
6 introduced that? Dr. Kleinpell, would you
7 like to?

8 DR. KLEINPELL: Sure. Our group
9 had two comments or two questions that we
10 wanted to identify or have questions on with
11 respect to 0116, which was anti-platelet
12 medication at discharge.

13 We noted that this measure is part
14 of a composite reporting measure within the
15 CABG composite score, and we wanted to know
16 how is that measure treated within the
17 composite score? For instance, is it weighted
18 equally with all measures?

19 DR. SHAHIAN: In the composite,
20 there are four domains: Risk-adjusted
21 mortality; risk-adjusted morbidity; use of the
22 IMI; and adherence to guideline recommended

1 medications.

2 Within the medications domain,
3 there are four preoperative beta blockade and
4 discharge beta blockade anti-platelet agents
5 and anti-lipid agents. That domain, just as
6 the morbidity domain, is a -- It is an all or
7 none.

8 So to get credit for that domain,
9 you need to prescribe all those medications,
10 or you fail. However, in terms of the
11 weighting among the domains, they are not --
12 They have equal weight, although because of
13 the rather tight distribution of mortality
14 scores, mortality ends up being, by far, the
15 most important component, just by virtue of
16 the standardization process. But there was no
17 attempt to assign greater weighting to one or
18 the other domains. Does that answer your
19 question?

20 DR. KLEINPELL: Yes, thank you.
21 That was helpful. We just weren't sure of
22 that.

1 DR. SHAHIAN: Sure.

2 DR. KLEINPELL: Then the other
3 issue: One of our reviewers mentioned that
4 the exclusion criteria only really speaks to
5 the contraindications for aspirin. So if a
6 patient is on Plavix, would the measure have
7 been considered met?

8 DR. SHAHIAN: Yes.

9 DR. KLEINPELL: Okay. That is
10 what we thought. So thank you.

11 DR. WILHOIT: And related to that,
12 that is something that is not clear in the
13 document, whether you take the numerator event
14 first or the exclusion first. So that is a
15 slight improvement that could be made in terms
16 of the documentation.

17 DR. SHAHIAN: We will note that.
18 Thank you.

19 CHAIR MORRIS: Okay. So at this
20 point, we are ahead of schedule, which I hope
21 will last, but who knows. So let's go ahead
22 and take a break until 10:30, and I will see

1 you all back here at 10:30.

2 (Whereupon, the foregoing matter
3 went off the record at 10:14 a.m. and went
4 back on the record at 10:37 a.m.)

5 CHAIR MORRIS: We are going to go
6 ahead and get started here. The next measures
7 are going to be discussed by our
8 representative contractor with CMS. These are
9 all maintenance measures, and the first one is
10 0300, introduced by Steve Findlay, cardiac
11 patients with controlled 6 am postoperative
12 serum glucose.

13 MR. FINDLAY: So this is measure
14 0300 titled cardiac patients with controlled
15 6 am post-op glucose. This is a hospital
16 process measure around the issue of lowering
17 the risk of infection associated with
18 hyperglycemia for both diabetes and non-
19 diabetes patients.

20 The numerator is surgery patients
21 with controlled 6 am glucose below 200 on
22 post-op day one and two. The denominator is

1 cardiac patients with no evidence of prior
2 infection. There are quite a few exclusions.
3 I won't go through them. They are in your
4 paperwork.

5 The measure steward is CMS, and
6 the measure has been in use since 2001, and it
7 is used interactico and has been since 2007.
8 It is also used as an accreditation measure by
9 the Joint Commission, and the measure is going
10 to be retooled for EHRs in the next year or
11 two.

12 For the last two years, the
13 measure score on this has been 90 to 95
14 percent in 2009-2010. Disparities were not
15 assessed.

16 We had a really lively discussion
17 on this measure on the work group call.
18 Several people took issue with the measure's
19 importance, clinical importance, the
20 usefulness and design. I am not a clinician.
21 So I can't respond to those issues, but I
22 would invite particularly Bob and, I think,

1 Ruth raised some issues around whether this
2 measure -- whether the 6 am value is indeed
3 the best assessment of this. So I would
4 invite those comments.

5 There was also concern about the
6 measure being vague and just generally poorly
7 designed at this point.

8 DR. KLEINPELL: I think some of
9 the things we highlighted in the call was that
10 it is difficult. If you have an early
11 surgical patient come back, you have more time
12 to rectify elevated glucose levels versus a
13 later surgical day patient.

14 I think we have seen clinically an
15 increased use in insulin drips in patients
16 just to try and get their glucose to be below
17 200 the following a.m. to meet this criteria,
18 and with increased use of insulin -- IV
19 insulin therapy, we have had some cases of
20 hypoglycemia, and the literature clearly
21 indicates that even one case of hypoglycemia
22 can increase hospital patient mortality.

1 So I think there are some issues
2 with trying to meet it at 6 a.m. I think,
3 clinically, we see from experience at our
4 setting and other settings and talking to
5 other clinicians, it is not necessarily the
6 first day.

7 It is the second day when they are
8 off the insulin drip, you know, to really try
9 and keep them euglycemic, but I know this
10 measure has been used now for several years,
11 and everyone tries to achieve it. But it is
12 intensive in terms of labor, you know, to be
13 able to do hourly ECU checks and to keep
14 patients in range. So it is labor intensive
15 as well.

16 DR. CIMA: I think, from our point
17 of view, my point of view, that is one of the
18 main problems, is just the structure of it.
19 You know, with the skip, one, two and three,
20 with the antibiotics, we say 24 hours from
21 some point, but in institutions that are doing
22 high volume cardiac surgery, there is a huge

1 difference between a patient that is first
2 case in the day and one that comes out at
3 seven, eight o'clock at night as far as that
4 6:00 a.m., and it is not the way it is
5 designed.

6 It is not the way the abstraction
7 is done. It doesn't necessarily mean to be
8 6:00 a.m. It could be the 3:00 a.m. one, and
9 then the next one is at 9:00 a.m., and you
10 take the 3:00 a.m., but if it were a person
11 that just got out of the OR at 9:00 o'clock at
12 night.

13 So are you comparing apples and
14 oranges? So that is a real -- It is not the --
15 - The goal is good, although there is now a
16 lot of data that says this probably isn't the
17 best measure. Intensive insulin therapy has
18 only been really shown to be effective in
19 critically ill patients, and even then that is
20 up for debate.

21 So whether it is actually a
22 measure that actually does anything is another

1 story for two time points over a 48-hour
2 period. It should be maybe a consideration of
3 an aggregate measure of insulin control, but
4 certainly, the way it is written is very
5 vague. It makes for a lot of heterogeneity in
6 the data that you are comparing.

7 That was my main concern from the
8 get-go from this when it was first introduced,
9 is that it is just poorly designed to find
10 what you want, because you are comparing a lot
11 of times apples and oranges.

12 DR. MORTON: I want to add to
13 those comments, because what we see a lot of
14 times in practice is people rushing around
15 just to get that 6:00 a.m. value, and some
16 other care doesn't always get rendered. So it
17 is the arbitrary part about the 6:00 a.m. that
18 bothers a lot of people in terms of
19 implementing logistically.

20 DR. DILLON: Is this -- For those
21 of you who have to hit the target of 200, is
22 this going to change in the immediate time

1 period? I know there has been some talk about
2 loosening how tightly controlled they have to
3 be in the postoperative period. So are we
4 going for an arbitrarily too harsh a measure
5 here?

6 DR. KLEINPELL: No. You do want
7 it less than 200. In fact, less than 150 is
8 really recommended in cardiac surgery
9 patients. I think the issue we are looking at
10 in the literature is: Is glycemic variability
11 a better indicator than just one isolated 6:00
12 a.m. glucose level?

13 DR. DILLON: Right, but as you
14 point out, the issue of the hypoglycemia and
15 the risk in terms of the population management
16 is of growing concern, at least in our
17 institution.

18 DR. STAFFORD: So the hypoglycemia
19 was actually seen with what is classically
20 described as intensive insulin therapy that
21 came out of the Vanderburg study with less
22 than 110, which is why I think the nice thing

1 about this measure is that they did choose 200
2 as opposed to 110, so that you don't get into
3 as much trouble with the hypoglycemia.

4 I think you will find most
5 institutions have gotten away from that 110,
6 even for all of their other patients, because
7 we have learned that that was a problem.

8 DR. DILLON: But the problem with
9 that is that the 200 number is an arbitrary
10 number, and it has not been shown to be
11 effective. What is the difference between 210
12 and 190? There is no science that says that
13 is a difference.

14 DR. CIMA: If you are chronically
15 above that number in the hospitalized surgical
16 patient, that is a problem. And at 6:00 a.m.
17 the morning after a CABG, you know, you don't
18 adjust for patients who are still on
19 inotropes, which increase blood sugar levels,
20 no matter what you give them.

21 So it was a poorly designed
22 measure from the get-go, and it has not

1 improved, and I am really wondering if there
2 is any evidence to support that it has made a
3 significant difference.

4 MS. STEED: To comment, in my
5 organization, even though I agree with the
6 comments about using the 6 am glucose, I think
7 you just take the blood sugar closest to that
8 time frame. In our organization we started
9 with the SIP measure and that initiative back
10 in the early days in the early 2000's.

11 We saw 50 percent reduction in our
12 sternal surgical site infection rate by
13 controlling glucose, and can we prove it was
14 that? Maybe not completely, no, but the
15 perspective of the cardiovascular team was
16 that the glucose control had an impact on our
17 infection rates.

18 DR. CIMA: Did you also
19 standardize the antibiotic dosing and the one
20 hour before and everything? There is no other
21 published literature that supports what you
22 just said.

1 DR. HALPERN: And also, was it
2 overall glucose support? Their main point is
3 it is two arbitrary readings as opposed to
4 total glucose control, and it is total glucose
5 control that really makes the difference, not
6 just two arbitrary readings.

7 MS. STEED: I agree with that.

8 DR. KLEINPELL: It is clearly a
9 significant clinical issue. You don't want to
10 have hyperglycemia in your critically ill
11 patients, and I think this is less than 200.
12 Really, you do want it less than 150, and many
13 ICUs, regardless of if they are cardiac
14 surgery patients or not, have developed
15 insulin -- intensive insulin therapy with
16 certain ranges.

17 We used to have 80 to 110. We
18 moved it to 80 to 120, and now for our cardiac
19 surgery we are up to about 150. So,
20 certainly, it is clearly of clinical
21 significance, but I think with this measure
22 there are some issues in terms of usability

1 and, really, what is the impact.

2 DR. HALPERN: I think we are
3 saying the same thing. I am basically saying
4 it is overall glucose control rather than two
5 arbitrary points which may or may not actually
6 capture -- because if they are 500 the rest of
7 the day, you are not really fixing them.

8 DR. STAFFORD: Yes. A better
9 measure might be X percentage of blood glucose
10 values below whatever. You are not going to
11 find data for that, but it might be a more
12 useful way to measure, because that would get
13 at how well controlled you are for that entire
14 period of time.

15 The other thing that I find
16 interesting about all of this is that there is
17 nothing being said about what blood glucose
18 they come in with, and we all know that well
19 controlled diabetes with hemoglobin A1c levels
20 that are in the normal range before somebody
21 gets operated on has an effect on outcome as
22 well, and many of these cases are elective

1 cases.

2 So I would encourage people to
3 start thinking about actually moving this kind
4 of a measure back even further in the
5 preoperative care of patients.

6 DR. DUTTON: I will comment on
7 that as well. From the anesthesia
8 perspective, the glucose control should start
9 when we first see the patient and should be
10 continuous through the operation, recover, and
11 to the intensive care unit. So the time point
12 is, I think, an arbitrary or pragmatic
13 decision to make it easy to measure.

14 It is looking for your car keys
15 where the light is good, because we can get
16 that data easily, but there is no question
17 that control should be continuous.

18 DR. CIMA: And, clearly, the
19 evidence supports exactly what you said.
20 Patients who are known diabetics who come in
21 with A1c in the acceptable range -- their
22 postoperative morbidity is less.

1 So a better measure, if you really
2 wanted to make population improvement, would
3 be to say people with known diabetes, you
4 don't operate on them until their Alc is in a
5 certain level unless it is an emergency. But
6 that is not what we are faced with.

7 We are faced with a very poorly
8 designed measure that was an attempt to get
9 people to do insulin therapy, but it doesn't
10 support -- The science doesn't support this
11 value. It should be lower, which is not
12 necessarily practical or safe, necessarily, in
13 some cases; and it is very arbitrary in how it
14 is designed, and doesn't take into account the
15 heterogeneity of the population in which it is
16 being applied.

17 If everyone did one CABG a day,
18 and that patient got out and got to the ICU at
19 Noon, then I would say it is reasonable to go
20 to 6:00 a.m. as your first marker, but other
21 than that, it doesn't seem to pass sort of --
22 It is something people are gaming right now,

1 and it is not really showing a benefit.

2 DR. WILHOIT: I had one technical
3 question about the measure. In the
4 calculation algorithm, which is 2.a.21 on page
5 9, it talks about if the postoperative glucose
6 is missing either on day one or day two. It
7 says it is a measure category assignment of X
8 and will be rejected, stop processing.

9 I don't know if that means it is a
10 numerator failure or that you don't even
11 bother to look at it, if there is not a value.
12 So I was just curious, because if the members
13 being -- or the patient is being excluded from
14 the measure because you are missing a glucose,
15 that really seems to miss the point. But I
16 wasn't sure if that was what was meant.

17 DR. HALPERN: I would find it
18 unusual that any CABG patient would not have
19 a blood glucose the next morning. I mean,
20 they all get labs.

21 DR. STAFFORD: The other question
22 I have is: In the denominator exclusions, why

1 would you exclude patients who expire
2 perioperatively? They may have died as a
3 result of their sternal wound infection,
4 because their blood glucose wasn't controlled.
5 So why would you exclude those patients?

6 CHAIR MORRIS: Any other issues?
7 Okay. Dale, you were present -- Correct me if
8 I am wrong. I think you were present for the
9 time that this measure was initially developed
10 several years ago. So you probably have sort
11 of a --

12 DR. BRATZLER: I have lived with
13 this measure from the outset. So, actually,
14 you know, the comments that I am hearing
15 actually make me pretty happy when I am
16 hearing that there are a lot more patients
17 getting insulin infusions perioperatively in
18 cardiac patients, particularly on pressures
19 that are driving their sugars up, and other
20 things, because of the known association of
21 hyperglycemia with higher infection rates and
22 higher mortality in cardiac surgery patients,

1 and indeed, as I was telling some of the folks
2 in the room, increasing evidence that
3 hyperglycemia is a risk factor for infection
4 in many other operations also.

5 A couple of points really quickly:
6 The measure is not about intensive insulin
7 therapy. I have pushed back on that many
8 times before. We have never pushed anybody to
9 drive down to 110. We always set the control
10 limit at 200, and the current national
11 recommendation from the American Society of
12 Clinical -- or the American -- the clinical
13 endocrinologists and ADA now are, for
14 hospitalized patients, 140 to 180 is the
15 recommended range, and I think that is quite
16 reasonable, and we are more liberal than the
17 national recommendations.

18 The third thing that I do agree
19 with is that 6:00 a.m. blood sugar is
20 arbitrary, and that is by design. When we
21 were initially starting the measure, we worked
22 closely with Tony Fenari and his group out of

1 Portland who had implemented insulin protocols
2 for cardiac surgery for sometime, and we
3 thought about how do we capture the glucose
4 postoperatively in patients who have had
5 surgery.

6 Now lots of people have suggested
7 all sorts of great ideas: Let's take the
8 average glucose over a 24-hour period; let's
9 look at the proportion of glucoses that are
10 less than a certain value, or other things.
11 But in reality, think about the data
12 collection burden to do any of those things.

13 So we had to make a compromise
14 here, and that was we could try to have a
15 hospital capture a bunch of glucoses,
16 calculate and then have an algorithm calculate
17 an average, or look at a proportion or other
18 things, or pick one time a day that we would
19 look at just to see if the sugar was 200 or
20 less in that time frame. That is what we did
21 for data collection burden.

22 There was simply no other easy way

1 to capture the data on relative blood sugar
2 control. Is it perfect? No. Has it improved
3 a lot over time? Yes.

4 Finally, the number 200: Is it
5 arbitrary? Well, it was based on the study
6 that was published by Latham and his
7 colleagues out of Vanderbilt that looked at
8 1,000 consecutive cardiac surgery patients,
9 and they used the cutoff of 200, finding that
10 patients who had blood sugars that were above
11 200 in the two days postoperatively were about
12 three times more likely to have surgical site
13 infections versus those patients whose blood
14 sugars were kept less than 200.

15 We wanted to be liberal with our
16 number, because we weren't trying to drive
17 hypoglycemia, but we did feel that 200 was a
18 reasonable number based on Latham's study, and
19 that is how the number was chosen.

20 Some people have argued that we
21 should use the 140 to 180 range. That is now
22 the current national recommendation from the

1 clinical endocrinologists, but we've stuck
2 with 200 at this point.

3 The missing data policy -- Maybe
4 somebody on the phone can assure me. I
5 believe the case is rejected from the clinical
6 warehouse. It is sent back to the hospital to
7 fill in the data point. So they either have
8 to list the data.

9 Is Wanda or Tory or somebody on
10 the call for the missing data?

11 DR. JOHNSON: This is Wanda. That
12 is correct, Dale. Rejects from the warehouse
13 only doesn't exclude it from the measure.

14 DR. WILHOIT: So then just to help
15 me understand, so if it is sent back, if it is
16 rejected initially, it would still come back
17 into the warehouse, but would need that value
18 added.

19 DR. BRATZLER: Yes. The hospital
20 has to complete their data collection.

21 DR. WILHOIT: So then if somebody
22 genuinely didn't have a blood sugar done, it

1 would be a deficient event as opposed to an
2 exclusion?

3 DR. BRATZLER: That is correct. I
4 believe those cases fail the measure if they
5 don't have the blood sugar collected. So they
6 can't send in the chart and just leave the
7 data field blank. If they leave it blank, the
8 case gets rejected and goes back to the
9 hospital to complete the data point.

10 DR. CIMA: Could you make the
11 measure 24 hours as opposed to 6:00 a.m. from
12 the time the patient is closed or something,
13 much like we do with SCIP. It is not an undue
14 data burden to do that.

15 DR. BRATZLER: Yes, I suppose we
16 could think about whether there is a way to
17 look at a set period of time, you know, the
18 closest blood sugar 12 hours after closure or
19 24 hours or whatever the time frame. You
20 know, 6:00 a.m. is what we chose, just to have
21 an arbitrary once a day time so the
22 abstractors would be able to look at the chart

1 at one point in time and take a look.

2 I mean, ideally, you know, as I
3 mentioned, we would look at total glucose
4 control. I agree that, if I am in the
5 hospital setting, that is what I want to do,
6 but for measurement purposes to keep burden
7 low, that is what we did for this particular
8 measure.

9 DR. DUTTON: I don't think that
10 would be an undue increase in data burden now,
11 because science has marched on since this
12 measure was first created when the 6:00 a.m.
13 was the glucose that went to the lab, and that
14 was the one that was in the system, and it was
15 easy to get. But now I suspect that most of
16 us are measuring it hourly using wireless
17 devices that put all of that in the computer
18 anyway, and picking out any one is no harder
19 than picking out any other one.

20 DR. MORTON: The other thing about
21 data burden is that the person who usually
22 gets this particular measure gets the other

1 SCIP measures as well, and one of them is, you
2 know, within 24 hours antibiotics are
3 discontinued.

4 So I don't think there is going to
5 be anymore data burden around that, and the
6 6:00 a.m. thing is just -- As mentioned
7 before, there's cases that go pretty late, and
8 you've got very little time to kind of get
9 that blood glucose in order.

10 CHAIR MORRIS: Okay. Were you
11 going to say anything about the VPS with
12 regard to this measure at all, the payment
13 system?

14 DR. BAUS: It is in the VBP
15 proposed rule.

16 CHAIR MORRIS: Could you repeat
17 that?

18 DR. BAUS: It is in the value
19 based purchasing Notice of Proposed Rulemaking
20 that is out for public comment right now.

21 CHAIR MORRIS: And can you
22 describe to the group what the implications of

1 that are?

2 DR. BAUS: Can you repeat the
3 question?

4 CHAIR MORRIS: Can you describe
5 that a little bit further to the group?

6 DR. BAUS: I am not the VBP person
7 from CMS. I am the measures person. But
8 basically, the measure will be calculated as
9 a composite. Somewhat of a composite of
10 process measures will be weighted as a total.

11 This is how it is all proposed in
12 the rule. The HCAHPS will be weighted as a
13 total. This is how it is all proposed in the
14 rule. The HCAHPS will be weighted as a total.

15 So based on the weights of the
16 different measure domains, that is how the
17 hospital is scored. So individual measures,
18 I am not sure as to how their performance will
19 affect the overall score. That is something
20 I would have to get back to you on, but just
21 to make it clear that this measure is, in
22 fact, proposed for value based purchasing.

1 CHAIR MORRIS: Thank you.

2 DR. CIMA: That is an important
3 point, because everything else has been based
4 on at least some scientific merit. Their very
5 comment was, multiple times, it is an
6 arbitrary time point. If you are going to do
7 that, then you better have some good science
8 to support it.

9 DR. BRATZLER: I have got lots of
10 arbitrary things. So, you know, most experts
11 don't think antibiotics should continue beyond
12 closure of the wound, but we arbitrarily
13 picked 24 hours as a measurement point. So I
14 think you do certain arbitrary things in
15 measurement for data collection burden and
16 consistency of the abstractors doing the work.

17 I mean, I am more than happy to
18 take back the concept of picking a time frame,
19 you know, a set number of hours. I think that
20 is a reasonable thing to consider, but there
21 are lots of things that are arbitrary.

22 Thirty days is arbitrary for

1 surgical site infections, but sometimes they
2 happen on day 31. But we do that for
3 measurement purposes.

4 CHAIR MORRIS: That is why it is
5 important to continue to examine these things
6 and determine when arbitrariness should be
7 mitigated.

8 DR. KLEINPELL: When you look at
9 clinical feasibility, 24 hours is a much
10 clinically reasonable timeline than possibly
11 6:00 a.m. for a patient who just comes back at
12 nine at night.

13 DR. BURSTIN: There is a new STS
14 guideline that just came out in 2009 on
15 postoperative glucose control with very good
16 recommendations, grading all these things.
17 Again, 110 to 180 is the number they have put
18 in here.

19 Just one final comment. I think
20 we sometimes get confused about a guideline
21 versus a measure. So the guideline is more
22 clear. The measures -- some of these are

1 truly just expediency of being able to collect
2 the data consistently across all hospitals in
3 America.

4 So I think the issue is when does
5 the science, in fact, make that decision for
6 expediency not work. I think that is really
7 the issue that we have given to Dale to
8 consider and bring back to us.

9 DR. CIMA: That 6:00 a.m. number
10 is not a hard and fast. Not everyone is sent
11 in at six. It could be 2:00 a.m., the most
12 closest one to it, which could be the first
13 blood glucose for a guy that got up at 11:00
14 a.m. and midnight. So that is the main
15 concern, is that it is not designed, as the
16 other ones, although arbitrary, we are more
17 reasonable in their clinical attempt to say 24
18 hours as opposed to 6:00 a.m.

19 CHAIR MORRIS: Thank you. Are
20 there any other comments before we move on to
21 the vote? Okay.

22 So first: Does the measure meet

1 NQF criteria for importance to measure and
2 report? Sixteen say yes; five, no.

3 Next vote: Does the measure meet
4 NQF criteria for scientific acceptability of
5 measure properties? Two say completely; 12
6 say partially; 7 minimally.

7 Next vote: Does the measure meet
8 NQF criteria for usability? Five say
9 completely; 6, partially; 10 say minimally.

10 Does the measure meet NQF criteria
11 for feasibility? Five say completely; 9
12 partially; 7 say minimally.

13 Then lastly: Does the measure
14 meet all of the NQF criteria for endorsement?

15 Before we vote, the major issues
16 that were raised were the sense among the
17 Steering Committee that there is a need for
18 more flexibility in this measurement to better
19 look at the global care to apply to a variety
20 of patient situations or times of departure
21 from the operating room or differing times of
22 closure; and then also a concern about the

1 possibility of unintended consequences,
2 specifically hypoglycemia.

3 I think that that was clarified by
4 Dale, that the measure was staying at 200 in
5 order to avoid that. Of course, there
6 probably will be more events of hypoglycemia.
7 I don't think we have any hard numbers, but it
8 is certainly a risk.

9 Anybody want to add to that at
10 all? Dr. Cima? Okay.

11 So does the measure meet all of
12 the NQF criteria for endorsement? Nine said
13 yes; 10 said no; two abstained.

14 This is tricky, because it is very
15 close to a tie, and I think that we should
16 probably revisit this as a Steering Committee,
17 ask for you guys to review this and think
18 about changing the flexibility and the timing
19 of the measurement, and then bring it back to
20 us. Anybody disagree with that?

21 Allan, do you want to add
22 anything?

1 DR. MORTON: I was going to say, I
2 think that is exactly it. We all agree this
3 is a laudable goal to get blood sugar better.
4 The number is set at a rate where hypoglycemia
5 would be relatively rare.

6 The only quibble we have is just
7 the logistics about doing this, because
8 surgery has become 24 hours, and the 6:00 a.m.
9 time frame is not one that is, I think,
10 measuring what we really want to get at, and
11 the within 24 hours would get at it without an
12 undue burden, because the data abstractors are
13 doing the same thing already for other SCIP
14 measures.

15 DR. BURSTIN: Let's just let Dale
16 and CMS respond to the concerns of the
17 committee, and then we will re-vote and
18 reconsider after that point.

19 DR. BRATZLER: So, I mean, it is a
20 little bit tough to respond immediately
21 without going to -- there is a technical
22 panel, an expert panel that does meet

1 periodically and discuss this performance
2 measure.

3 So it is tough for me to speak for
4 that technical panel, but I think it is a
5 reasonable request to go back and ask about
6 changing the time frame for the collection of
7 those two glucoses, those postoperative blood
8 sugars, and I don't see any big problem with
9 that. I just can't make that statement at the
10 moment without going to the technical expert
11 panel.

12 There are individuals that we task
13 to actually periodically review these
14 measures.

15 CHAIR MORRIS: Understood. We are
16 going to go out of order for the next measure
17 and ask for Dr. Cima first to introduce 0218,
18 surgery patients who received appropriate
19 venous thromboembolism prophylaxis within 24
20 hours prior to surgery --

21 DR. ROGERS: Could I ask a
22 question before we do that? Terry here. Is

1 our task the next time we meet, in fact, to
2 revisit some of the issues that have been
3 questionable or had some discussion at this
4 meeting?

5 MS. MURPHY: The next time that
6 the group meets in person, it will be to look
7 at the next group of measures. What we will
8 be doing is to set up some conference calls to
9 talk about some of these issues between now
10 and that time.

11 CHAIR MORRIS: So measure 0218,
12 and then we will move on to Dr. Zambricki.

13 DR. CIMA: This is measure 0218.
14 As already pointed out, it is the number of --
15 It is a measure to assess patients who are
16 getting appropriately ordered VTE prophylaxis
17 administered within 24 hours prior to surgery
18 or the 24 hours after surgery end time.

19 This is a continuing measure.

20 CHAIR MORRIS: Let me just
21 interrupt you for a second. This is not the
22 patients for whom it was ordered, but rather

1 those who received it. Right?

2 DR. CIMA: Yes. Oh, excuse me.
3 Received it, yes. Sorry. I as thinking about
4 the other one -- who received appropriate
5 veno-thrombo prophylaxis 24 hours prior to or
6 24 hours after surgery.

7 This is, like I said, a continuing
8 measure. The overall goal of this measure is
9 to ensure that patients -- any patient,
10 basically, who is hospitalized is considered
11 a high risk patient for veno thromboembolism,
12 and that we want to ensure that, although
13 things may be ordered, as the other measure
14 is, that they actually are documented as being
15 performed, at least for the first 24 hours or,
16 in some cases, actually administered before
17 the patient enters into the surgical suite.

18 The rationale behind this is
19 clear. VTE is a major morbidity of patients.
20 A recent Enox study, which was discussed, the
21 number one cause of 30-day mortality in cancer
22 patients after surgery is related to veno

1 thromboembolism, one of the critical events,
2 which is pulmonary embolism. This is an
3 attempt to minimize that risk in these
4 patients.

5 There wasn't a lot of discussion
6 about the need for this measure in our work
7 group. Everyone agreed that it is a tragic
8 event, if someone has this, and that anything
9 which should be done should minimize it.

10 There is a lot of evidence to
11 support this. There are, certainly, high risk
12 surgical patients, pelvic surgery, GYN
13 surgery, orthopedic surgery to some extent,
14 and so there is a lot of data out there.
15 There is also a significant number of trials
16 that have looked at different interventions,
17 and these are all documented well in here.

18 The numerator and denominator are
19 pretty clear. It is basically those patients
20 that are having these surgical procedures, a
21 very sort of broad spectrum, major abdominal
22 surgery, GYN surgeries, orthopedic, total

1 knees and hips, cardiac surgery, and sort of
2 the whole gamut of major surgical procedures.

3 The exclusions are pretty clear:
4 Patients that have a purely laparoscopic
5 procedure, patients that have a surgery less
6 than 30 minutes, patients who don't stay in
7 hospital greater than 24 hours. Those
8 patients are all excluded for very reasonable
9 reasons.

10 The data does show a gap, although
11 it is much better now. So that was very
12 heartening, but since it is such a significant
13 morbidity, unlike when we were talking about
14 mediastinal infections where it is such a
15 small number of patients, but a more tragic
16 outcome in these patients. It is a huge
17 number of patients at risk. So there is a big
18 difference between 90 percent and 92 percent,
19 even in the just total numbers. So trying to
20 get to 100 is reasonable.

21 The only real discussion that we
22 had was almost all of the criteria are based

1 upon the American Academy of Chest Physicians
2 criteria, which most people agree with, are
3 sort of the gold standards for sort of
4 treatment. However, increasingly now, there
5 is some new data and, particularly, by certain
6 societies, namely, the American Academy of
7 Orthopedic Surgeons, which have made
8 recommendations to their members that use
9 different guidelines, so that the combination
10 of anti-platelet therapy plus mechanical
11 devices is a reasonable alternative.

12 That would not meet the criteria
13 used for this measure, because that is not in
14 the Chest Physician guideline. So we do --
15 That was the one issue that was brought up in
16 our discussion, as well as in the discussion
17 of the other measure, which is what is the
18 appropriate order any thromboembolism issues
19 that certain very large clinical societies
20 have recommendations that differ than this
21 one?

22 I don't know if you really want to

1 call it a harmonization issue, just a
2 difference of opinion about the science. So
3 that would be, clearly -- I think that is a
4 worthy discussion here. I don't know if it is
5 in our scope to address that.

6 Other than that, it was very
7 clear. It has been used. It is associated
8 with -- It is in the bundle for value based
9 purchasing. There is no mention about
10 disparities in it.

11 So that was it. Our work group
12 felt it was supported with that one caveat
13 about what constitutes reasonable prophylaxis
14 in a certain subpopulation where the experts
15 in that field feel differently?

16 CHAIR MORRIS: Thank you. Dr.
17 Carpenter, can you talk a little bit more
18 about this?

19 DR. CARPENTER: Sure. Thanks. I
20 think this is, obviously, an important
21 guideline, and I think it is important to have
22 this in here. The question is what is

1 appropriate prophylaxis, and what guidelines
2 should be followed to satisfy this criteria?

3 The main difference between the
4 guidelines that the American Academy of
5 Orthopedic Surgeons has published and the
6 Chest Physician guidelines has to do with
7 whether we are trying to prevent DVT or
8 symptomatic PE.

9 So it uses a different subset of
10 the literature, and the problem with
11 symptomatic PE is it is not as common. So the
12 literature is not as powerful. So the Chest
13 Physician guidelines does have a better level
14 of evidence, but it is designed for DVT
15 prophylaxis rather than symptomatic PE
16 prophylaxis.

17 The feeling has been these are
18 guidelines designed to balance the risk
19 between clotting and bleeding. The risk for
20 bleeding in certain surgeries is -- The
21 consequences of bleeding are very high.
22 Intracranial procedures, for example, mostly

1 get a bye on these because of the significance
2 of a bleed postoperatively, and bleeding
3 postoperatively into an orthopedic wound is
4 fairly common because of the amount of exposed
5 bone tissue and other areas in the joint that
6 doesn't close as well.

7 There is often dead space in these
8 wounds. The consequence of postoperative
9 bleeding into these wounds is very
10 significant. Draining wounds, hematomas, have
11 a higher rate of postoperative infections, and
12 postoperative infections in orthopedic implant
13 cases are very problematic. Usually, it means
14 removing the implant, using a temporary
15 implant, potentially reimplanting the implant
16 later on with, generally, about a 10 percent
17 reinfection rate.

18 So the consequences are higher.
19 So the focus has been on preventing
20 symptomatic PEs and trying to reduce the
21 bleeding risk. So the guidelines mainly
22 differ in that they -- They are very similar

1 for most of the things, but they do allow for
2 surgeons to accept a platelet -- anti-platelet
3 therapy along with early mobilization and
4 mechanical prophylaxis as an acceptable
5 prophylaxis, which these guidelines do not.

6 There is a bit of a work-around
7 with these guidelines, if the wound or the
8 situation is considered high risk for
9 bleeding. So if you consider all your hip
10 patients high risk for bleeding, then they can
11 -- and you document that, then that can be
12 excluded from this measure.

13 So the differences are
14 significant. They may be subtle, but they are
15 significant, and I think that is really the
16 question. This is an important measure. It is
17 just what guidelines are we going to follow,
18 and the guidelines are under revision
19 consistently.

20 So, hopefully, over time the
21 guidelines will come closer together, as
22 evidence gets more complete. But those are

1 the main issues.

2 CHAIR MORRIS: And, Dr. Cima, can
3 you confirm. So it looks like one of the
4 exclusions is if the provider gives a reason
5 for not administering the medication.

6 DR. CIMA: Yes. It needs to be
7 documented, but that is one of the exclusions.
8 One of the other work-arounds, if you want to
9 call it, which we know is being done is people
10 giving one milligram of Coumadin and
11 documenting that, which certainly is not
12 therapeutic, but it meets the measurement
13 criteria. So they get one milligram of
14 Coumadin, and then they do other things.

15 It is well known in the orthopedic
16 community that that is how you work around
17 this.

18 CHAIR MORRIS: That is
19 interesting. I had not heard of that
20 particular work-around.

21 DR. CIMA: Oh, yes.

22 DR. BURSTIN: It is really a work-

1 around. It is not intended to be therapeutic
2 in any way.

3 DR. CIMA: No. It is purely a
4 work-around for this very measure.

5 CHAIR MORRIS: It is every
6 definition of a work-around.

7 DR. CIMA: Exactly. There is
8 another exclusion, that if you are on Coumadin
9 preop that you are excluded from the measure,
10 because you are anti-coagulated for other
11 reasons. So we have noticed this in our
12 literature, in our review of other practices,
13 that the orthopedic surgeon will prescribe the
14 patient one dose of Coumadin before surgery,
15 document that they were on it, and that is a
16 work-around.

17 Not that I am criticizing
18 orthopedic surgeons. Some of my best friends
19 are orthopedic surgeons. I am just saying
20 that those outside of my friends do that.

21 DR. ROGERS: The other comment I
22 would make from my pulmonary critical care

1 days, what bothers me a little, Dr. Carpenter,
2 is the issue of symptomatic PE, because this
3 is an illness that simply does not give you a
4 clear sign. There is no bumper sticker on the
5 forehead that is saying I have PE.

6 Oft times, it is missed, set aside
7 as anxiety or whatever. So I understand the
8 protection and the natural protection you
9 would have with respect to trying to sustain
10 and protect your surgical site, but you don't
11 die of a bloody knee, and -- well, you can,
12 but the point is that -- and it may not be
13 pertinent to this conversation, and I am not
14 going to change where our Society's position
15 is. But it is just a little scary from a
16 pulmonary standpoint.

17 CHAIR MORRIS: Dr. Saigal.

18 DR. SAIGAL: A question about the
19 documentation. Appendix A that has all the
20 procedures that are being covered -- I don't
21 see where that is in what I received at least,
22 from a urology point of view.

1 DR. CIMA: Yes. It is not in
2 this, but having spent the last six years with
3 it, basically, urologic procedures, anything
4 that is just a stent, anything that is brief -
5 - prostates are excluded. I am not quite sure
6 why, but they are, but that is in the way it
7 is set up. But it is mainly the big oncologic
8 cases that end of staying, because a lot of
9 the urologic cases are excluded, because they
10 are either purely done endoscopically or they
11 are short stay.

12 DR. DILLON: Can you just comment
13 on the -- One of the exclusions, at least as
14 I just quickly went through this, is
15 procedures performed entirely by the
16 laparoscope. Is that a problem with our
17 surgical oncology patients now, who are all --
18 I mean, many of our whipples are done
19 laparoscopically.

20 DR. CIMA: Well, the way the
21 criteria are -- and I can just speak to that,
22 because I supervise our institution's group

1 that does it -- if any incision is made other
2 than to put the trocars in, then it is
3 considered purely laparoscopic.

4 So if I do a laparoscopic
5 colectomy and then have to make a 4 centimeter
6 incision to extract the specimen, that is no
7 longer a laparoscopic case. So they are
8 basically referring to diagnostic laparoscopy,
9 you know, gall bladders and things like that.

10 I think the reason why prostates
11 are excluded is because oftentimes you can
12 bring it out through the port and, therefore,
13 the robotic and laparoscopic prostatectomies
14 are excluded, where open prostatectomies,
15 although they are very -- they are rarer now -
16 - were not excluded.

17 DR. MORTON: I am not sure if I
18 read it right, but would that mean like, say,
19 laparoscopic gastric bypass is excluded; and,
20 clearly, those patients are at extremely high
21 risk.

22 We have ignored the exclusion and

1 continue to give prophylaxis ahead of time,
2 because they are obese. Their BMI is high,
3 obviously, and there is potential for risk.
4 We actually give prophylaxis, even though it
5 is excluded.

6 I think, you know, with the
7 population getting bigger and bigger, that is
8 something we all have to think about. Cases
9 used to be kind of short and easy to do. With
10 a bigger population, maybe not as much. So
11 those cases used to be short, but not always
12 the case anymore.

13 DR. CIMA: If it is purely
14 laparoscopic, they are excluded from this
15 measure. Now it doesn't make that it is
16 right, but it is just that is how it is done.

17 DR. DILLON: I think that is a
18 significant problem then with this, as it is
19 written.

20 DR. ZAMBRICKI: One comment about
21 exclusions: A perioperative death is listed
22 is an exclusion, if the perioperative death is

1 due to PE.

2 DR. WILHOIT: The numerator
3 specification for the measure talks about
4 appropriate VTE prophylaxis, but I couldn't
5 find any definition in the measure itself of
6 what appropriate is.

7 There was discussion in the
8 background about whether aspirin is adequate
9 or not and the pros and cons and so on, but I
10 couldn't find a clean definition, and it
11 seemed like for comparability across
12 hospitals, it would be very important to have
13 a clear, explicit definition of what
14 appropriate VTE prophylaxis is.

15 DR. CIMA: In the abstraction
16 details, which are not provided here, they are
17 based almost completely on the ACCP guideline,
18 and it does discuss in some detail what they
19 are in the upper portion.

20 It is not in the detail that the
21 abstractors have, but it talks about whether
22 or not they should use -- based on these

1 studies, whether or not it is appropriate to
2 use low molecular weight heparin versus
3 unfractionated heparin versus a combination of
4 both with mechanical.

5 So those are in the abstraction
6 guidelines. It is not in there. So I don't
7 know if it has to be from a point of view, but
8 it is very clear. The abstractors know very
9 clearly what, for each of the procedures, is
10 required.

11 DR. WILHOIT: Right, which is a
12 good thing, but I think in the measure itself
13 that we are approving -- you know, this is
14 what goes out to the public, and I should be
15 able to read it and be able -- There should be
16 enough information here that I could go do it
17 and measure and get the same results as an
18 abstractor and, you know, I don't have even
19 the basic information to be able to do that.

20 DR. CIMA: That is a technical
21 issue. I mean, I know the data is in the
22 abstraction guidelines, but whether it should

1 be here -- that is up to the Steering
2 Committee. As Melinda has said, we are voting
3 on what we see in front of us and, if it is
4 incomplete, then that should be considered in
5 your vote.

6 DR. ZAMBRICKI: You know, it seems
7 like 1.c.9 is pretty specific, specific
8 guideline recommendation. They go through
9 each procedure and whether it should be
10 aspirin alone, low molecular weight heparin,
11 etcetera.

12 DR. WILHOIT: That is saying what
13 the guideline recommends, but it is not what
14 is in the measure. The measure comes under
15 number 2, and the measure itself -- the
16 numerator description does not tell me what to
17 count and what not to count.

18 DR. BURSTIN: I just pulled up the
19 last ACCP guidelines, and one thing they do
20 specifically note is that for patients
21 undergoing laparoscopic procedures in whom
22 additional VTE risk factors are present, which

1 I think obesity would certainly count, the
2 guideline developers recommend the use of
3 thrombo prophylaxis.

4 DR. CARPENTER: These guidelines,
5 I don't believe, follows -- It is mostly ACCP,
6 but not exactly. For example, the INR is not
7 specified. That is why one dose of coumadin
8 might suffice versus a specific INR level
9 which ACCP recommends.

10 DR. CIMA: The ACCP guideline
11 recommendations do specify an INR to achieve
12 therapeutic effect, but not necessarily in the
13 prophylaxis period. So that is the
14 difference. They do say, you know, molecular
15 weight -- low molecular weight at this weight
16 based dosing is effective at prophylaxis, but
17 for long term treatment you would need, you
18 know, X INR.

19 CHAIR MORRIS: Any other comments
20 or issues? I would like to just recap the
21 discussion. Of course, we want for you to
22 have an opportunity to respond, but just to

1 recap: The major points that seemed to come
2 out were that this is very valuable.
3 Everybody agrees with the goals. We believe
4 that they are laudable.

5 It gave the group pause that these
6 don't harmonize with guidelines from the
7 American Academy of Orthopedic Surgeons, but
8 that was explained in, I think, a pretty
9 reasonable way by Dr. Carpenter, in
10 particular, that the goals are actually
11 slightly different here.

12 There are issues around
13 laparoscopic surgery not being well defined,
14 and I think that the role of laparoscopic
15 surgery has changed substantially since this
16 measure was first developed.

17 One of the particular ways that
18 this becomes an issue is, for example, with
19 patients undergoing a laparoscopic bariatric
20 procedure. They are, obviously, higher risk,
21 and they probably should be included in the
22 measure.

1 In addition, more detail could be
2 more readily available in the measure, and I
3 think this was noted among several measures by
4 the different work groups, that more detail
5 could have been made more easily available,
6 and that would have been appreciated by the
7 Steering Committee, particularly given the
8 very large number of documents that we needed
9 to read to prepare for this.

10 Then lastly, there is a true -- We
11 brought up gaming the system among several
12 different measures before, and it was
13 something that was more sort of projected, but
14 this sounds like more clearly orthopedic
15 surgeons are gaming the system, probably in
16 their patients' best interests, but we do want
17 to avoid situations where people will clearly
18 game the system in kind of silly ways that are
19 wasteful of resources, time, and a little bit
20 wasteful of our integrity, frankly.

21 So I wanted to bring those issues
22 up, and I would certainly like to hear your

1 responses.

2 DR. BRATZLER: All right. Thanks.
3 It has been a great discussion, and I am just
4 launching at the bit to respond to some of the
5 issues.

6 So let me start with a couple of
7 issues. A whole lot of things have been
8 raised. So to the question of
9 appropriateness, both of the VTE measures that
10 are submitted, VTE 1 and 2 that we call them
11 or 0217 and 0218 -- both of them use the same
12 specifications for what is recommended
13 prophylaxis, which is based largely on the
14 American College of Chest Physicians'
15 recommendations that were published in 2008,
16 with minor revisions.

17 The performance measure looks at,
18 basically, the hospital abstracts of what was
19 given to the patient, and then the algorithm
20 calculates performance based on whether or not
21 the forms of prophylaxis given to the patient
22 were consistent with guidelines.

1 So the hospital abstractor
2 actually doesn't have to know what the
3 guidelines say. They simply abstract what was
4 actually given to the patient, and then the
5 algorithm calculates whether or not it was
6 consistent with the guidelines or not.

7 There was a lot of conversation
8 about the potential out for passing the
9 measure if the patient has bleeding risk or
10 the issue that we have discussed with our
11 orthopedic colleagues.

12 The performance measure basically
13 looks at those forms of prophylaxis that are
14 recommended in guidelines, but clearly, we
15 recognize that some patients can't take, for
16 instance, pharmacologic prophylaxis. You
17 can't give a shot of an anti-coagulant to a
18 patient who has had a bleeding ulcer or you
19 are concerned. Maybe they have a low platelet
20 count or other reasons.

21 When we developed the performance
22 measure, we tried not to try to define what

1 the list of bleeding risks are, because there
2 are just so many different things that could
3 be considered bleeding risk.

4 So we leave that completely up to
5 the clinician at the bedside. If they
6 document that they are concerned about
7 bleeding risk in any way, then they can use
8 mechanical prophylaxis on the patient, and the
9 case will pass the performance metric.

10 We do the same thing for
11 neuroaxial anesthesia, even though neuroaxial
12 anesthesia is not a contraindication to
13 pharmacologic prophylaxis, if neuroaxial
14 anesthesia is used, the case will
15 automatically pass with mechanical
16 prophylaxis, if that is used.

17 Similarly, if the orthopedic
18 surgeon, as I was telling Dr. Carpenter -- If
19 the orthopedic surgeon is concerned about
20 bleeding risk, they don't want to use
21 something because they are concerned about a
22 wound hematoma, then they can document that,

1 put mechanical prophylaxis on the case, and
2 the patient will pass.

3 The reason that we have not
4 incorporated some of the issues around the
5 AAOS guideline I have discussed with Dr.
6 Carpenter and on many national agendas -- a
7 couple of reasons.

8 Number one, it was mentioned
9 before that the AAOS guideline focuses only on
10 symptomatic pulmonary embolism and did not
11 focus on the literature around DVT, and I
12 think our technical panel was concerned about
13 that, because we know that patients who have
14 DVT may have recurrence of their disease years
15 later, well outside of the surgical time
16 frame, but does put those patients at risk for
17 recurrent DVT and potentially pulmonary
18 embolism in the future.

19 The second thing is just one
20 problem with the AAOS guidelines. All of
21 their recommendations have Level 3 grade of
22 evidence, and that was a problem; whereas, the

1 performance measure is based only on the grade
2 1 recommendations in the ACCP performance
3 measures -- or guidelines.

4 A couple of issues about
5 laparoscopic surgery: We completely agree
6 with you that most patients having these major
7 laparoscopic operations should get VTE
8 prophylaxis. They should also get antibiotic
9 prophylaxis, when appropriate.

10 So when we designed the measure,
11 we painstakingly went through the list of ICD-
12 9 codes and tried to only include operations
13 in the denominator for which VTE prophylaxis
14 is routinely recommended.

15 The only laparoscopic cases that
16 get excluded are those that are done entirely
17 by laparoscope with no other incisions, and
18 that actually came up when we originally got
19 the measure endorsed by NQF, because there was
20 concern about excluding laparoscopic cases.

21 It turns out that nationally only
22 about one or two percent of our cases get

1 excluded because of that data element, because
2 we have such a strict definition. If there is
3 hand assist, if incisions are extended in any
4 way, then for data collection purposes the
5 hospital has to say, no, this is not a
6 laparoscopic case, and the case is in the
7 denominator.

8 In fact, the exclusions are so
9 rare that we are now contemplating simply
10 removing the laparoscope data element, because
11 it is rarely used to exclude cases from any of
12 our measures. So it will make abstraction
13 easier, and it is going to have minimal impact
14 on the measures.

15 Finally, the issue of gaming is
16 one that our technical panel was very
17 concerned about, because we, too, have heard
18 the concerns about use of single dose
19 prophylaxis to pass the measure. It can
20 happen. So what we are actually considering
21 is another performance metric.

22 Our technical panel has asked us

1 to evaluate it. We actually have a learning
2 lab that will be testing it in the near
3 future, looking at continuation of prophylaxis
4 up until the day of discharge or day seven,
5 whichever comes first; because, really, when
6 you look at all the guidelines, they suggest
7 continuing prophylaxis until the patient is
8 discharged from the hospital or for at least
9 a week postoperatively.

10 There is no published study of DVT
11 prophylaxis that is used less than a week of
12 DVT prophylaxis. So we are addressing that,
13 but we are planning to address gaming through
14 an additional performance measure that we will
15 submit in the future.

16 CHAIR MORRIS: Dr. Morton, would
17 you like to add to this discussion in terms of
18 bariatric laparoscopic cases, particularly?

19 DR. MORTON: Yes.

20 CHAIR MORRIS: Before you start,
21 let me just say one other thing. I think that
22 it is important not just to stop the gaming,

1 but to look carefully at the reason for the
2 gaming. It is there for a reason. So I think
3 that addressing that might be more fruitful in
4 the long run than simply stopping the gaming.

5 DR. MORTON: I am still a little
6 confused as to whether or not the laparoscopic
7 cases are excluded. There is probably 150,000
8 gastric bypasses being done a year. They are
9 almost all laparoscopic now.

10 If you look at the most recent
11 data, about 90 percent are laparoscopic, and
12 they carry very high risk, and they are all
13 done with just making incisions with a trocar.
14 There is really no extraction for any of
15 these.

16 So from what I heard, it is that
17 you said very few cases end up making a
18 difference for the denominator, but that is
19 150,000 cases that should probably be
20 included.

21 DR. BRATZLER: So Tory or Wanda or
22 whoever is on the call, do we have bariatric

1 surgery actually in the denominator for the
2 measure at all? Is it on the appendix, the
3 tables?

4 DR. JOHNSON: I think we are going
5 to have to look real quick to make sure. I do
6 have a feeling that there are a couple of
7 bariatric surgeries, and we will look real
8 quick.

9 DR. BRATZLER: I don't have the
10 number for bariatric surgery of the exclusion,
11 but I can tell you for the data element
12 laparoscopic, because we are so strict for the
13 hospitals about when they can use that data
14 element and say yes that very few cases
15 nationally, across all operations, get
16 excluded. I can't tell you what the
17 proportion of the bariatric is.

18 DR. MORTON: Well, it is a real
19 opportunity for quality improvement, because
20 those patients should be getting prophylaxis.
21 I know there is some concern in the bariatric
22 surgery community about staple line bleeds and

1 issues like that, but that has never been
2 proven through the literature.

3 So it is a real important segment
4 of the population at target because of the
5 increased risk. Also keep in mind, about half
6 of all the deaths that occur after bariatric
7 surgery are due to PE. The other half is
8 roughly leaks. So it is something that really
9 should be addressed, especially with more and
10 more of these cases being done.

11 DR. CIMA: I can tell you just
12 from our experience looking at this that they
13 are excluded. Our abstractors do not -- If
14 they are done purely -- We do a lot of
15 revisional ones that are open, but Mike
16 Starry, you know, does a lot of those, but for
17 the straightforward bariatric cases, lap bands
18 and things like that, those are all just
19 basically excluded from the analysis.

20 Now we have a very rigid VTE
21 prophylaxis in those patients, but as far as
22 the measure goes, they are excluded.

1 DR. MORTON: I can tell you for a
2 fact, they are excluded at Stanford, too. We
3 still go ahead and give the prophylaxis,
4 though. So I think we are just missing it
5 with the measure where laparoscopic bariatric
6 surgery isn't cover for a high risk
7 population.

8 DR. CARPENTER: If the measure was
9 just left to patients 24 or less were
10 excluded, would that get rid of most of these
11 laparoscopic procedures that are completely --
12 that should be excluded anyway, the simplest
13 laparoscopic procedures that could be
14 excluded, and could you just eliminate the
15 laparoscopic exclusion altogether, keep the
16 24-hour exclusion?

17 DR. BRATZLER: And that is
18 actually exactly what we are doing. So right
19 now the performance measure is actually -- it
20 is not 24 hours. It is actually any patient
21 who has a length of stay that is less than
22 three calendar days. In other words, if they

1 are in the hospital for less than two nights,
2 they are excluded from the performance
3 measure, because I am aware of no study that
4 has ever shown that a single dose of
5 prophylaxis in the hospital impacts DVT rates.

6 So that takes care of many minor
7 operations that are done laparoscopically.
8 You are correct. But our approach right now
9 is that we are in the process of looking at
10 simply removing that data element from the
11 data collection laparoscope, taking it out of
12 the algorithms, and then all of the operations
13 that are in the denominator will stay in the
14 performance measures, because we are excluding
15 so few cases right now.

16 Again, I can't tell you the
17 bariatric specific numbers, but nationally for
18 all operations, we see about a million
19 operations a year in the dataset. It is a
20 very, very small percentage that get excluded.

21 MS. ZAMBRICKI: I have two
22 questions. One had to do with the idea of the

1 exclusion of perioperative death, and I was
2 wondering --

3 DR. BRATZLER: Yes, and I should
4 have corrected that for the previous
5 conversation about the cardiac surgery also.
6 Perioperative death is defined as in the OR or
7 through the PACU. So there is no chance to
8 give either insulin drips or VTE prophylaxis.
9 So if they die in the immediate perioperative
10 period, they are excluded.

11 MS. ZAMBRICKI: Then my second
12 question was: It looks like the denominator
13 exclusion is patients who stayed less than or
14 equal to 24 hours postoperatively. You were
15 saying something about three days and two
16 nights.

17 DR. BRATZLER: Yes. So I can't
18 tell you the exact date. Tory, can you tell
19 me the update? The measure was always
20 supposed to be three calendar days, which is
21 two nights in the hospital. So they may say
22 24 hours.

1 DR. CIMA: 2.a.10, it specifically
2 says three days, but elsewhere it says 24
3 hours, but in the exclusion in 2.a.10,
4 denominator exclusion details, like maybe 75
5 percent of the way down it says patients with
6 hospital stays less than or equal to three
7 calendar days.

8 The only issue with that now is
9 with clinical pathways. Most bariatric
10 patients are probably out the door the morning
11 of that third day, if not even the day before.
12 I know 50 percent of our colectomies are out
13 of the hospital on day two.

14 DR. BRATZLER: That issue has
15 actually come up in the orthopedic world. Dr.
16 Lieberman updated us that there are increasing
17 number of overnight stays for certain joint
18 replacements where there is pretty good
19 evidence that those patients should be
20 continuing prophylaxis in the ambulatory
21 setting.

22 I don't know in the bariatric

1 surgery literature, even for somebody that has
2 a one or two-day stay in the hospital, is
3 there good evidence on DVT prophylaxis in that
4 immediate -- for those extremely short stays.

5 DR. MORTON: No. There is not a
6 lot of good data yet, but we do know that most
7 of the time when there is a clot that is
8 formed, it is generally on the table, because
9 that is when patients become veno-dilated, and
10 that is when the clot forms, and that is where
11 the prophylaxis would make its most benefit.

12 If they already have a clot after
13 surgery, I agree. That is a different story,
14 and there isn't a lot of consensus about how
15 long to extend it, but a single preoperative
16 prophylactic dose makes a lot of sense.

17 CHAIR MORRIS: Any other --

18 DR. JOHNSON: There are
19 gastrectomy codes collected for the VTE
20 measures. And, Dr. Bratzler, the correction
21 for the length of stay will be fixed with the
22 April 11 manual.

1 DR. BRATZLER: Okay, but you said
2 gastrectomy codes. I understand that, but
3 what about lap, just the banding procedures
4 and others that are purely done
5 laparoscopically? I don't know that those
6 codes are actually in our denominator.

7 DR. MORTON: So for gastric
8 bypass, it is 4431, 4438, and 4439. I've got
9 those burned in my memory, those procedure
10 codes.

11 DR. JOHNSON: And those are not
12 included.

13 DR. BRATZLER: Okay, those are not
14 in the denominator currently.

15 CHAIR MORRIS: Thank you.

16 MS. ZAMBRICKI: I was just going
17 to mention this might be in the next
18 conversation. The 217 exclusion criteria is
19 different than the 218, even though the
20 algorithm calculation is the same. So it
21 probably was somewhere lost in passing. The
22 exclusion times are different in 217 and 218.

1 DR. BRATZLER: I can tell you
2 officially it is supposed to be three calendar
3 days, two nights in the hospital, officially,
4 and that is -- The manual is clear on that
5 beginning for April discharges.

6 DR. CARPENTER: So I just wanted
7 to say before we move to a vote that
8 orthopedic surgeons are in favor of guidelines
9 and the use of these guidelines, and actually,
10 according to Dale, we are one of the highest
11 compliant groups with this.

12 DR. BRATZLER: That is correct.
13 The orthopedic surgeons have the highest
14 performance in the nation on this measure.

15 DR. CARPENTER: So this work-
16 around stuff is a minority of situations, but
17 surgeons do want the option of not having to
18 follow these guidelines for some patients that
19 they think it is too aggressive for and could
20 learn to wound complications.

21 To do that, they do have to use a
22 bit of a work-around, which is better done

1 with just calling them high risk for bleeding
2 rather than these other things, but the
3 concern really is with what guidelines are
4 being used to determine compliance.

5 The hope will be that CMS and ACCP
6 and orthopedic surgeons will come together and
7 have a one acceptable set of guidelines that
8 is useful for this measure.

9 DR. DILLON: If that is true, what
10 should our expectations be in terms of
11 determining whether we go forward with this
12 request, because if we pass it, are we
13 immediately going to put a segment of surgeons
14 or hospitals at odds or out of compliance with
15 this?

16 CHAIR MORRIS: I think one of the
17 issues, and potentially one of the reasons
18 that orthopedic surgeons are so overwhelmingly
19 compliant with this measure or adherent to
20 this measure is that they are actually gaming
21 the system. So they look adherent, even
22 though for good reasons, they may not be

1 adherent to the spirit of the measure.

2 DR. BRATZLER: I actually don't
3 think that is the case. I don't have the
4 numbers in front of me. We have actually --
5 We can look at the case level, at the actual
6 use of prophylaxis, and it turns out that, if
7 you just use ACCP recommendations, orthopedic
8 surgeons have the highest rates of performance
9 on this measure.

10 Most actually do use pharmacologic
11 prophylaxis for their hips and, if they don't,
12 they use mechanical prophylaxis, and there is
13 a way that they can document if they are
14 concerned about bleeding risk.

15 So I don't think there is -- I
16 think there is some gaming that happens. I
17 don't think it is the majority, and we can
18 look at the actual case level data and see
19 what is actually being used for each type of
20 operation.

21 DR. BURSTIN: Just one process
22 point. If the guidelines evolve and the

1 measure changes, we do have an ad hoc review
2 policy. We can bring the measure back in at
3 anytime. It will probably come back to you
4 guys, too.

5 DR. BRATZLER: Yes, that is the
6 other point I would make. We actually have a
7 technical expert panel. AAOS is represented
8 on that panel. We actually update minor
9 details every three months, and they go into
10 the manual every six months.

11 So if new guidelines come out that
12 change specifications, we change the
13 performance metrics.

14 DR. CARPENTER: So I think Melinda
15 said we can pass things with a recommendation,
16 with sort of a tag that says we recommend that
17 these differences be worked out, rather than
18 this is the winner and this is not the winner.
19 The guidelines abstraction do follow the ACCP,
20 not completely, not letter for letter, and it
21 says appropriate guidelines.

22 So there is, I think, room to

1 follow the recommendation, or to follow the
2 measure, but tweak the recommendations, the
3 guidelines that are followed even before it is
4 re-reviewed.

5 DR. DILLON: So there are two key
6 points then, particularly pertaining to
7 laparoscopy as well, that this has to be
8 addressed. So just that our recommendations
9 going forward need to have both points
10 included.

11 DR. WILHOIT: Thank you. The
12 third thing that I think, when it goes out for
13 public comment and so on, if it passes here,
14 I think the numerator description needs to
15 define what is counted in the numerator,
16 because that does alter how one interprets it,
17 and there just isn't enough detail there to
18 know.

19 CHAIR MORRIS: Okay. Anything
20 else? Let's go ahead and move on to the vote.

21 Does the measure meet NQF criteria
22 for importance to measure and report? Now I

1 will ask everybody to push their button once
2 more, and push Send again. Twenty out of 20
3 says yes.

4 Next vote: Does the measure meet
5 NQF criteria for scientific acceptability of
6 measure properties? Six said, yes, it
7 completely meets the criteria; 13, partially;
8 one says minimally.

9 Does the measure meet NQF criteria
10 for usability? Nine say completely; 11 say
11 partially.

12 Does the measure meet NQF criteria
13 for feasibility? Thirteen say completely; 7
14 say partially.

15 The last vote: Does the measure
16 meet all of the NQF criteria for endorsement?

17 We had quite a discussion here,
18 and so I am going to make the recap really
19 brief, because I think it has really already
20 been done.

21 Concerns about gaming the system:
22 There were some concerns. They have been

1 acknowledged by CMS and the contractors for
2 CMS, but they may not be quite as profound as
3 they initially seemed to be in our discussion.

4 There are concerns about a need
5 for a better definition of which laparoscopic
6 cases should be included and excluded, or
7 maybe just getting rid of the laparoscopic
8 exclusion altogether, and there is a need for
9 more consistency in language throughout the
10 measure or uniformity of language.

11 Any other major issues that I am
12 leaving out that anybody wants to bring up?

13 Okay. Let's move on to the vote.
14 Does the measure meet all of the NQF criteria
15 for endorsement? Sixteen say yes; 3 say no;
16 1 abstains.

17 Now I would like to move on to the
18 last measure, 0217, surgery patients with
19 recommended venous thromboembolism prophylaxis
20 ordered, and that is Ms. Zambricki.

21 MS. ZAMBRICKI: Yes. This measure
22 is surgery patients with recommended venous

1 thromboembolism prophylaxis. I think all the
2 discussion of the previous measure, 0218, is
3 really the discussion of this measure.

4 The only remaining issue is the
5 uniformity of language in terms of exclusions
6 in the denominator. Other than that, i don't
7 think that there is anything new to cover in
8 this measure. This is the actual ordering
9 versus the administration.

10 CHAIR MORRIS: That might be the
11 major thing to cover, and can you describe
12 that discussion in the work group about
13 whether this measure would actually be
14 necessary, given that the other measure is
15 present?

16 MS. ZAMBRICKI: Actually, our work
17 group on our phone call, we didn't really
18 discuss that.

19 CHAIR MORRIS: Okay. Well, let's
20 discuss it now. What is your opinion?

21 MS. ZAMBRICKI: My opinion is that
22 it is not. It is superseded by the actual

1 event. The compliance was 94-95 percent with
2 the ordering. So it seems that the actual
3 administration would be the relevant measure.

4 CHAIR MORRIS: Anybody differ with
5 that? I guess our burning question is why
6 have two measures?

7 DR. BURSTIN: One point of
8 clarification is part of the recent NQF
9 Evidence Task Force report, we very clearly
10 said we wanted process measures to be as close
11 to the outcome as possible, and ones that are
12 more distal that are really covered well by
13 the proximate one of administration should
14 really supersede, and really no need for both.

15 DR. BRATZLER: I am trying not to
16 get in trouble with my colleague on the left
17 here, so being quite cautious about what I
18 say. We have had some of the same thoughts.

19 So when we first started these two
20 measures nationally, the performance rates in
21 2005, we sampled 19,000 Medicare patients, and
22 the performance rate on the measures was 70

1 percent.

2 So I am really happy to see that
3 we have seen substantial improvement ranging
4 in the 92 percent range for the measures, with
5 minimal racial disparities, by the way, only
6 about three percent disparity rate for all
7 races.

8 We internally have been having a
9 conversation about whether it makes sense to
10 continue both of these measures. One is
11 whether the recommended forms of prophylaxis
12 are ordered, and then the second measure looks
13 at the timeliness, specifically focusing on
14 whether it is given in that perioperative
15 period, either before surgery or sometimes it
16 is appropriate to wait until after surgery,
17 depending on the type of surgery and
18 anesthesia.

19 So they do overlap a lot, and the
20 measures are quite similar. Quite frankly, in
21 our conversations we have been discussing
22 about whether we should move to two measures,

1 but one that focuses on the appropriateness in
2 timing initially, and then the second one
3 which I discussed earlier about, you know,
4 that would be a new measure submission, would
5 be to look at continuation postoperatively to
6 make sure that patients really are getting
7 effective prophylaxis for their operation
8 beyond just the immediate stay.

9 So none of -- Again, we have a
10 technical panel that meets this month that
11 will be reviewing some of those issues, and it
12 takes time to test new measures, but we have
13 had that conversation also.

14 CHAIR MORRIS: So my synopsis of
15 your answer to the question, why have two
16 measures, would be -- and I would like for you
17 to correct me if I am wrong -- would be that
18 you have -- There are two separate measures,
19 because compliance with this was so poor when
20 it was originally developed.

21 DR. BRATZLER: Yes. So, really,
22 when we started, it was first -- It

1 recommended form of prophylaxis ordered for
2 the patient. That was the first issue. then
3 the second one was timing appropriate. Were
4 they giving it in that close perioperative
5 period? So that was how we saw the difference
6 between the two, was recommended form of
7 prophylaxis, and was timing appropriate.

8 CHAIR MORRIS: Thank you. Anybody
9 want to say anything else about this measure?
10 Let's go ahead and move on to the vote.

11 Does the measure meet NQF criteria
12 for importance to measure and report, and
13 specifically around impact, a performance gap,
14 and outcome or evidence? Two say yes; 17 say
15 no. So that means no further discussion of --
16 or no further voting on the criteria for this
17 measure.

18 Anybody want to say anything else
19 about that measure before we move on? Dale,
20 would you like to say anything else about it?

21 DR. BRATZLER: I don't think there
22 is much else to say.

1 DR. CIMA: What does that mean,
2 though? Now that we have voted no on that,
3 what does that mean?

4 CHAIR MORRIS: Well, it is not
5 important enough to be assessed as a measure.

6 DR. CIMA: But in reality, that is
7 one of the SCIP measures. Does that mean it
8 goes away? What does that mean?

9 DR. BURSTIN: It means that at
10 this point, importance to measure and report
11 is a must pass criterion for NQF endorsement,
12 and you have all just decided it didn't pass
13 the must pass criterion.

14 So, technically, at this point,
15 unless we hear discussion and follow-up from
16 CMS and Dale that may convince you otherwise
17 to reconsider it, at this point it would be
18 put forward for public comment as not
19 recommended by the Steering Committee.

20 It doesn't mean it is not
21 endorsed. There is still a long process
22 beyond this meeting, but that at least begins

1 that process with your recommendation that it
2 not be recommended for endorsement.

3 DR. BRATZLER: And then I will
4 just make a couple of other points, and
5 Christine can correct whatever I say
6 incorrectly. But typically, NQF has given
7 some grace period. Some of these measures are
8 in -- well, not in the proposed rule about
9 value based purchasing, but the bigger issue
10 that some of these measures are required
11 currently for the Hospital Inpatient Quality
12 Data Reporting Program. I always get that
13 acronym wrong.

14 So it does take some time for
15 measures to be backed out of the system, but
16 if at the end of the process this measures
17 loses endorsement, then we will begin the
18 process, working with CMS and Joint Commission
19 and others, to pull it out of the measure set
20 for the future.

21 DR. BURSTIN: So, for
22 example, NQF did not continue endorsement for

1 the smoking cessation measures in hospitals.
2 That had become essentially check-box
3 measures, not valid indicators of smoking
4 cessation. Again, CMS has continued to use
5 them in this period of time, but they now know
6 going forward those are not recommended for
7 use.

8 CHAIR MORRIS: All right. Thanks,
9 everybody. We are going to have a moment for
10 NQF member and public comment. I particularly
11 want to encourage those on the phone to
12 comment, if they would like to.

13 Anybody want to add anything else
14 to our discussion from this morning? Dale?

15 DR. BRATZLER: I am going to make
16 a member comment that I will make to every NQF
17 Steering Committee, and that is simply about
18 the issue of topped out measures, and Helen
19 knows. She has heard me say this many times
20 before.

21 Sometimes measures do become
22 topped out, because scientifically valid, good

1 measures become topped out, because of
2 incentive programs or other things, and I will
3 again make my plea that I am not convinced
4 that we will maintain performance if measures
5 are withdrawn, and if at least there is some
6 way in the future to have a category of
7 measures that are scientifically valid that
8 can be pulled off the shelf down the road,
9 even though -- That is where I worry about
10 losing endorsement for scientifically valid
11 measures. If NQF can figure out a way to have
12 some category of measures that can be
13 resurrected in the future without perhaps
14 having to go through the entire reendorsement
15 process, when they were scientifically valid.
16 They are just topped out.

17 DR. BURSTIN: That is something we
18 are actually actively engaged in discussing.
19 We will have a discussion with our CSAC this
20 month, actually the end of the month, to
21 specifically see if there is -- it would be
22 interesting to get your perspectives on it --

1 a set of criteria that you would say no one
2 doubts that this is a valid indicator, a valid
3 reliable indicator of quality. It is just
4 topped out.

5 Should it be on the front burner
6 of public reporting or should it be somehow
7 put into the background of saying this is a
8 measure that maybe periodically comes up for
9 surveillance, especially if it can be done in
10 a way without a lot of burden, so we don't
11 have to crack a chart to get that piece of
12 information. You can make it more of an
13 electronic surveillance perhaps. Is that
14 something that should remain as sort of some -
15 - we haven't figured out the right word for it
16 yet, but we are working on it.

17 DR. KLEINPELL: Arden, can I just
18 make a general comment. This is more -- Maybe
19 it is more for the measure, the steward
20 measures. I notice in reviewing the measures
21 that the scientific evidence references
22 oftentimes were 1999, 2002, 2004, and I feel

1 that, if a maintenance measure is coming
2 forward for review, that the references should
3 definitely be updated.

4 I don't know if it is optional for
5 them to do that, but that was just a side
6 comment that I had in terms of the measures
7 for maintenance.

8 CHAIR MORRIS: Thank you for
9 making that point.

10 Any other issues that anybody
11 wants to bring up? So now it is time for our
12 lunch break, which will be from 12:00 to
13 12:30. I think that is going to be basically
14 the same as yesterday. I will see you again
15 at 12:30.

16 (Whereupon, the foregoing matter
17 went off the record at 11:58 a.m.)

18 - - -

19

20

21

22

1 to ask developers, particularly if it is a
2 single developer, whether they would like to
3 combine these measures or whether they are
4 able or would be willing to harmonize the
5 measures. So those are the sorts of things we
6 want to keep in mind with this discussion.

7 You can see, so we are just
8 basically getting kind of the bird's eye view
9 here, making comments that you feel are
10 important to bring up at this time, knowing
11 that we are going to have a more in depth
12 discussion later.

13 So first of all is a cardiac
14 measure, internal mammary artery. You can see
15 the first two -- or the second and third
16 column there, maintenance measure 0134 and
17 measure 0516. The particular difference here,
18 I believe, is that the level of measurement or
19 analysis, which is on the third page, page 3
20 at the top -- level of measurement analysis in
21 the first column is facility, in the second
22 column is individual. Those are the biggest

1 difference that strike me. Melinda, are there
2 any other differences that you would like to
3 point out?

4 MS. MURPHY: No, not that there
5 might not be some other differences within the
6 specifications, but those were the key
7 differences of note from the standpoint of the
8 developer.

9 CHAIR MORRIS: Okay. The next one
10 is another cardiac surgery measure, and this
11 is maintenance measure 0113 and measure 0456.
12 Participation in a systematic database for
13 cardiac surgery is 113.

14 Participation in a systematic
15 national database for general thoracic surgery
16 is 456, and this is one where I think that we
17 are probably going to have a particularly
18 interesting discussion.

19 Again, there is a new generic
20 measure that will be forthcoming, and that
21 will be -- This list will be updated. That
22 will be added. Helen, would you like to add

1 anything about that?

2 DR. BURSTIN: Just to point out
3 that I think, as I mentioned yesterday, it
4 would cover all disciplines as opposed to
5 being very specialty specific. So something
6 for you to consider. And I think the issue
7 around does it drive people to use registries
8 in the way we discussed yesterday, I think, is
9 something we need to talk about.

10 DR. CARPENTER: Is that what was
11 sent out by email yesterday? Yes, okay.

12 DR. CIMA: The one question I have
13 is, when you say that, though, how is this
14 applied? So let's say your institution
15 participates in X registry. Does that give
16 you a pass on everything else? How can I
17 phrase it ?

18 So let's say cardiac surgeons want
19 to -- Is this only for cardiac surgery or is
20 this for all specialties? So if I have a
21 multi-institutional practice and I participate
22 in the STS, does that cover my general

1 surgeons, too?

2 DR. BURSTIN: No. The STS
3 measure, no. The STS measure is pretty
4 clearly about a cardiac --

5 DR. CIMA: No, but I am talking
6 about that big measure.

7 DR. BURSTIN: That big measure
8 would cover anything. Of course, yes, it
9 does. It is not specific to a specific
10 discipline.

11 DR. CIMA: So does that really
12 meet the purpose of driving quality
13 improvement in one specific area?

14 DR. BURSTIN: I mean, that is the
15 other question. Could it be stratified? I
16 mean, are there ways to approach it without a
17 separate measure that points people to a
18 specific registry, I think, is the question.

19 DR. HALPERN: I don't remember if
20 the one we sent out last night covered -- I
21 think you are asking individuals versus
22 facilities.

1 DR. BURSTIN: It is both. It is
2 individuals, groups and hospitals. Yes.

3 CHAIR MORRIS: So to be continued,
4 I guess.

5 Esophagectomy: This was 360,
6 esophageal resection mortality rate, and 361,
7 esophageal resection volume. I thought we had
8 a very comprehensive discussion of the
9 relationship between these measures, and these
10 are both from -- The first two, 363, 361, are
11 from AHRQ, and there is another measure, an
12 endorsed measure, survival predictor for
13 esophagectomy which is from Leapfrog.

14 So we will discuss whether or not
15 we would request of the developers that they
16 combine these measures, whether we think that
17 that is a reasonable thing to do.

18 DR. BURSTIN: Let me make just one
19 more point. It is kind of unlikely that they
20 would actually -- these are very complex
21 measures -- just combine them, but I think the
22 question would be is there a way that

1 particularly the AHRQ measure could
2 potentially -- we talked about it yesterday --
3 move closer toward incorporating the volume in
4 the way that Leapfrog does.

5 The Leapfrog measure doesn't have
6 clinical risk adjustment. So the issue is
7 really is there a better mousetrap that you
8 can kind of get to by taking the best of both,
9 and that would be a question going forward,
10 but probably not something they could turn on
11 a dime and do in the course of this project,
12 but more so recommend before the next
13 evaluation.

14 DR. ROGERS: Arden, if I may, on
15 the first three of these it seems the
16 significant difference is -- on the level of
17 measurement, it is facility agency, and the
18 first three add the individual.

19 Now if we agree, and we may not,
20 that quality improvement is actually justified
21 and important to change behavior, and that
22 comes down to the individual behavior, there

1 is something important, I think, in
2 recognizing the identification of who actually
3 -- who individually is responsible for what
4 happens. So I see that as one of the
5 differences between these.

6 I would personally favor that
7 quite strongly, that we include the individual
8 reference. So I just wanted to comment.

9 CHAIR MORRIS: Thank you for
10 bringing that up, and please continue to keep
11 that in mind, because this should arise, and
12 it will arise. We will be discussing it more,
13 and where that level of -- where we want to
14 put the crowbar in some ways. Do we want for
15 hospitals -- beg pardon, you don't use
16 crowbars? Would the onus be on hospitals to
17 have their physicians comply in a certain way.
18 Should it be among physician groups, etcetera.
19 We will be talking about that more.

20 DR. HALPERN: Will we get more
21 details on the Leapfrog measure

22 CHAIR MORRIS: As we are asked to.

1 Page 14 is the next measure, and this is -- As
2 Melinda pointed out, it is really a moot
3 point, because the JCH measures did not pass
4 the importance criteria. I'm sorry, Ingenix.
5 I apologize. That is 1479.

6 Let's see. Then we have page 18,
7 venous thromboembolism. 217 went down as well
8 in terms of meeting the importance criteria,
9 wasn't it? The importance or maybe it was the
10 overall.

11 So that leaves 0218 and a related
12 measure. It is related. It is not under
13 consideration at this time, and that is 0371,
14 covers medical and surgical patients. It has
15 some, to my mind, substantial differences from
16 0218, but that is something that we will be
17 discussing as a group.

18 DR. CARPENTER: If measures such
19 as 0217 didn't pass here, that doesn't mean --
20 It could be reinstated at another time. Does
21 that mean any one that didn't pass here, we
22 don't consider in the next level of discussion

1 for those purposes?

2 DR. BURSTIN: Just one comment --
3 two. Actually, the measure developer could
4 certainly come back to you and say these are
5 the following points you didn't consider, and
6 you could reconsider it. That is one
7 possibility.

8 The second possibility is we do
9 put out all measures for public comment, both
10 ones you recommend and not recommend.
11 Although it is not very common, we have had a
12 few instances where not recommended measures -
13 - actually, often in the other direction more
14 so, recommended measures -- the public comment
15 is persuasive enough to make the Steering
16 Committee reassess. So you will have another
17 chance to consider those again.

18 CHAIR MORRIS: Any other
19 discussion on the related and competing
20 measures for now? We will opportunities to
21 readdress these and again to dig down a little
22 bit.

1 The next thing on our agenda is
2 gaps to be filled to more fully capture an
3 episode of care. There are about 150 endorsed
4 surgical measures right now. You guys, I
5 think -- is this the list that was received by
6 the group by email? No? Okay. But you will
7 be receiving it.

8 Having considered the measures
9 that w went through yesterday and today, and
10 then also with an eye to the endorsed measures
11 that you will receive a list of, we would like
12 for the entire Steering Committee to think
13 carefully about topic areas in which further
14 measure development would be useful for
15 quality improvement.

16 Where do we see the serious gaps,
17 based on your expertise or clinical expertise
18 and quality expertise? So we will be tackling
19 this later, but we just wanted to plant the
20 seed and get you to start thinking about where
21 are the gaps? What measures should be brought
22 up that haven't really been brought up thus

1 far? Melinda, do you want to say anything
2 about that?

3 DR. BURSTIN: And one particular
4 thing to consider as we move toward,
5 hopefully, having interoperable electronic
6 specifications, thinking about measures that
7 could be built de novo for that system as
8 opposed to what we are doing now, which is
9 often retrofitting measures developed for
10 paper or claims. So you are, somebody
11 mentioned earlier, looking under the
12 lamplight. There is a lot of that going on.

13 So the question is have you had
14 good clinical data combined with cost data
15 issues, risk data, whatever it is, what would
16 be the measures you would actually want to
17 assess quality and report on it?

18 MS. MURPHY: In terms of
19 sequencing the two conversations, one about
20 the related and competing and the one about
21 gaps, is between now and the next time we have
22 a face to face meeting we will resolve the

1 questions about the related and competing
2 measures for this group of measures.

3 For the gaps, we really can hold
4 this -- we expect to hold this until after our
5 second face to face meeting where you have had
6 an opportunity to see all of the measures you
7 will be evaluating, but we will go ahead and
8 send you the complete list of endorsed surgery
9 measures so you can be thinking about that.

10 CHAIR MORRIS: We are moving
11 through our agenda so quickly that I am
12 finding this a little bit alarming. Should we
13 be having more of a discussion about these
14 items right now? Okay.

15 Well, I think this is probably a
16 good time to go through some of the things
17 that came up repeatedly and for us to
18 basically develop a little bit of a list of
19 the things that we thought were very important
20 that came up repeatedly in our discussions,
21 both yesterday and today.

22 I can kick this off with some sort

1 of simple ones. One was consistency of
2 language throughout the measure. That was --
3 and it should be easy to correct. It should
4 be done before we actually receive the
5 measures. So we would ask for the developers
6 to pay special attention to that.

7 Another one that came up that was
8 also sort of a simple and fairly concrete
9 thing was the time frame. So the time frame
10 that was listed, consistency of the time
11 frame, and whether the -- and some thought to
12 and rationalization of or justification of
13 whether the time frame is an index
14 hospitalization or whether it is a 30-day
15 period or whatever other time frame is used.

16 Then, Terry, would you mind just
17 reiterating the point that you had about the
18 importance of the JCH measures that did not
19 pass our importance criteria?

20 DR. ROGERS: Yes. I perhaps was
21 not alone in feeling a little bad for the
22 person who was at the receiving end of most of

1 our comments yesterday, and I hope that she
2 got the message, and I think the message
3 should come from us, that our criticisms were
4 not in any way directed at the importance of
5 the issue that was in front of us. It is just
6 that their approach didn't seem to hit the
7 mark with what needs to be done.

8 Personally, I honestly don't know
9 what all JCH does, but one of the things they
10 might do is embrace the notion of how
11 important the issue of transfusions is, and
12 think about -- I hesitate to talk about
13 mandates -- but to at least encourage, if not
14 require, that hospitals have a very structured
15 and reliable and predictable and responsible
16 way of dealing with transfusions, up to and
17 including perhaps having a transfusion
18 specialist.

19 I think that where it struck me
20 was recognizing that just measuring a
21 hematocrit is a tiny part of whether somebody
22 really needs a transfusion or not. It has to

1 do with perfusion and oxygenation and, you
2 know, the whole deal.

3 So somehow if we get the message
4 back to them that we are very supportive of
5 what they are doing, that it just didn't make
6 it the way they had presented it.

7 MS. MURPHY: And I think that you
8 did that multiple times yesterday. You
9 reinforced that. The suggestion was made to
10 them yesterday about considering a national
11 patient safety goal that would get at the
12 whole topic area of the transfusion issues,
13 and Dr. Stafford reinforced with them before
14 they left yesterday about the potential for
15 doing just as you have suggested.

16 It turns out that in their
17 reorganization, their performance measures
18 group and their patient safety goals group are
19 under the same umbrella. They had already
20 made a note of going back to have that
21 conversation with them.

22 So I talked with them before they

1 left yesterday. I think they were clear that
2 the issue was the structure and the way in
3 which the measures were put together, not the
4 topic area.

5 DR. ROGERS: Just one other
6 comment. Certainly, it is a patient safety
7 issue, but -- and maybe things have changed in
8 the past 20 years since I have been doing
9 clinical medicine, but I think one of the
10 issues that we as a profession have to address
11 is to get away from the notion that, oh, just
12 give him a couple of units of blood.

13 I think it is the ordering piece.
14 We allow people to have this privilege of
15 giving blood who may not have any interest in
16 or engagement with responsibility that is
17 attendant upon that, and I think that is not
18 a patient safety issue. That is a physician
19 or ordering behavior issue that I think we
20 have to take responsibility for.

21 DR. CARPENTER: Let me just
22 comment while we are talking about the

1 submitted forms. The biggest challenge for
2 some of us was their abstraction criteria or
3 the -- It is usually in the numerator criteria
4 was often a complex list of abstraction
5 instructions, multiple pages even for some of
6 them that was really code and jargon,
7 referring to other documents.

8 Usually, those documents, I think,
9 were available if you followed it far enough,
10 but you couldn't do that for all of them.

11 Having some simplified language about what
12 meets the criteria for that measure in plain
13 language -- you know, what is acceptable from
14 the record for meeting some of these criteria
15 -- would be a lot more helpful than the long:
16 This is a yes, if yes is no, and go to the
17 next level and the whole algorithm which the
18 abstractors use, isn't very helpful for us.

19 So putting that out in plain
20 language, a paragraph of that. If they have
21 to include the other part, fine, but having
22 that up front would be very helpful.

1 MS. MURPHY: And we can pass that
2 information back to them, but the balance for
3 them is meeting the expectation to have their
4 specifications fully articulated versus having
5 some brief form kind of presentation. But
6 what you suggest may be able to do it.

7 The other thing is that, in
8 talking with some of the developers and some
9 of the NQF staff who look at how the
10 information is imported into the document, is
11 that some of the things they want to be able
12 to convey are not easily imported into the
13 document. So they default to the position of
14 giving you extra pieces of paper.

15 So we both need to work some at
16 that.

17 DR. CIMA: I was just going to
18 say, to follow Ruth's point, I went back and
19 looked at ones that were coming up for
20 maintenance. I think a lot of times, when you
21 are doing like a grant renewal, you have to
22 submit recent literature.

1 It seemed like for some of the --
2 one of the maintenance ones, it was as if it
3 was the same stuff they gave 12 years ago. So
4 maybe having a section on -- for that group,
5 that this was the background literature we
6 used initially, and since then there have been
7 this, might be something useful.

8 MS. STEED: Not only the
9 literature, but their data. Some of them did
10 not have updated data, and in fact, Peter was
11 talking about earlier how several times they
12 have said, oh, well, we actually looked at
13 that, and we are changing it anyway, but we
14 are presenting this now.

15 DR. KLEINPELL: In terms of the
16 literature, I actually had to go and do a
17 literature search, because the references, I
18 felt, were just way outdated, and it wasn't
19 difficult for me to find updated literature.
20 So I think that should be a requirement for
21 them, not just a recommendation.

22 DR. SIPERSTEIN: But also a clear

1 summary of how the measure has impacted health
2 care since it was enacted, because there is a
3 lot of that information, and you really kind
4 of had to --I mean, there are a lot of tables
5 and graphs that were cut and pasted in there,
6 but it really didn't address the question in
7 a succinct way in terms of, you know, has
8 this measure been effective at moving the
9 needle since it was implemented.

10 So I think that would be helpful
11 for us and helpful for the public that
12 reviewing this as well.

13 DR. CIMA: Just to follow up on
14 that, you know, with the more and more recent
15 data that has come out, if someone were to
16 bring SCIP 1 as it exists currently, there is
17 a huge amount of data, a lot of it out of
18 NSQIP, out of the VA, that says that that
19 individual measure doesn't mean anything, but
20 the more important measure is actually a
21 composite of if you do 80 percent of these
22 things, then you will have that.

1 It really begs the question about
2 NQF saying, you know, should we look back and
3 say all these measures now -- now people have
4 been implementing them over the last decade
5 and have looked at it, there is now a huge
6 body of literature that says the individual
7 measures may, in and of themselves, although
8 important as a component of care, do not mean
9 anything, really, if -- You know, there may be
10 a very unique exception in these cases, but it
11 is the composite of doing all of them in a
12 timely fashion that is more important.

13 I don't know how you get that
14 across, but it would be now a very hard case
15 to make that SCIP 1 per se, if it were brought
16 back -- there is a huge literature that now
17 says it really doesn't matter about the exact
18 timing of it, to some extent.

19 DR. DUTTON: It is also an answer
20 for what you do with the measures that you
21 think have topped out. Maybe they all go into
22 a pile that becomes your maintenance report

1 card, that they have effectively become a
2 bundle that you just need to keep reviewing at
3 some lower intensity over time.

4 MS. MURPHY: And the one thing
5 that comes to my mind -- and Helen, I know,
6 can add to this -- is that the maintenance --
7 the rigor with which maintenance is approached
8 has continued to evolve for NQF over time, and
9 some of the things that we are asking that
10 developers do at this point, they have not yet
11 caught up with.

12 We are in the second group of
13 measures in the first cycle of this activity.

14 DR. BURSTIN: I have mentioned a
15 couple of times these task force reports that
16 we have recently done. So we have done one on
17 evidence, one on testing, and one on
18 harmonization.

19 All three of those guidances went
20 into effect with projects beginning of January
21 2011, because we had to have the measure
22 developers have an implementation period where

1 they have already kind of done their work.
2 They can slip into it, but a lot of the issues
3 you guys have raised are in the new submission
4 form.

5 There are very fair questions for
6 the newer projects about the use and
7 usefulness of the measure in the field,
8 evidence of importance. Actually, one of the
9 discussions it also had is in terms of measure
10 testing. What should be the requirements for
11 measure testing for measures at maintenance?
12 Should there be new testing done beyond the
13 reliability? Were they done when the measure
14 was begun and, if so, is that testing
15 different? Is that testing looking more at
16 issues of how has the measure actually
17 influenced the performance in the field?

18 Obviously, measurement alone
19 doesn't do that, but you want to at least be
20 able to say that it had some impact. So I
21 think you will see over time, and you guys are
22 right at the cusp of that, that it will get

1 tougher.

2 The evidence report -- if you guys
3 would like to see it, we are happy to share it
4 -- very clearly requires the developers to not
5 just give us the grade and the guideline, but
6 to actually give the quality of the evidence,
7 the quantity of the evidence, and any
8 inconsistencies in the evidence as being the
9 really important consideration for a lot of
10 our committees. With inconsistent evidence,
11 it is really hard to have a measure, as
12 discussed in some of these arenas.

13 So I think we are trying to make
14 this tougher. Maintenance used to be kind of
15 a pass, and I think the reality is, with so
16 many measures, it is time to just -- some of
17 these ones just need to go away.

18 In the Cardiovascular Committee
19 last week, or two weeks ago, many of the
20 measures we think of as being sort of bread
21 and butter hospital measures of aspirin on
22 arrival and beta blockers after MI. They are

1 at 98.5, 99 percent performance, and there is
2 an opportunity cost associated with it. if
3 you are doing that and you are not doing
4 something else that may actually be important
5 to get to the gaps discussion. That is
6 exactly where we are trying to go, but it is
7 interesting.

8 DR. MORTON: I was just going to
9 mention, maybe for maintenance measures we
10 ought to include impact on health care as a
11 criterion.

12 DR. DILLON: Right, because one of
13 the things we have to be able to encourage
14 with these is an evolution and a maturation in
15 all of these processes. To me, they are still
16 static. You said cut and paste, and it sounds
17 -- you know, so many of them were cut and
18 pasted out of their previous submissions, and
19 so we don't get to see the maturation.

20 DR. BURSTIN: CMS has some all or
21 none measures they have developed for SCIP and
22 AMI and THF. We are just beginning to start

1 to see those. So that is, clearly, the
2 direction, I think, all of us want to go. If
3 we are going to measure these things, it
4 should at least be something -- we do all of
5 them.

6 DR. HALPERN: Although I do think,
7 like we were talking about before, that some
8 of these, like aspirin on arrival, do need
9 maintenance. Just human nature is, if you
10 don't have to do it, you may forget to do it.

11 CHAIR MORRIS: I think that that
12 is actually a really important point, and I
13 would like to echo that related to Dale's
14 comment. When these are essentially backed
15 out and potentially retired on a shelf, some
16 explicit method for revisiting them. Once
17 they are not sort of required, are they still
18 being done? I think that is important.

19 DR. HALPERN: The way to judge
20 that is then to ask them, okay, so how did --
21 like your question before, how did this impact
22 health care? Did it actually -- what did you

1 say? -- move the needle, because those would,
2 obviously, be more important to maintain.

3 DR. BURSTIN: Somebody on our
4 cardiovascular committee, Tom Kottke who some
5 of you may know from Minnesota, just did this
6 great back-of-the-envelope calculation and he
7 said, okay, so if we went from 98.5 to 100, we
8 would save, you know, one life out of -- I
9 mean, just the number reality of it was so
10 striking that, I think, we also want to try to
11 be more quantitative as well and saying, okay,
12 if we are this high up, how much more reality
13 could you move that needle, and how much is
14 really just measurement noise. I mean the
15 noise to signal an issue in a lot of these is
16 not as good as we would hope.

17 CHAIR MORRIS: Is there another?

18 DR. DUTTON: It may be that we
19 need the Joint Commission to write us a
20 measure for retired measures as a Joint
21 Commission criteria. Now you pick five off of
22 these 30 retired measures for your hospital to

1 look at, you know, that kind of idea, but
2 using things that have already been defined,
3 have already been tested but topped out,
4 because they were, so that you are getting
5 some sample nationally of those each year.

6 DR. BURSTIN: Part of what Dale
7 shared with me is he recently gave a talk to
8 a huge group of hospitals, and one of the
9 things they pointed out was that they were
10 still -- they are very anxious about some of
11 these things coming off the front burner and
12 feeling like that they would go down in
13 performance.

14 We don't really know that, but I
15 had asked about some of the measures CMS has
16 retired like pulse oximetry and ED for
17 patients with pneumonia, and he said what was
18 interesting was the difference there is that
19 measure had just become a vital sign. You
20 can't walk into an ED without having a thing
21 stuck on your finger.

22 So I think one of the questions we

1 have to think through is when is a measure
2 topped out, because we have all just worked
3 really hard to make it top out, and when is it
4 actually built into systems that sort of
5 become infallible. That is, I think, what is
6 not always clear to make that decision.

7 DR. SIPERSTEIN: I just want to
8 comment. I don't know if the term legacy
9 measure makes sense, but there are different
10 reasons why a measure may be, quote,
11 "retired." I mean, we had a nice example
12 today in terms of we had another measure that
13 really supplanted it.

14 As we mature, we no longer really
15 care about writing the order about whether the
16 VTE prophylaxis was actually done. The first
17 measure is no way scientifically invalid.
18 There is no problem with it. You know, all of
19 the criteria still stand.

20 The issue is how to flag it as
21 being supplanted by a better measure or a more
22 mature measure versus a measure that, in the

1 example you gave, in that medicine changes,
2 and it really no longer is a clinically
3 relevant matter to continue to follow. It
4 would not improve quality to continue to
5 follow it.

6 DR. DILLON: I just have a quick
7 question for the NQF then, because I was
8 impressed with the composite -- or at least
9 some of the data and literature that we have
10 gotten on the composite scores coming out of
11 the STS. Is this, to me, the evolution of
12 composite scores which will incorporate a lot
13 of processes, like now all of a sudden it is
14 standard of care to get your pulse ox. Is the
15 NQF encouraging the development of composite
16 scores like that to address these issues?

17 DR. BURSTIN: Yes, and we actually
18 just endorsed the STS composite in our recent
19 Outcomes Committee. We have endorsed several
20 AHRQ safety composites, and I am hoping some
21 of these measures that are out there now,
22 these all or none composites, will come early

1 as well.

2 So we are very much encouraging
3 them. I think the issue is it is still an
4 interesting question of which measures should
5 be in a composite, sort of the next step. So
6 one of the issues we had with the
7 cardiovascular composite, for example, that
8 CMS brought forward to us last week is a lot
9 of those measures are pretty close to topped
10 out. So you wind up with, even in a
11 composite, a very small, narrow range.

12 So something for you guys to help
13 us think through. It is just does that even
14 make sense? If they are really high and you
15 put them together, they are still really high.
16 The all or none helps a bit there.

17 DR. DILLON: We still struggle
18 with SCIP, though I don't believe necessarily
19 that the individual components, as you said,
20 are that valid, but again the all or none
21 process -- We may be at 98 percent on any
22 given one, but when we look at the all or none

1 or you start bundling them, then we clearly
2 have room for improvement.

3 DR. KLEINPELL: This is sort of in
4 a different direction, but what happens -- The
5 woman from CMS said that the 6:00 a.m. glucose
6 was part of a value based performance set that
7 is out for comment.

8 So we really had issue with that,
9 and we are asking them to come back with
10 different considerations. But could CMS
11 technically move forward based on getting
12 public comment to then say this has to be
13 measured? That seems a little challenging
14 then for clinicians.

15 DR. BURSTIN: yes. So the process
16 is that the Federal government is obligated to
17 use consensus standards when they are
18 available. They can choose to use -- and,
19 actually, the recent Affordable Care Act made
20 this a bit stronger. They specifically said
21 the Secretary should use endorsed standards
22 and, if they choose not to, they actually

1 have to post something in the Federal Register
2 and seek public comment.

3 So doing that, going beyond what
4 is endorsed will be, hopefully, something --
5 It has got a pretty big burden associated with
6 it, but at times we have had just clear
7 disagreements.

8 I mean ESRD -- a few years ago our
9 committee refused to put forward an upper
10 limit hemoglobin measure, given all the
11 controversy about EPO, and they are like, no,
12 no, no, it is in the payment rule, we are
13 going forward with this. It is one of those
14 things I was very glad our Steering Committee
15 had actually voted with their conscience, and
16 they were, in fact, correct that there was
17 lots of unintended consequences with going
18 down that path.

19 It is always an issue for us, just
20 in terms of -- That is why I always just tell
21 committees, just vote with what you think
22 makes the most sense. Ground it in the

1 evidence.

2 That is why we are being very
3 vigilant, more so than even four years ago
4 when I came to NQF, that you really are
5 voting on every criteria and subcriteria,
6 because it gives us something to then pass on
7 and say these were the clear issues here.
8 Use, if you need to, but you need to
9 understand what you are potentially choosing
10 to use.

11 MS. MURPHY: If I heard Dale
12 correctly, the proposal is that this would go
13 into 2013. So my -- Two things. One is that
14 it seems that CMS is better than some about
15 using the NQF endorsed measures and seeking
16 those measures. So they, too, have an
17 opportunity to withdraw from implementation of
18 something that they are talking about two
19 years out.

20 CHAIR MORRIS: There is another
21 subject that hasn't come up yet in this
22 particular section of our discussion, and that

1 is the attention to disparities in care.
2 Isn't that one of the core values or core
3 parts of the mission of NQF, is equity in
4 care?

5 It seems to me that it really got
6 short shrift from most of the measure
7 developers. A few of them cited numbers. For
8 example, Dale did, but one of the recurrent
9 refrains from STS was that they hadn't done
10 it; they could do it, they hadn't done it.

11 I think that, if this is something
12 that is truly important to NQF, that that
13 needs to be underscored and needs to be
14 attended to.

15 DR. DUTTON: I would comment on
16 the emphasis that the committee put on
17 outcomes, and the closer you were to an actual
18 clinical outcome, the more we like you in
19 general. I hope that message gets back to the
20 developers, that we killed a lot of process
21 measures that we thought posed undue burden
22 with insufficient evidence that it had any

1 clinical impact.

2 That was the biggest problem with
3 the Joint Commission, not that we don't
4 consider transfusion important, but that there
5 was no evidence that their measures would have
6 any impact on clinical practice or on a real
7 patient outcome.

8 CHAIR MORRIS: I think that that
9 also is a real important point. Previously,
10 it seemed that NQF's focus was really more on
11 processes of care and not so much on outcomes,
12 processes of care because that is something
13 you can actually change, a behavior or an
14 action that can be changed; whereas, outcomes,
15 it was unclear what it is that would have
16 changed the outcome. So a process of care
17 changes the outcome, but were the proper
18 processes of care being identified?

19 Just as you pointed out, a lot of
20 times the processes that were identified are
21 processes that could be -- in which a change
22 could be measured, really had nothing to do

1 with the outcomes. It is this ongoing
2 conundrum.

3 I think that the paired process
4 and outcome measures are probably the most
5 valuable. I want to know if you would like to
6 say anything about that.

7 DR. BURSTIN: As I mentioned,
8 again this Evidence Task Force report could
9 not have been more clear about the hierarchy
10 of which measures we seek, with outcomes being
11 the highest priority. Process measures with
12 a very strong evidence based link to outcomes
13 is the second priority, so really trying to
14 move down that path.

15 I think, really, it wasn't so much
16 that NQF had an emphasis on process measures
17 as that the development world was at the
18 process measure stage, with the exception of
19 surgery, actually. Surgery has probably been
20 further ahead on the outcome side and
21 anesthesia than, certainly, most of the
22 medical disciplines have been.

1 I think that we have started to
2 see that evolution, and it has been very
3 interesting watching as specialties come
4 forward with measures, where they begin, as
5 opposed to -- You know, we are actually seeing
6 some new specialties come on the horizon.
7 They are bringing outcomes to us, and they are
8 kind of skipping all the process stuff we got
9 mired in for so long. I think we need both,
10 when they are good.

11 CHAIR MORRIS: I do think there is
12 an ongoing problem. Surgical care is so often
13 cross-sectional that looking at outcomes is
14 feasible; whereas, medical care is so often
15 longitudinal that processes are enormously
16 easier to measure. But the truth is that, if
17 we want to change an outcome -- So many times
18 we have said, well, we really can't change
19 this outcome. Then somebody would change
20 something, and they would demonstrate that the
21 outcome could indeed be changed.

22 So there is something that

1 happens. There is some action, and that
2 action is a process. We just need to figure
3 out what those processes are.

4 DR. DUTTON: On that last one, I
5 would point out that the central line
6 infections were a perfect example of that,
7 where 15 years ago, we can't fix that. It's,
8 you know, certain patients are just going to
9 get these. We are going to have that rate.
10 But once somebody started looking at the
11 outcome, we all had a target, and then the
12 ways were found to get there. That is one of
13 the reasons I think that outcomes are really
14 important for driving the process.

15 CHAIR MORRIS: Thanks. Anything
16 that anybody else wants to bring up in terms
17 of really important points that came up
18 repeatedly?

19 One, I was sort of waiting for
20 you, Dr. Cima, to bring up was around
21 participation in a registry, what that means
22 for hospitals. What are the implications? If

1 you would rather not bring this up and just
2 bring it up in the context of our upcoming
3 discussion about related measures, then that
4 is fine, but if there is anything else you
5 would like to say -- Do you know what I am
6 talking about?

7 It was participation in the STS --
8 almost mandated participation in the STS
9 registry versus some other registry. Sorry if
10 I am not being clear.

11 DR. CIMA: The issue is -- and I
12 am still trying to understand who this data
13 steward is from an NQF point of view. I guess
14 cardiac is different, because they already
15 have the market share. They have 95 percent
16 of the market share, and everyone -- as Wanda
17 said, well, everything is there, if someone
18 else can do it, you know. Well, that is a
19 burden.

20 If you don't really understand the
21 risk modeling and everything, that is a huge
22 burden, especially for the person often at the

1 institution who is tasked to do this. It is
2 often someone who is not a statistician, is
3 not familiar with it.

4 So I understand the rationale
5 behind places going to someone and saying,
6 well, we have most of the data and using it,
7 and I support registries, but at the same
8 time, you know, you are selecting -- That
9 person's group has the right answer, and that
10 is the way of doing it.

11 It just seems that that is not a
12 very open way of doing this. If you wanted
13 people to say what is our mediastinal
14 infection after CABG, well, then you ask them
15 to report what is my mediastinal rate after
16 CABG. You don't ask them to go submit their
17 data, that they have to pay, to send it to
18 somebody else to do the analysis and send it
19 back to you.

20 I mean, it is picking winners, and
21 I just think -- I don't think that is
22 necessarily the best way to do it, and it is

1 a burden on institutions; and just because the
2 fact that it is out there and free in the
3 sense of the process which STS uses, that
4 doesn't mean it is easy and doable. It is
5 very complex.

6 It would be just like saying,
7 yeah, you can collect the 35 variables for
8 NSQIP and here is the algorithm you use to
9 risk adjust it and do all this. A lot of
10 hospitals can't do that. They don't have the
11 sophistication to do it, and I think it would
12 be burdensome.

13 I don't know if going that way is
14 the best way. And you saw, STS has a lock on
15 it. Is that right? What if an institution
16 doesn't want to use STS? What if they want to
17 use NSQIP? Then you have to redo all your
18 data collection, reprocess it to meet their
19 standard. So they set the standard. It is
20 not right.

21 DR. DILLON: And it is going to be
22 a challenge as databases proliferate, and that

1 is what we are seeing right now, either at the
2 state level or the society level or the
3 consortium level. So that is going to be a
4 challenge that NQF and others in terms of data
5 collection are going to face, and for the very
6 reason that we can't be in a position where
7 you specify what database you must be in, in
8 order to meet a certain quality criterion.

9 DR. MORTON: Just two follow-up
10 points. One is I think this issue is going to
11 get worse over time, because there is going to
12 be pressure on hospitals to say, well, you can
13 only go with one of these systems; you can't
14 go with them all.

15 As we were talking the other day,
16 you know, every specialty wants to have their
17 own database, and there is going to be
18 competition in the hospital, and they are
19 going to have to choose. So when you set up
20 a potential advantage for one, it can create
21 some issues.

22 One other follow-up point that I

1 think Richard was making earlier was about
2 moving toward elimination. I've kind of moved
3 toward that in NSQIP where we are trying to
4 move away a little bit from O to E ratios,
5 because what really matters is getting rid of
6 the complication.

7 We all know the patients are
8 sicker. Okay, great. That doesn't take away
9 the complication, and we still need to work on
10 those cases, too. So I understand. The risk
11 adjustment, in my mind, is just to make
12 clinicians comfortable with the data at the
13 end of the day, because you still have to
14 change some of those practices and see if
15 there are some things that you can eliminate.
16 You know, we have to start thinking that way.
17 Some of these things could go away.

18 DR. HALPERN: And I think the
19 other thing about tracking like the O to E
20 ratio was in living in it in a VA system,
21 there is, talking to many people around the
22 VA, the sense that, okay, I am a little afraid

1 to operate on this patient who is a little
2 sicker, because it might affect my O to E
3 ratio, and I don't think that is good for the
4 quality of patient care, and I can tell you,
5 it is a very real phenomenon.

6 DR. CIMA: Just to go back to the
7 example we started off with, and I can tell
8 you, at Mayo Clinic I sit on our three-site
9 committee. We have a site in Arizona, Florida
10 and Rochester, and at some point it does come
11 down to finance.

12 Arizona -- I mean Florida recently
13 said, you know, we participate in STS. We now
14 participate in the multi-specialty NSQIP,
15 because the state of Florida has now sort of
16 said everyone is going to do it. I said, we
17 are going to pull out of STS. We are paying
18 abstractors to do both things. We can get
19 cardiac surgery from NSQIP.

20 So now we are just going to -- Now
21 I am going to go back and say, well, that's
22 good, guys, but guess what? That is what I

1 talk about an undue burden. We should not be
2 deciding at the local level what you have to
3 do in that sense.

4 If they are participating in a
5 registry database, then they should be able to
6 give you the data from that, but what we
7 basically are saying, you can't use that data,
8 you have to use the STS data system and, yes,
9 you can provide it, but STS says you have to
10 do 100 percent of your cardiac cases. NSQIP
11 says I have to do 20 percent.

12 So now I have to go do the 80
13 percent abstraction on that, have to format it
14 their way. I have to use their coding. That
15 is inappropriate. That is picking a winner,
16 and that is not what we are supposed to do.
17 At least, that is -- As I sit here as an
18 individual, that is not what I -- Give me the
19 science, but I am not picking the winner, and
20 basically you are. NQF is.

21 DR. BURSTIN: And again, some of
22 this is because these are historical. These

1 are the only games in town. They are the only
2 ones who have submitted the measures.

3 I think I -- It was interesting.
4 After our conversation yesterday, I had a
5 conversation offline with Frank Opelka, who is
6 on our CSAC, and in some ways what you really
7 want to get to is we identify what the
8 measures are. Here is the specifications.
9 They meet criteria, and there is some cloud
10 computing that allows you to just submit
11 wherever, but the problem is it is not there
12 yet.

13 I think that is all -- We have a
14 sense that ultimately all these registries
15 will, hopefully, use harmonized endorsed
16 specifications, and then submit them however
17 they so choose, but I think that it is a great
18 concept. I don't know that we are there yet,
19 and I think we are hopeful that that is the
20 next step.

21 DR. CIMA: What do we tell the
22 institutions that have to respond to what we

1 just passed yesterday?

2 DR. BURSTIN: They don't have to
3 do anything. It is not required for public
4 reporting that you use STS.

5 DR. CIMA: No, but if it becomes
6 public reporting.

7 DR. BURSTIN: Well, I think we
8 would tell them that you don't have to, based
9 on at least what we know at this point. You
10 do not have to submit your data to STS. It is
11 burdensome. I agree with you.

12 You don't have to submit your data
13 to STS to perform those measures, just like
14 the two recent measures we passed from ACS
15 that Bruce Hall had done for CMS, two surgical
16 outcome measures based on NSQIP, and the
17 agreement was that, if CMS took those forward
18 for public reporting, you didn't have to
19 submit them via NSQIP.

20 CMS would put forward another data
21 platform for you to submit electronically, but
22 you wouldn't have to be a participant in NSQIP

1 to do that. I think that is where we are
2 going, and the question is how does that
3 proceed over time.

4 It will be interesting to see.
5 Same model as well with the ACC registry as
6 well for PCI, is that, yes, you can submit to
7 ACC. We have a PCI registry, or they will
8 also potentially have a -- you know, build an
9 alternative platform. But the sampling issue
10 is a really big harmonization issue. It is
11 the same issue we've got with SSIs, frankly,
12 between the ACS measure and HSN, the CDC
13 measure.

14 This is a -- Again, this is where
15 we look to what the science tells us. We
16 don't have a horse in this unless -- We are
17 just trying to stay very, very evidence based,
18 and the science tells us 20 percent is
19 adequate, like we know for CAPS 30 patients
20 per practice is adequate, and that is what it
21 should be.

22 Harmonization has now become, I

1 would argue, probably 50 percent of our work,
2 and it used to be probably five or 10 percent
3 when I came to NQF four years ago. It is
4 where the game is right now, because there are
5 so many competing efforts, as the stakes have
6 gotten higher. Everybody wants to be in the
7 measurement game in a way that we didn't see
8 before.

9 Do you read about some of this,
10 Steve, from where you sit as a consumer at
11 Consumer Reports?

12 MR. FINDLAY: We continue to push
13 for more outcomes measures and are very
14 focused on patient engagement and family
15 engagement measures. That is our big push
16 over the next year, joined with many other
17 consumer groups.

18 DR. SEARS: What role is
19 comparative effectiveness going to play here?

20 DR. BURSTIN: That is the second
21 question in two weeks on that. It is an
22 interesting question. Not directly, I think,

1 other than the fact that I think comparative
2 effectiveness provides a broader evidence base
3 that can be used to support measurement.
4 Beyond that, I don't know.

5 DR. SEARS: Are they subscribing
6 to databases or are they going to create their
7 own? That is the question, because if they
8 are going to create their own and it is run by
9 the Feds, it may be a solution that we are not
10 endorsing a particular database.

11 CHAIR MORRIS: Allan, did you have
12 something to add?

13 DR. SIPERSTEIN: Just to follow up
14 a little bit with what Bob said. Each of our
15 institutions spend a huge amount of time and
16 resources submitting very similar bits of data
17 to different organizations, and obviously, it
18 is a big financial and time resource doing a
19 lot of menial work, where it kind of detracts
20 the impact from really focusing on areas that
21 are important or taking on new projects, new
22 creative projects.

1 So just to -- We all suffer with
2 these multiple competing standards, and it
3 would be nice in an ideal world to have a
4 single entity to which electronic data is
5 uploaded, and then maybe analyzed in various
6 ways. But part of the problem I see with
7 multiple competing organizations -- and I know
8 in John's world there are two very head to
9 head competing bariatric databases that exist,
10 and it is very time and labor intensive to use
11 both, and institutions are picking one or the
12 other.

13 From a national impact level,
14 you've got this apples and orange comparison.
15 So you really cannot see how bariatric surgery
16 is evolving over time in this country, because
17 it really is difficult to make direct
18 comparisons.

19 So maybe just a plea to try to
20 move toward a uniform standard. It may not be
21 perfect, but the whole issue of uniformity is
22 going to really increase a lot of the

1 efficiency in terms of what we do.

2 DR. HALPERN: Or maybe one data
3 entry place from which others can then extract
4 their data.

5 DR. CIMA: Yes, that is the big
6 issue, is using the -- and if you are going to
7 go to what you were saying earlier about risk
8 adjustment, yesterday STS said, well, we risk
9 adjust if it is a re-operation. We risk
10 adjust if it is bad. But what if the risk
11 adjustment is different in the different
12 datasets?

13 So then, you know, what --
14 Institutions are supposed to say, well, my
15 internal data says this, but when we send it
16 to them, it comes out differently, because
17 their models are different. That is why I
18 would -- You know, I tell the residents and
19 staff we work with , keep it simple.

20 You want to know what your
21 mediastinal infection rate is? This is sort
22 of what John was saying. That is the

1 mediastinal infection rate. Doesn't risk
2 adjust it. Let us know what the rate is, and
3 more and more, there is a lot of data coming
4 out that is saying risk adjustment may be --
5 We are swinging too far the other way, in that
6 we need to be a little bit more cautious in
7 saying, well, they are a high risk patient.
8 If you know what your infection rate is in
9 that group of patients, then you should try
10 and lower it.

11 DR. HALPERN: I think that also
12 goes to what Terry said yesterday about what
13 is the cause of the bad outcome in individual
14 patients, and how do we learn from that,
15 rather than looking at just an overall
16 mortality rate -- our risk adjusted mortality
17 rate, which may or may not reflect the real
18 issue.

19 DR. DUTTON: I think part of the
20 emphasis on risk adjustment has to do with an
21 unintended consequence from public reporting.
22 If you only look at the data privately, if

1 your quality management data is for your own
2 quality management purposes, then you just
3 want it raw rates and trends over time, and
4 you understand what the risks are, so that you
5 don't need that over-adjustment. But when you
6 present it to the public who doesn't
7 understand all of those issues, or you compare
8 between institutions, it becomes much more
9 important.

10 CHAIR MORRIS: I was going to ask
11 what you have to say about that, because I
12 think it becomes then to educating the public.

13 MR. FINDLAY: Yes, which is just a
14 huge hill, maybe even 80 degrees. A lot of us
15 are looking forward to a meeting that AHRQ is
16 hosting on the 23rd, which is an invite-only
17 meeting, I think, just to keep it as a sort of
18 a working meeting, on public reporting,
19 tackling these questions.

20 I don't think there has been a
21 similar meeting where everyone is called
22 together to sit in a room for a day and try to

1 hash some of this stuff out. So I hope that
2 we are going to get some clarity coming out of
3 that meeting for at least a path forward. I
4 don't think we are going to get a lot of
5 answers, but I think we will get, hopefully,
6 a path forward.

7 There are six commissioned papers
8 on public reporting of health care quality
9 information, and I would urge you all,
10 obviously interested in this area, to get hold
11 of those when they come out. They should be
12 out probably right around the 23rd.

13 DR. BURSTIN: I just submitted
14 mine while we have been sitting here on
15 standardization of metrics. So, yes.

16 MR. FINDLAY: I reviewed one, and
17 it was exceptional. I think that AHRQ went
18 through some steps to identify excellent
19 people like Helen to write these things. So,
20 hopefully, there will be some galvanizing
21 around that and some coordination around that
22 conference and those papers.

1 MS. STEED: Helen, can you send us
2 -- Can we get a copy of your paper?

3 DR. BURSTIN: That's AHRQ. As
4 soon as they are done, yes, I will certainly
5 share it with you. Ours is really about the
6 benefits of standardization and where does
7 standardization allow us to go in a way that
8 we can't move if we are kind of still stuck in
9 this sort of fiefdoms of data and the fiefdoms
10 of measures.

11 MR. FINDLAY; Yes. There is a
12 huge emphasis on standardization and
13 harmonization at this meeting and how that is
14 going to happen for public reporting.

15 DR. HALPERN: When are these
16 papers going to be coming out?

17 DR. BURSTIN: I don't know yet,
18 but AHRQ will publish them on the website. So
19 we will send you the link. Yes.

20 MR. FINDLAY: They will spread it
21 around pretty fast, I think, on the 23rd.

22 DR. DUTTON: I wanted to comment

1 quickly on the data collection burden. I
2 mean, it has always been true that we can
3 afford as much quality management as we can
4 pay for, and then you can look at every -- the
5 process of administration of every individual
6 drug and every blood pressure but, obviously,
7 we don't have the money or the resources to do
8 that.

9 So there is always the decision as
10 a quality manager, how much can we afford, and
11 what can we stand to look at. But the answer
12 around the burden of collecting data: Some of
13 it will be in advancing technology.

14 The anesthesia registry that we
15 are building is entirely based on passive
16 electronic data without going through a nurse
17 abstractor or eyeballs. I think, as we become
18 more digitized in the future, that is going to
19 be a more viable model.

20 The other thing that I have seen
21 at a lot of the large institutions I have been
22 with and visited is that, faced with multiple

1 reporting burdens, the way they are dealing
2 with that is they are creating their own
3 internal repositories that gets all the data
4 in that everybody might need for any purpose
5 into one registry and then writes reports out
6 of that. So they can just hit the STS button
7 once a month, and the STS report goes off, and
8 they hit the NSQIP button, and the NSQIP
9 report goes off. But that involves,
10 obviously, organizing all your data internally
11 so you can connect it.

12 Incidentally, it is much harder to
13 aggregate at the national level, because we
14 can't collect identifiers right now. So it
15 makes much more sense to aggregate it locally
16 under the current HIPAA approach.

17 DR. ROGERS: I may make one other
18 -- or ask a question, actually. We have
19 talked for two days about the process of
20 evaluating services that have already been
21 performed. I doubt it is the charge of this
22 committee, but does the NQF spending time

1 thinking about appropriateness of care and
2 whether the service should have been actually
3 done to begin with?

4 DR. BURSTIN: Yes. It is a major
5 emphasis. What we have done, we have just
6 almost completed a very large project on
7 imaging efficiency, third rail for sure, so
8 both radiologic and cardiac imaging in
9 particular. We are now beginning to see
10 appropriateness measures and overuse measures
11 coming into pretty much every single project.

12 For those of you who -- I was
13 mentioning this to Christopher before he left.
14 Those of you who didn't see it, the Washington
15 Post today had an excellent piece on physician
16 ownership of radiation oncology for prostate
17 cancer and sort of potential conflicts,
18 really, really interesting work. MEDPAC is
19 going to come out with a report, etcetera. So
20 lots coming down the road on overuse as well.

21 DR. DUTTON: The comment about
22 maybe not doing an operation, because you are

1 concerned about your O to E ratio -- what the
2 anesthesiologist thinks of that remark is, oh,
3 good, maybe you shouldn't do that operation.

4 DR. HALPERN: The only thing I say
5 about that is, especially as a vascular
6 surgeon where we have very many sick patients,
7 some surgeries are palliative, and they need
8 to be viewed as that.

9 So if you have some guy whose foot
10 is rotting off and it is causing him a lot of
11 pain, even though he is sick, he still -- you
12 know, it is a palliative procedure.

13 CHAIR MORRIS: All right. I think
14 that that was a valuable discussion. Let's
15 see. We have an opportunity for NQF member
16 and public comment, and that is actually
17 scheduled for 2:00 p.m. Is it fair to --
18 Okay.

19 So if there is anybody on the line
20 who would like to comment now, please feel
21 free. They are just as verbose as throughout
22 the rest of the meeting. It is really quiet

1 out there.

2 I think that there are probably a
3 lot of questions about next steps and the
4 timeline for this project, and I would really
5 like for us to talk a little bit more about
6 that.

7 Several people came up to me
8 during the break and asked about what happens
9 next for us in terms of telephone meetings,
10 what are our goals, and next in person
11 meeting.

12 MS. MURPHY: And Alexis and
13 Jessica will have to help here, but one thing
14 we will get you out soonest will be a summary
15 of the information from the voting today, so
16 to get you the numbers back with the major
17 issues identified and the decisions you have
18 made. So you can just take a look at that.
19 Be sure we got it right.

20 Then we will provide you an
21 updated document on the related and competing
22 measures, and at the time we provide that to

1 you, probably would query you in terms of your
2 availability for a conference call for the
3 purpose of discussing the related and
4 competing measures in more detail, and
5 offering recommendations about going forward
6 with those.

7 Then the next activity for the
8 face to face meeting that will occur on -- May
9 4th and 5th, is it? Alexis says yes -- will
10 be that we will put together a similar set of
11 documents that you got for this meeting and
12 get those out to you, and I guess I would plan
13 that we would reconvene the work groups in the
14 way we did before, but saying that out loud,
15 I know what we need to ask, is did you find
16 the work groups useful to you in preparing for
17 the meeting and the discussions? Okay. So
18 you are open to doing the work groups for the
19 next phase. Okay.

20 So that in broad strokes, I think,
21 are the things that we will be doing between
22 now and the 4th of May.

1 Alexis or Jessica, other things
2 that you would add to that?

3 MS. FORMAN: Once we send you the
4 voting results and the conditions for the
5 measures that you would like for us to send
6 back to the measure developers, we will give
7 them about a two-three week deadline to get
8 the responses back to us, and then we will
9 provide that to you all, and we will try to do
10 it before we send you the Phase II measures,
11 so it won't get too confusing.

12 MS. MURPHY: The other thing that
13 we will be doing, given some of the
14 conversation today -- which by the way, was
15 very useful to us for the next phase and very
16 useful, I think, to NQF overall -- is that we
17 will go back to the developers whose measures
18 we will be looking at in Phase II and say you
19 might want to know that this Steering
20 Committee finds it very important that these
21 things be addressed, and give them an
22 opportunity to get that done before you see

1 them.

2 CHAIR MORRIS: Okay. Is this the
3 first NQF Steering Committee meeting that is
4 finished before the actual time?

5 MS. MURPHY: No, but pretty close.

6 DR. BURSTIN: I said joking to
7 Melinda earlier, I mean, it is just something
8 about a room full of people who do surgery.
9 It is just kind of moving on through. As a
10 flea myself, we can circle the evidence for an
11 hour before we make a decision. So way to go,
12 surgical team. Does everybody know the term
13 flea? Oh, yes. The last to jump off a dying
14 dog -- that would be me.

15 CHAIR MORRIS: Thanks again for
16 your time, your effort. Really appreciate it,
17 and everybody's willingness to play well in
18 the sandbox, and also bring forth all of your
19 ideas.

20 I would encourage anybody who
21 didn't find an opportunity to speak up quite
22 as much as some others to -- Definitely, your

1 ideas, your thoughts are very much valued by
2 the group. So please feel free to contribute
3 as you see fit.

4 DR. ROGERS: I have done this
5 personally,. but I would like to publicly
6 compliment Arden on her superb leadership
7 capability.

8 MS. STEED: And the fact that you
9 had to do it solo.

10 CHAIR MORRIS: They say a
11 benevolent dictatorship is the most efficient
12 form of government.

13 (Whereupon, the foregoing matter
14 went off the record at 1:33 p.m.)

15 - - -

16

17

18

19

20

21

22

A				
AAOS 125:5,9,20 141:7	46:22 52:11	addressed 52:18 53:5 131:9 142:8 220:21	215:13,15	altogether 132:15 144:8
abdominal 103:21	accountable 24:14 34:18 42:5 52:13 52:13	addressing 22:22 128:12 129:3	aggressive 138:19	ambulatory 135:20
able 31:17 34:22 37:14 44:3 47:11 52:7 74:13 90:22 96:1 117:15,15,19 157:4 174:6,11 179:20 181:13 202:5	accounted 31:15	adequate 52:5 116:8 205:19,20	ago 48:9 85:10 175:3 180:19 189:8 190:3 195:7 206:3	America 96:3
abscess 62:17	ACCP 116:17 118:19 119:5,9,10 126:2 139:5 140:7 141:19	adherence 68:22	agree 27:21 44:14 79:5 80:7 86:18 91:4 99:2 105:2 126:5 136:13 156:22 162:19 204:11	American 2:4 56:8 56:15 57:14 58:9 86:11,12 105:1,6 107:4 120:7 122:14
absolute 18:16	accreditation 72:8	adherent 139:19,21 140:1	agreed 103:7	AMI 181:22
abstained 98:13	accurate 51:18	Adjourn 3:22	agreement 204:17	amount 29:12 108:4 176:17 207:15
abstaining 55:10	achieve 74:11 119:11	adjust 78:18 198:9 209:9,10 210:2	agrees 120:3	analyses 13:10
abstains 144:16	acknowledged 144:1	adjusted 210:16	AHA 20:16	analysis 31:20 131:19 157:19,20 197:18
abstract 123:3	acquire 53:8	adjustment 64:18 162:6 200:11 209:8,11 210:4,20	ahead 11:9 14:9 16:17 21:17 23:5 47:21 50:9 66:14 70:20,21 71:6 115:1 132:3 142:20 149:10 156:4 168:7 193:20	analyzed 18:11 208:5
abstraction 75:6 116:15 117:5,22 127:12 141:19 173:2,4 202:13	acronym 151:13	administered 101:17 102:16	AHRQ 161:11 162:1 186:20 211:15 212:17 213:3,18	analyzing 30:19
abstractor 117:18 123:1 214:17	ACS 204:14 205:12	administering 110:5	alarms 168:12	anastomosis 60:14
abstractors 90:22 94:16 99:12 116:21 117:8 131:13 173:18 201:18	Act 20:15 188:19	administration 145:9 146:3,13 214:5	Alexis 2:9 218:12 219:9 220:1	and/or 55:20
abstracts 122:18	action 192:14 195:1,2	admission 35:19 38:22 48:6	algorithm 84:4 87:16 122:19 123:5 137:20 173:17 198:8	anecdotal 61:4
academic 41:14	active 62:19	advancing 214:13	algorithms 133:12	anesthesia 1:17 82:7 124:11,12,14 147:18 193:21 214:14
Academy 56:8 105:1,6 107:4 120:7	actively 153:18	advantage 25:18 32:15 199:20	alima 20:9	anesthesiologist 217:2
ACC 205:5,7	activity 178:13 219:7	affect 93:19 201:2	Allan 2:1 98:21 207:11	Anesthetists 2:5
accept 109:2	actual 140:5,18 145:8,22 146:2 191:17 221:4	afford 214:3,10	allergic 12:3 18:16	annually 8:18
acceptability 10:1 14:15 18:2 21:22 50:11 66:19 97:4 143:5	ad 141:1	Affordable 188:19	allow 20:3 109:1 172:14 213:7	answer 8:1 11:22 13:12 19:15 57:10 69:18 148:15 177:19 197:9 214:11
acceptable 15:11 82:21 109:4 139:7 173:13	ADA 86:13	afraid 200:22	allows 203:10	answers 212:5
accepted 8:21	add 10:18 30:7 32:2 59:17 61:11 66:1 67:18 76:12 98:9,21 128:17 152:13 158:22 162:18 178:6 207:12 220:2	age 8:11 25:5 27:8 27:13 30:15 34:13 55:17	alter 142:16	Anthony's 1:22
accomplish 20:2	adding 27:3 44:16	agency 162:17	alternative 12:17 15:12 105:11 205:9	anti 6:4
account 83:14	addition 121:1	agenda 3:2 11:9 166:1 168:11		antibiotic 79:19 126:8
accountability 34:17 42:14 46:16	additional 25:15 118:22 128:14	agendas 125:6		antibiotics 62:20 74:20 92:2 94:11
	address 11:17 35:8 106:5 128:13 172:10 176:6 186:16	agents 6:5 17:3 63:5 69:4,5		anticipate 19:16
		aggregate 76:3		anti-coagulant 123:17
				anti-coagulated

111:10	appropriate 7:17 7:18 42:10 100:18 102:4 105:18 107:1 116:4,6,14 117:1 126:9 141:21 147:16 149:3,7	asking 160:21 178:9 188:9	87:17	133:17 135:9,22 208:9,15
anti-lipid 16:8 17:8 40:13 69:5	appropriately 101:16	aspects 59:4	avoid 98:5 121:17	base 207:2
anti-lipids 6:4	appropriateness 122:9 148:1 216:1 216:10	aspirin 9:15,19 12:3,3,9,15 15:10 70:5 116:8 118:10 180:21 182:8	aware 59:6 133:3	based 7:6 20:16 22:16 60:16 88:5 88:18 92:19 93:15 93:22 94:3 104:22 106:8 116:17,22 119:16 122:13,20 126:1 151:9 166:17 188:6,11 193:12 204:8,16 205:17 214:15
anti-platelet 8:4,7 8:13,20 68:11 69:4 105:10 109:2	approved 56:13	assess 101:15 167:17	A-F-T-E-R-N-O-... 156:1	basic 117:19
anxiety 112:7	approving 117:13	assessed 33:3 64:12 72:15 150:5	a.m 1:10 4:2 71:3,4 73:17 74:2 75:4,8 75:8,9,10 76:15 76:17 77:12 78:16 83:20 86:19 90:11 90:20 91:12 92:6 95:11 96:9,11,14 96:18 99:8 155:17 188:5	basically 81:3 93:8 102:10 103:19 113:3 114:8 122:18 123:12 131:19 155:13 156:12 157:8 168:18 202:7,20
anxious 184:10	Approximately 7:20	assessment 46:20 73:3	A1c 81:19 82:21 83:4	basis 33:3
anybody 10:18,19 13:17 16:1,2 21:3 22:12 25:8,13 33:11 40:22 53:11 59:1 67:18 86:8 98:9,20 144:12 146:4 149:8,18 152:13 155:10 195:16 217:19 221:20	Arden 1:10,13 154:17 162:14 222:6	assign 69:17	<hr/> B <hr/>	battery 51:3,4,5
anymore 92:5 115:12	arbitrarily 77:4 94:12	assignment 84:7	back 20:21 27:7 41:12 47:7 54:5 71:1,4 73:11 79:9 82:4 86:7 89:6,15 89:16 90:8 93:20 94:18 95:11 96:8 98:19 100:5 141:2 141:3 165:4 171:4 171:20 174:2,18 177:2,16 188:9 191:19 197:19 201:6,21 218:16 220:6,8,17	BAUS 92:14,18 93:2,6
anytime 141:3	arbitrariness 95:6	assist 127:3	backed 151:15 182:14	bedside 124:5
anyway 91:18 132:12 175:13	arbitrary 76:17 78:9 80:3,6 81:5 82:12 83:13 86:20 88:5 90:21 94:6 94:10,14,21,22 96:16	associated 5:10 17:21 66:4 71:17 106:7 181:2 189:5	background 116:8 154:7 175:5	beg 163:15
apologize 164:5	Arden 1:10,13 154:17 162:14 222:6	association 2:4 85:20	back-of-the-enve... 183:6	beginning 138:5 178:20 181:22 216:9
apparent 60:16	area 160:13 171:12 172:4 212:10	assure 89:4	bad 169:21 209:10 210:13	begins 150:22
apparently 59:7	areas 108:5 166:13 207:20	attempt 69:17 83:8 96:17 103:3	balance 107:18 174:2	begun 179:14
appear 35:10	arenas 180:12	attendant 172:17	banding 137:3	behavior 162:21,22 172:19 192:13
appears 39:7	argue 206:1	attended 191:14	bands 131:17	believe 7:5 17:11 17:14 23:14,22 24:7,18 27:16 42:13 44:12 49:11 58:14 89:5 90:4 119:5 120:3 156:21 157:18 187:18
appendix 112:19 130:2	argued 88:20	attending 41:18	bariatric 120:19 128:18 129:22 130:7,10,17,21 131:6,17 132:5	benefit 27:11 31:2 31:4,10,13 32:4 35:2 84:1 136:11
apples 75:13 76:11 208:14	Arizona 201:9,12	attendings 41:17		benefits 27:15,16
application 14:1	arose 13:21 15:5	attention 4:10 34:5 169:6 191:1		
applied 15:17,19 15:21 83:16 159:14	arrival 180:22 182:8	attribute 29:20		
applies 37:12	arteries 66:12	attributed 38:1		
apply 97:19	artery 9:2 157:14	Attributing 42:6		
appreciate 221:16	articulated 174:4	attribution 29:4,19 34:6,16 37:21 41:12,12 43:10,15 46:16 47:5 52:11		
appreciated 121:6	aside 112:6	authors 54:6		
approach 44:10 61:20 133:8 160:16 170:6 215:16	asked 19:21 127:22 163:22 184:15 218:8	automatically 124:15		
approached 178:7		availability 26:1,8 219:2		
approaching 20:13		available 25:13 26:3 121:2,5 173:9 188:18		
		Avenue 1:10		
		average 64:7 87:8		

33:6 213:6	107:21 108:2,9,21	155:11 157:10	184:6 186:17	63:21 81:6 87:3
benevolent 222:11	109:9,10 123:9,18	176:16 195:16,20	188:15 193:7	87:15 88:1 166:2
best 46:19 47:4	124:1,3,7,20	196:1,2 221:18	202:21 204:2,7	captured 34:13
73:3 75:17 111:18	139:1 140:14	bringing 163:10	206:20 212:13	35:3,17,21
121:16 162:8	bleeds 130:22	194:7	213:3,17 216:4	capturing 15:21
197:22 198:14	blockade 69:3,4	broad 103:21	221:6	62:6
beta 69:3,4 180:22	blockers 180:22	219:20	Burstin's 54:11	car 82:14
better 28:22 29:21	blood 78:19 79:7	broader 207:2	butter 180:21	card 178:1
46:4,8 54:17	81:9,17 84:19	brought 51:11	button 50:21 143:1	cardiac 7:9,11
77:11 81:8 83:1	85:4 86:19 88:1	105:15 121:11	215:6,8	20:19 36:9 61:17
94:7 97:18 99:3	88:10,13 89:22	166:21,22 177:15	buttons 50:7	66:9 71:10,14
104:11 107:13	90:5,18 92:9	187:8	bye 108:1	72:1 74:22 77:8
138:22 144:5	96:13 99:3 100:7	Bruce 204:15	bypass 8:22 114:19	80:13,18 85:18,22
162:7 185:21	172:12,15 214:6	build 205:8	137:8	87:2 88:8 104:1
190:14	bloody 112:11	building 214:15	bypasses 129:8	134:5 157:13
beyond 21:10	Blue 2:3	built 167:7 185:4		158:10,13 159:18
45:18 94:11 148:8	BMI 115:2	bumper 112:4	C	159:19 160:4
150:22 179:12	Bob 72:22 207:14	bunch 87:15	CABG 8:12 10:8	196:14 201:19
189:3 207:4	body 20:16 177:6	bundle 106:8 178:2	17:3,8 20:13	202:10 216:8
bias 32:6 41:12	bone 55:20 108:5	bundling 42:5	23:12,17,18 25:2	Cardiac-CABG
54:22	bother 84:11	188:1	38:22 48:5 55:18	3:5
big 33:22 51:16	bothers 76:18	burden 5:8 35:5	68:15 78:17 83:17	cardiologists 48:13
100:8 104:17	112:1	53:10 87:12,21	84:18 197:14,16	cardiovascular
113:7 160:6,7	Bratzler 2:14 6:18	90:14 91:6,10,21	CABGs 30:21	79:15 180:18
189:5 205:10	6:20 85:12 89:19	92:5 94:15 99:12	calculate 87:16,16	183:4 187:7
206:15 207:18	90:3,15 94:9	154:10 189:5	calculated 93:8	care 1:22 8:22 9:11
209:5	99:19 122:2	191:21 196:19,22	calculates 122:20	14:1 17:12 24:19
bigger 115:7,7,10	129:21 130:9	198:1 202:1 214:1	123:5	33:2 42:5 45:7
151:9	132:17 134:3,17	214:12	calculation 84:4	52:8 76:16 82:5
biggest 44:15 56:22	135:14 136:20	burdens 215:1	137:20 183:6	82:11 97:19
58:4 157:22 173:1	137:1,13 138:1,12	burdensome	calendar 132:22	111:22 133:6
192:2	140:2 141:5	198:12 204:11	134:20 135:7	166:3 176:2 177:8
bird's 157:8	146:15 148:21	burned 137:9	138:2	181:10 182:22
bit 4:21 33:15 52:1	149:21 151:3	burner 154:5	call 72:17 73:9	185:15 186:14
62:3 93:5 99:20	152:15	184:11	89:10 106:1 110:9	188:19 191:1,4
106:17 109:6	bread 180:20	burning 146:5	122:10 129:22	192:11,12,16,18
121:19 122:4	break 51:2 70:22	BURSTIN 2:8	145:17 219:2	194:12,14 201:4
138:22 165:22	155:12 218:8	25:12 45:12 57:1	called 211:21	212:8 216:1
168:12,18 187:16	brief 113:4 143:19	57:8 58:13 95:13	calling 139:1	carefully 129:1
188:20 200:4	174:5	99:15 110:22	calls 101:8	166:13
207:14 210:6	briefly 4:6 22:13	118:18 140:21	cancer 102:21	care,improving
218:5	bring 13:17 16:1	146:7 150:9	216:17	33:2
bits 207:16	20:21 21:3 22:13	151:21 153:17	candidate 3:5 5:16	Carl 1:19
bladders 114:9	40:22 53:12 58:12	159:2 160:2,7,14	capability 222:7	CAROL 2:3
blank 90:7,7	59:1 96:8 98:19	161:1,18 165:2	CAPS 205:19	Carolina 2:2 58:1
bleed 108:2	114:12 121:21	167:3 178:14	capture 7:21 25:6	Carol's 27:21
bleeding 107:19,20	141:2 144:12	181:20 183:3	39:3 52:5,5 55:5	28:14 29:13

Carpenter 1:14 106:17,19 112:1 119:4 120:9 124:18 125:6 132:8 138:6,15 141:14 159:10 164:18 172:21	centimeter 114:5 central 195:5 certain 29:8 66:9 80:16 83:5 87:10 94:14 105:5,19 106:14 107:20 135:17 163:17 195:8 199:8	challenge 173:1 198:22 199:4 challenging 188:13 chance 10:20 65:3 134:7 165:17 CHANDLER 2:8 change 51:2 76:22 112:14 141:12,12 162:21 192:13,21 194:17,18,19 200:14	117:20 119:10 131:11 135:1 150:1,6 159:12 160:5,11 174:17 176:13 195:20 196:11 201:6 203:21 204:5 209:5	72:19 80:9,20 86:12,12 89:1,5 95:9 96:17 105:19 135:9 162:6 166:17 167:14 172:9 191:18 192:1,6
carry 129:12 case 6:9 31:3 58:7 61:4 73:21 75:2 89:5 90:8 114:7 115:12 124:9,14 125:1 127:6,6 140:3,5,18 177:14	certainly 33:15 76:4 80:20 98:8 103:11 110:11 119:1 121:22 165:4 172:6 193:21 213:4	changed 21:15 120:15 172:7 192:14,16 194:21 changes 59:22 141:1 186:1 192:17	circle 221:10 cited 191:7 claim 23:15,22 claims 24:15 25:14 25:22 28:1,2,6,12 32:16,18 35:7 38:14 39:4 51:22 52:18,19,22 53:3 53:6,7 167:10	clinically 73:14 74:3 95:10 186:2 clinician 47:1 72:20 124:5 clinicians 74:5 188:14 200:12 close 98:15 108:6 146:10 149:4 187:9 221:5
cases 21:13 64:6 73:19 81:22 82:1 83:13 90:4 92:7 102:16 108:13 113:8,9 115:8,11 126:15,20,22 127:11 128:18 129:7,17,19 130:14 131:10,17 133:15 144:6 177:10 200:10 202:10	cessation 152:1,4 Chair 1:10,13 4:3 6:7 8:2 10:17 13:5,16 14:7 16:16 18:3 21:2 25:7 32:1 33:10 34:10 36:12,17 37:1 39:5,12 40:17,21 42:13 45:11 47:15,21 49:4 50:1 54:9 55:6 58:22 60:11 65:22 66:13 68:3 70:19 71:5 85:6 92:10,16,21 93:4 94:1 95:4 96:19 100:15 101:11,20 106:16 110:2,18 111:5 112:17 119:19 128:16,20 136:17 137:15 139:16 142:19 145:10,19 146:4 148:14 149:8 150:4 152:8 155:8 156:3 158:9 161:3 163:9,22 165:18 168:10 182:11 183:17 190:20 192:8 194:11 195:15 207:11 211:10 217:13 221:2,15 222:10	charge 215:21 chart 51:22 90:6,22 154:11 charts 39:18,19 cheap 53:8 check 13:11 checks 74:13 check-box 152:2 Chest 105:1,14 107:6,12 122:14 choose 78:1 188:18 188:22 199:19 203:17 choosing 190:9 chose 90:20 chosen 88:19 Christine 2:4 151:5 Christopher 1:23 216:13 chronically 78:14 Cima 1:14 28:13 43:2 74:16 78:14 79:18 82:18 90:10 94:2 96:9 98:10 100:17 101:13 102:2 110:2,6,21 111:3,7 113:1,20 115:13 116:15	clarification 10:9 146:8 clarified 98:3 clarify 39:5 clarifying 50:2 clarity 212:2 classically 77:19 clean 116:10 cleaner 30:6 clear 6:19 30:12 45:13 55:22 70:12 93:21 95:22 102:19 103:19 104:3 106:7 112:4 116:13 117:8 138:4 172:1 175:22 185:6 189:6 190:7 193:9 196:10	closed 90:12 closely 86:22 closer 109:21 162:3 191:17 closest 79:7 90:18 96:12 closure 90:18 94:12 97:22 clot 136:7,10,12 clotting 107:19 cloud 203:9 CMS 6:16,19,22 9:4 63:11,18 71:8 72:5 93:7 99:16 139:5 144:1,2 150:16 151:18 152:4 181:20 184:15 187:8 188:5,10 190:14 204:15,17,20
catastrophic 66:8 categories 20:14 category 84:7 153:6,12 caught 178:11 cause 102:21 210:13 causing 217:10 cautious 146:17 210:6 caveat 106:12 CDC 56:7 57:1,12 57:14,21 58:2,9 59:4,11,20 60:5 63:12,19 67:9,9 205:12 CDC's 56:17,20 63:14 Center 1:17,19,21 1:23 centers 41:14		Christian 2:4 151:5 Christopher 1:23 216:13 chronically 78:14 Cima 1:14 28:13 43:2 74:16 78:14 79:18 82:18 90:10 94:2 96:9 98:10 100:17 101:13 102:2 110:2,6,21 111:3,7 113:1,20 115:13 116:15	clearly 10:1 27:13 48:7 73:20 80:8 80:20 82:18 106:3 114:20 117:9 121:14,17 123:14 146:9 160:4 180:4 182:1 188:1 Cleveland 2:1 Clinic 1:14 2:1 201:8 clinical 28:8,10	code 23:19 38:7,7 38:15 40:2,7,8,8 40:10,12 173:6 codes 41:22 42:2 126:12 136:19 137:2,6,10 coding 202:14 coffee 18:6 colectomies 135:12 colectomy 114:5 colleague 146:16

colleagues 88:7 123:11	184:11 186:10 210:3 212:2	108:4 165:11	139:19	219:2
collect 96:1 198:7 215:14	213:16 216:11,20	community 110:16 130:22	complication 66:8 200:6,9	confirm 110:3
collected 90:5 136:19	comment 3:16,20 21:5 23:14 27:20	company 23:13	complications 138:20	conflicts 216:17
collecting 214:12	44:6 47:19 53:15 54:10,11 56:5	comparability 116:11	compliment 222:6	confounders 28:17
collection 44:3 87:12,21 89:20	63:10 79:4 82:6 92:20 94:5 95:19	comparative 206:19 207:1	comply 163:17	confused 95:20 129:6
94:15 100:6 127:4 133:11 198:18	111:21 113:12 115:20 142:13	compare 211:7	component 10:8 69:15 177:8	confusing 220:11
199:5 214:1	150:18 152:10,12 152:16 154:18	compared 51:13,14	components 187:19	connect 215:11
College 56:16 57:14 58:9 122:14	155:6 163:8 165:2 165:9,14 172:6,22	comparing 51:22 75:13 76:6,10	composite 10:8,11 11:1,20 15:13	Connecticut 1:10
Collins 1:15 16:7,9 16:10,21 23:8	182:14 185:8 188:7,12 189:2	comparison 39:17 208:14	64:3 68:14,15,17 68:19 93:9,9	CONNIE 2:2
49:5,11	191:15 213:22 216:21 217:16,20	comparisons 208:18	176:21 177:11 186:8,10,12,15,18	cons 116:9
colon 62:18	comments 10:19 17:11 18:1,3	competing 3:18 16:20 23:1 49:8	187:5,7,11	conscience 189:15
colonopy 60:14	24:11,19 25:8 45:12 49:5 66:14	49:12,17 67:7 156:5,8,10,13	composites 186:20 186:22	consecutive 88:8
colorectal 60:13	68:9 73:4 76:13 79:6 85:14 96:20	165:19 167:20 168:1 206:5 208:2	comprehensive 161:8	consensus 136:14 188:17
column 157:16,21 157:22	119:19 157:9 170:1	208:7,9 218:21 219:4	compromise 87:13	consequence 108:8 210:21
columns 156:11	commercial 30:16 31:6	competition 199:18	computer 91:17	consequences 98:1 107:21 108:18
combination 105:9 117:3	Commission 72:9 151:18 183:19,21	complete 32:17 89:20 90:9 109:22	computing 203:10	189:17
combine 157:3 161:16,21	192:3	168:8	concept 6:1 94:18 203:18	consider 12:6 57:5 58:2 94:20 96:8
combined 167:14	commissioned 212:7	completed 216:6	concepts 46:4	109:9 159:6
come 20:3 65:1 73:11 81:18 82:20	committee 1:4,9 4:5,8 46:15 97:17	completely 14:18 14:21 15:2 22:1,5	concern 27:19 29:3 29:19 33:6 34:1	164:22 165:5,17
89:16 109:21 120:1 135:15	98:16 99:17 118:2 121:7 150:19	22:8 48:1,8,22 49:17 50:12,16	37:4 38:4 51:16 73:5 76:7 77:16	167:4 192:4
139:6 141:3,11 165:4 170:3	152:17 165:16 166:12 180:18	51:5 53:6 59:22 63:7 66:20 67:1,4	96:15 97:22 126:20 130:21	consideration 3:5 76:2 164:13 180:9
176:15 186:22 188:9 190:21	183:4 186:19 189:9,14 191:16	79:14 97:5,9,11 116:17 124:4	139:3	considerations 188:10
194:3,6 201:10 212:11 216:19	201:9 215:22 220:20 221:3	126:5 132:11 141:20 143:7,10	concerned 20:9 43:1 123:19 124:6	considered 7:3 57:12 58:18 62:6
comes 46:15 54:4 75:2 95:11 118:14	committees 180:10 189:21	143:13	124:19,21 125:12 127:17 140:14	70:7 102:10 109:8
128:5 154:8 162:22 178:5	common 107:11	complex 161:20 173:4 198:5	217:1	114:3 118:4 124:3
209:16		compliance 17:13 39:10,15 45:15	concerns 29:11 99:16 127:18	156:13 166:8
comfortable 200:12		53:19 139:4,14 146:1 148:19	143:21,22 144:4	considering 127:20 171:10
coming 27:7 36:6 155:1 174:19		compliant 138:11	concrete 169:8	considers 58:2
			conditions 220:4	consistency 94:16 144:9 169:1,10
			conduct 57:21	consistent 60:1,4 122:22 123:6
			conference 101:8 156:19 212:22	consistently 51:1 96:2 109:19
				consortium 199:3
				constitutes 106:13
				consumer 206:10 206:11,17

consumers 1:18 10:2	conversation 56:3 112:13 123:7 134:5 137:18 147:9 148:13 171:21 203:4,5 220:14	145:11 159:4,22 160:8	crowbar 163:14 crowbars 163:16 CSAC 153:19 203:6	133:10,11 136:6 140:18 151:12 167:14,14,15 175:9,10 176:15 176:17 186:9 196:12 197:6,17 198:18 199:4 200:12 202:6,7,8 204:10,12,20 207:16 208:4 209:2,4,15 210:3 210:22 211:1 213:9 214:1,12,16 215:3,10
contemplating 127:9	conversations 147:21 167:19	coverage 24:7,7 52:7	curious 60:12 84:12	database 13:3 23:16 24:2 28:7 28:12 30:16 31:18 31:20 37:5,14 55:3,5 158:12,15 199:7,17 202:5 207:10
context 196:2	convince 150:16	covered 27:10 29:13 43:5 112:20 146:12 160:20	current 86:10 88:22 215:16	databases 5:10 31:22 198:22 207:6 208:9
continuation 128:3 148:5	convinced 54:1 153:3	covers 164:14	currently 7:4,13,21 8:21 9:4 137:14 151:11 176:16	dataset 25:17 27:14 133:19
continue 4:11 5:7 21:1 54:6 94:11 95:5 115:1 147:10 151:22 163:10 186:3,4 206:12	coordination 212:21	CPT-2 40:7	CURTIS 1:15	datasets 209:12
continued 152:4 161:3 178:8	copy 213:2	crack 154:11	culp 179:22	date 58:15 134:18
continues 34:4	core 6:22 191:2,2	create 199:20 207:6,8	customers 37:10	Dave 20:11 47:18 59:16
continuing 27:12 101:19 102:7 128:7 135:20	coronary 9:1	created 91:12	cut 176:5 181:16,17	David 2:15 10:22 11:5,19 13:14 61:1,10
continuous 82:10 82:17	correct 14:6 45:1 45:20 48:19 85:7 89:12 90:3 133:8 138:12 148:17 151:5 169:3 189:16	creating 215:2	cutoff 88:9	day 3:3 4:4,13 47:3 59:9 60:10,19 61:6 71:22 73:13 74:6,7 75:2 81:7 83:17 84:6,6 87:18 90:21 95:2 128:4,4 135:11,11 135:13 199:15 200:13 211:22
contractor 6:21 71:8	corrected 134:4	creative 207:22	C-O-N-T-E-N-T-S 3:1	days 23:17,18 24:5 35:19 36:4 38:21 55:18 56:19 57:9 60:16,20 79:10 88:11 94:22 112:1
contractors 144:1	correction 41:3 136:20	credit 69:8	<hr/> D <hr/>	
contraindicated 9:16,20 15:11 17:9 19:14	correctly 190:12	criteria 9:19 12:8 14:11,15,20 15:1 15:4 16:5 21:18 21:22 22:4,6,10 23:4 50:3,10,15 50:19 51:9 55:8 66:15,18,22 67:3 67:20 70:4 73:17 97:1,4,8,10,14 98:12 104:22 105:2,12 107:2 110:13 113:21 137:18 142:21 143:5,7,9,12,16 144:14 149:11,16 154:1 164:4,8 169:19 173:2,3,12 173:14 183:21 185:19 190:5 203:9	Dale 2:14 6:19 85:7 89:12 96:7 98:4 99:15 138:10 149:19 150:16 152:14 184:6 190:11 191:8	
contraindicated/... 40:13	correlation 28:8	criticism 150:11,13 181:11 199:8	Dale's 182:13	
contraindication 124:12	cost 5:8 24:20 35:4 53:9 167:14 181:2	critical 103:1 111:22	data 7:21 13:11 17:21 23:22 25:11 25:14 26:1,2,7 27:4,8 28:2 29:12 30:4 32:6,8,12,13 32:17,18 37:11 38:14 39:18 42:6 51:13 52:1,18 53:4,6,7 60:17 63:12 64:8 75:16 76:6 81:11 82:16 87:11,21 88:1 89:3,7,8,10,20 90:7,9,14 91:10 91:21 92:5 94:15 96:2 99:12 103:14 104:10 105:5 117:21 127:1,4,10 129:11 130:11,13	
contraindications 12:8 18:16 70:5	coumadin 110:10 110:14 111:8,14 119:7	critically 75:19 80:10		
contribute 222:2	count 12:13,14,20 57:17 118:17,17 119:1 123:20	criticisms 170:3		
control 29:9 43:4 46:11 48:8,10 52:14 76:3 79:16 80:4,5 81:4 82:8 82:17 86:9 88:2 91:4 95:15	country 208:16	criticizing 111:17		
controlled 7:10 71:11,14,21 77:2 81:13,19 85:4	couple 4:12 11:16 35:6 61:3 68:3 86:5 122:6 125:7 126:4 130:6 151:4 172:12 178:15	Cross-Blue 2:3		
controlling 79:13	course 20:18 49:16 98:5 119:21 160:8 162:11	cross-sectional 194:13		
controversies 57:13 58:4	cover 132:6 145:7			
controversy 189:11				
conundrum 193:2				

132:22 134:15,20 135:2,7 138:3 215:19 DC 23:18 DCRI 13:14 19:2 de 167:7 dead 108:7 deadline 220:7 deal 28:9 35:7 53:3 53:6 171:2 dealing 170:16 215:1 dealt 52:16 death 115:21,22 134:1,6 deaths 131:6 debate 75:20 decade 177:4 decided 150:12 decides 42:21 deciding 202:2 decision 34:3 82:13 96:5 185:6 214:9 221:11 decisions 218:17 deep 6:6 55:12,19 63:15 65:11 default 174:13 deficient 90:1 define 38:3 123:22 142:15 defined 120:13 134:6 184:2 definitely 17:20 19:14 40:9 155:3 221:22 definition 56:16,17 56:18 58:5,16 59:5,21 60:5 63:14 67:9,10 111:6 116:5,10,13 127:2 144:5 definitions 56:9,12 67:10,12 degrees 211:14 delivered 45:8 delivery 32:11	demand 19:8,8 demonstrate 194:20 demonstrated 65:21 DENNIS 1:22 denominator 13:8 15:22 17:7 40:11 56:1 71:22 84:22 103:18 126:13 127:7 129:18 130:1 133:13 134:12 135:4 137:6,14 145:6 departure 97:20 dependent 38:9 depending 31:8,8 31:11 32:20 147:17 depends 31:7 depth 156:17 157:11 derived 51:22 describe 92:22 93:4 145:11 described 65:16 77:20 description 8:10 118:16 142:14 design 72:20 86:20 designed 73:7 75:5 76:9 78:21 83:8 83:14 96:15 107:14,18 126:10 desire 22:18 Despite 9:7 detail 116:18,20 121:1,4 142:17 219:4 details 116:16 135:4 141:9 163:21 determine 48:11 95:6 139:4 determining 139:11 detracts 207:19	devastating 67:17 develop 55:19 168:18 developed 6:9 80:14 85:9 120:16 123:21 148:20 167:9 181:21 developer 10:20 157:2 158:8 165:3 developers 5:15 119:2 157:1 161:15 169:5 174:8 178:10,22 180:4 191:7,20 220:6,17 developing 56:19 development 166:14 186:15 193:17 devices 91:17 105:11 diabetes 71:18,19 81:19 83:3 diabetics 82:20 diagnostic 114:8 dictatorship 222:11 die 112:11 134:9 died 85:2 differ 105:20 108:22 146:4 difference 23:21 25:19,20 26:10 34:1 36:5 44:7 56:22 67:8 75:1 78:11,13 79:3 80:5 104:18 106:2 107:3 119:14 129:18 149:5 157:17 158:1 162:16 184:18 differences 20:7 59:4,20 109:13 141:17 158:2,5,7 163:5 164:15 different 26:5,7,7 26:10 33:11 34:11	35:11 39:7 41:7 46:1,4 48:1,22 49:2,9 51:19 67:13 93:16 103:16 105:9 107:9 120:11 121:4,12 124:2 136:13 137:19,22 179:15 185:9 188:4,10 196:14 207:17 209:11,11 209:17 differently 106:15 209:16 differing 97:21 differs 56:18 difficult 46:17 73:10 175:19 208:17 difficulty 11:4 dig 165:21 digitized 214:18 DILLON 1:16 76:20 77:13 78:8 113:12 115:17 139:9 142:5 181:12 186:6 187:17 198:21 dime 162:11 direct 208:17 directed 170:4 direction 165:13 182:2 188:4 directly 206:22 disagree 98:20 disagreements 189:7 discharge 6:5 8:5,8 8:21 16:8 17:7 23:19 24:13 35:19 45:22 48:15 68:12 69:4 128:4 discharged 8:13 128:8 discharges 138:5 discipline 160:10 disciplines 159:4	193:22 disconnect 27:6 discontinued 92:3 discrepancy 39:21 discuss 6:3 16:2 25:1 100:1 116:18 145:18,20 156:7 161:14 discussed 17:2 52:2 71:7 102:20 123:10 125:5 148:3 159:8 180:12 discussing 147:21 153:18 163:12 164:17 219:3 discussion 7:22 9:13 10:16 17:19 49:6,21 56:2 67:6 72:16 101:3 103:5 104:21 105:16,16 106:4 116:7 119:21 122:3 128:17 143:17 144:3 145:2,3,12 149:15 150:15 152:14 153:19 156:15,17 157:6 157:12 158:18 161:8 164:22 165:19 168:13 181:5 190:22 196:3 217:14 discussions 16:15 168:20 179:9 219:17 disease 9:2 125:14 dismissal 43:7 disparities 4:21 9:11 13:22 15:10 17:12 24:19 32:8 34:21 35:1 52:8 72:14 106:10 147:5 191:1 disparity 147:6 displays 156:12 distal 146:12
--	---	--	--	--

distribution 64:11 64:16 69:13	14:6 16:7,9,10,21 18:5 19:1 20:11	131:11 132:1,8,17 134:3,17 135:1,14	160:12 195:14	178:1
doable 198:4	23:8 25:10,12,15	135:15 136:5,18	drop 24:6	effectiveness 206:19 207:2
doctor 42:9	27:20 28:13 30:14	136:20 137:1,7,11	drug 12:17 26:11 44:3 46:7 214:6	efficacy 65:21
doctors 41:21	30:22 31:6 32:1,3	137:13 138:1,6,12	drugs 26:19,20	efficiency 209:1 216:7
document 70:13 109:11 111:15	32:9 33:5 36:1,2	138:15 139:9	due 116:1 131:7	efficient 222:11
124:6,22 140:13	36:15,18 37:3	140:2,21 141:5,14	Dutton 1:17 18:5 32:1,3 42:3 54:21	effort 4:9 58:15 221:16
174:10,13 218:21	39:9,13 40:1,6,10	142:5,11 146:7,15	61:16 82:6 91:9	efforts 206:5
documentation 70:16 112:19	40:15,20 41:2,6	148:21 149:21	177:19 183:18	EHRs 72:10
documented 102:14 103:17	41:11,20 42:3	150:1,6,9 151:3	191:15 195:4	eight 32:19 51:5 75:3
110:7	43:2,14 44:5,14	151:21 152:15	210:19 213:22	Eighteen 14:18
documenting 110:11	45:12 47:17,22	153:17 154:17	216:21	EILEEN 1:20
documents 14:3 121:8 173:7,8	48:20,21 49:5,11	159:2,10,12 160:2	DVT 107:7,14 125:11,14,17	either 5:4 19:8 23:17 24:1 26:15
219:11	53:14 54:10,20,21	160:5,7,11,14,19	128:10,12 133:5	84:6 89:7 113:10
dog 221:14	57:1,8,15 58:13	161:1,18 162:14	136:3	134:8 147:15
doing 29:18 44:11 63:1,14 66:10	59:3,16 61:1,12	163:20 164:18	dying 221:13	199:1
74:21 94:16 99:7	61:16 62:2,16	165:2 167:3	D.C 1:10	elect 34:18
99:13 101:8	63:21 64:1 65:5	169:20 171:13	<hr/> E <hr/>	elective 81:22
132:18 156:21	65:22 66:2,7	172:5,21 174:17	E 200:4,19 201:2 217:1	electronic 39:18 154:13 167:5
167:8 171:5,15	67:22 68:2,6,8,19	175:15,22 176:13	earlier 4:19 148:3 167:11 175:11	208:4 214:16
172:8 174:21	69:20 70:1,2,8,9	177:19 178:14	200:1 209:7 221:7	electronically 204:21
177:11 181:3,3	70:11,17 73:8	181:8,12,20 182:6	early 73:10 79:10 79:10 109:3	element 127:1,10 130:11,14 133:10
189:3 197:10,12	74:16 76:12,20	182:19 183:3,18	186:22	elevated 73:12
207:18 216:22	77:6,13,18 78:8	184:6 185:7 186:6	easier 127:13 194:16	eliminate 40:2 132:14 200:15
219:18,21 220:13	78:14 79:18 80:1	186:17 187:17	easily 82:16 121:5 174:12	elimination 200:2
domain 69:2,5,6,8	80:8 81:2,8 82:6	188:3,15 191:15	easy 10:14 53:7 82:13 87:22 91:15	email 159:11 166:6
domains 68:20 69:11,18 93:16	82:18 84:2,17,21	193:7 195:4,20	115:9 169:3 198:4	embolism 103:2 125:10,18
door 135:10	85:12 89:11,14,19	196:11 198:21	echo 182:13	embrace 170:10
dose 111:14 119:7 127:18 133:4	89:21 90:3,10,15	199:9 200:18	ECU 74:13	emergency 83:5
136:16	91:9,20 92:14,18	201:6 202:21	ED 184:16,20	emphasis 191:16 193:16 210:20
dosing 79:19 119:16	93:2,6 94:2,9 95:8	203:21 204:2,5,7	educate 53:20	213:12 216:5
doubt 215:21	95:13 96:9 98:10	206:18,20 207:5	educating 211:12	employers 27:10 27:11
doubts 154:2	99:1,15,19 100:17	207:13 209:2,5	effect 15:9 81:21 119:12 178:20	enacted 4:19 176:2
Dr 3:4,4 5:17,20 6:18 8:3,4,6 10:22	100:21 101:12,13	210:11,19 212:13	effective 75:18 78:11 119:16	encourage 21:6 42:4 54:6 82:2
11:1,3,5,7,11,13	102:2 106:16,19	213:3,15,17,22	148:7 176:8	152:11 170:13
11:16 12:5,10,12	110:2,6,21,22	215:17 216:4,21	effectively 62:22	
13:1,9,12,13,15	111:3,7,21 112:1	217:4 221:6 222:4		
	112:17,18 113:1	drainage 61:18 62:10,20 63:4		
	113:12,20 114:17	Draining 108:10		
	115:13,17,20	DRG 43:22		
	116:2,15 117:11	drilled 19:14		
	117:20 118:6,12	drip 74:8		
	118:18 119:4,10	drips 73:15 134:8		
	120:9 122:2	drive 47:8 86:9 88:16 159:7		
	124:18 125:5	driving 85:19		
	128:16,19 129:5			
	129:21 130:4,9,18			

181:13 221:20	error 45:10	178:8	40:11 52:16,17	199:5 219:8,8
encouraging	esophageal 161:6,7	evolving 208:16	72:2 84:22 104:3	faced 83:6,7 214:22
186:15 187:2	esophagectomy	exact 134:18	110:4,7 113:13	facilities 64:9
endocrinologists	161:5,13	177:17	115:21 127:8	160:22
86:13 89:1	especially 5:9	exactly 34:2 54:22	145:5	facility 157:21
endorsed 4:16	131:9 154:9	82:19 99:2 111:7	excuse 47:17 102:2	162:17
126:19 150:21	196:22 217:5	119:6 132:18	exist 52:3 208:9	fact 4:18 9:7 15:5
161:12 166:3,10	ESRD 189:8	181:6	existent 5:6	33:22 35:14 38:15
168:8 186:18,19	essentially 6:3	examine 95:5	existing 16:22	59:21 60:6 77:7
188:21 189:4	152:2 182:14	example 32:10	17:13	93:22 96:5 101:1
190:15 203:15	established 55:16	62:18 107:22	exists 176:16	127:8 132:2
endorsement 1:3	etcetera 118:11	119:6 120:18	expand 62:3	175:10 189:16
15:4 16:5 22:10	163:18 216:19	151:22 185:11	expect 168:4	198:2 207:1 222:8
23:4 51:10 55:8	euglycemic 74:9	186:1 187:7 191:8	expectation 174:3	factor 86:3
67:20 97:14 98:12	evaluate 49:19	195:6 201:7	expectations	factors 118:22
143:16 144:15	128:1	excellent 21:8	139:10	fail 69:10 90:4
150:11 151:2,17	evaluating 168:7	212:18 216:15	expediency 96:1,6	failure 84:10
151:22 153:10	215:20	exception 177:10	experience 32:16	failures 18:11,14
endorsing 207:10	evaluation 45:2	193:18	62:11 74:3 131:12	fair 179:5 217:17
endoscopically	162:13	exceptional 212:17	expert 99:22	Fairfax 1:18
113:10	event 12:14,18,22	exclude 37:16 85:1	100:10 141:7	fairly 20:16 108:4
ends 69:14	70:13 90:1 103:8	85:5 89:13 127:11	expertise 166:17,17	169:8
engaged 153:18	146:1	excluded 17:8	166:18	fall 20:14
engagement 172:16	events 98:6 103:1	27:16 55:2 84:13	experts 94:10	familiar 197:3
206:14,15	eventually 39:17	104:8 109:12	106:14	family 206:14
enormously 194:15	everybody 50:6,20	111:9 113:5,9	expire 85:1	far 17:21 22:19
Enox 102:20	120:3 143:1 152:9	114:11,14,16,19	explained 120:8	24:11,20 29:12
ensure 102:9,12	206:6 215:4	115:5,14 126:16	explicit 116:13	30:7 69:14 75:3
ensuring 5:5	221:12	127:1 129:7	182:16	131:21 167:1
enters 102:17	everybody's 221:17	130:16 131:13,19	exploration 61:20	173:9 210:5
entire 15:21 81:13	evidence 4:17 10:3	131:22 132:2,10	62:13	fashion 177:12
153:14 166:12	20:16,19 50:6	132:12,14 133:2	exposed 108:4	fast 96:10 213:21
entirely 46:8	72:1 79:2 82:19	133:20 134:10	extend 136:15	favor 49:1 138:8
113:15 126:16	86:2 103:10	144:6	extended 127:3	163:6
214:15	107:14 109:22	excluding 126:20	extent 103:13	feasibility 10:13
entities 26:3	125:22 135:19	133:14	177:18	15:1 18:2 22:7
entity 208:4	136:3 146:9	exclusion 9:18 12:7	extra 33:16 174:14	50:20 56:5 67:4
entry 209:3	149:14 154:21	12:15,16,21 31:14	extract 114:6 209:3	95:9 97:11 143:13
episode 42:12	178:17 179:8	33:7 70:4,14 90:2	extraction 129:14	feasible 194:14
166:3	180:2,6,7,8,10	111:8 114:22	extremely 114:20	Federal 188:16
episodes 42:6	190:1 191:22	115:22 130:10	136:4	189:1
EPO 189:11	192:5 193:8,12	132:15,16 134:1	eye 157:8 166:10	Feds 207:9
equal 69:12 134:14	205:17 207:2	134:13 135:3,4	eyeballs 214:17	feedback 25:22
135:6	221:10	137:18,22 144:8		feedings 18:15
equally 10:12	evolution 181:14	exclusions 13:6	F	feel 28:22 88:17
68:18	186:11 194:2	15:17,19 24:3	face 44:19 167:22	106:15 154:22
equity 191:3	evolve 140:22	28:10 35:9 38:11	167:22 168:5,5	157:9 217:20

222:2	76:8 82:9 83:20	199:9,22	freely 25:13	generally 15:20
feeling 107:17	91:12 96:12,22	fooling 26:21	friends 111:18,20	30:21 73:6 108:16
130:6 169:21	100:17 102:15	foot 217:9	front 118:3 140:4	136:8
184:12	120:16 128:5	force 146:9 178:15	154:5 170:5	generic 158:19
felt 49:7 58:11	146:19 148:22	193:8	173:22 184:11	genuinely 89:22
106:12 175:18	149:2 157:13,15	foregoing 71:2	fruitful 129:3	getting 11:4 55:3
Fenari 86:22	157:21 161:10	155:16 222:13	full 221:8	85:17 101:16
fiefdoms 213:9,9	162:15,18 178:13	forehead 112:5	fully 166:2 174:4	115:7 130:20
field 90:7 106:15	185:16 221:3	forget 182:10	fundamental 29:2	144:7 148:6 157:8
179:7,17	Fiscal 7:7	forgot 18:19	further 16:3 45:2	184:4 188:11
figure 153:11 195:2	fit 44:21 222:3	form 149:1,6 174:5	82:4 93:5 149:15	200:5
figured 154:15	five 32:19 51:5 61:7	179:4 222:12	149:16 166:13	get-go 76:8 78:22
fill 18:20 24:12	65:7 97:2,8,11	FORMAN 2:9	193:20	give 5:14 33:12
28:6,22 38:5 89:7	183:21 206:2	220:3	future 20:22 21:9	43:18 44:4 78:20
filled 3:19 24:8	fivefold 65:7	format 6:4 202:13	21:10 125:18	112:3 115:1,4
34:19 38:20 43:21	fix 195:7	formed 136:8	128:3,15 151:20	123:17 132:3
46:2 55:4 166:2	fixed 136:21	former 27:10	153:6,13 214:18	134:8 159:15
filling 26:11,20	fixing 81:7	forms 122:21	fuzzy 52:2	172:12 180:5,6
27:22 28:16 30:1	flag 185:20	123:13 136:10		202:6,18 220:6,21
53:21	flaps 63:7	147:11 173:1	G	given 9:11 96:7
fills 29:10 38:10	flea 221:10,13	forth 221:18	G 38:6 40:2,7,12	121:7 122:19,21
47:3	flexibility 97:18	forthcoming	gall 114:9	123:4 145:14
final 95:19	98:18	158:20	galvanizing 212:20	147:14 151:6
Finally 88:4 127:15	Florida 201:9,12	FORUM 1:1	game 46:13 54:17	187:22 189:10
finance 201:11	201:15	forward 139:11	121:18 206:4,7	220:13
financial 207:18	focus 4:12,20 5:2	142:9 150:18	games 203:1	gives 110:4 190:6
find 13:14 76:9	108:19 125:11	152:6 155:2 162:9	gaming 83:22	giving 48:13
78:4 81:11,15	192:10	187:8 188:11	121:11,15 127:15	110:10 149:4
84:17 116:5,10	focused 206:14	189:9,13 194:4	128:13,22 129:2,4	172:15 174:14
175:19 219:15	focuses 125:9 148:1	204:17,20 211:15	139:20 140:16	glad 189:14
221:21	focusing 4:22	212:3,6 219:5	143:21	global 34:7 97:19
finding 88:9 168:12	147:13 207:20	found 195:12	gamut 104:2	glucose 7:10 71:12
Findlay 1:18 71:10	folks 33:14 52:12	Foundation 1:22	gap 9:6 15:6 18:18	71:15,21 73:12,16
71:13 206:12	86:1	2:14,21 6:20	29:15 50:6 51:16	77:12 79:6,13,16
211:13 212:16	follow 28:13 49:22	four 32:19 68:20	104:10 149:13	80:2,4,4 81:4,9,17
213:11,20	58:21 109:17	69:3 190:3 206:3	gaps 3:19 33:1,2	82:8 84:5,14,19
finds 220:20	138:18 141:19	fourth 5:7 15:15,16	166:2,16,21	85:4 87:3,8 91:3
fine 173:21 196:4	142:1,1 174:18	frame 7:19 79:8	167:21 168:3	91:13 92:9 95:15
finger 184:21	176:13 186:3,5	87:20 90:19 94:18	181:5	96:13 188:5
fingers 61:14	207:13	99:9 100:6 125:16	gastrectomy	glucoses 87:9,15
finished 221:4	followed 107:2	169:9,9,11,13,15	136:19 137:2	100:7
first 4:11 5:18 6:15	142:3 173:9	Frank 203:5	gastric 114:19	glycemic 77:10
7:9,15 8:3,16	following 17:3	frankly 59:5 61:8	129:8 137:7	go 11:11 13:13 14:9
12:14,15,21,22	23:12,18 73:17	61:10 121:20	gather 13:7	16:17 21:17 23:5
13:4,7 14:10	165:5	147:20 205:11	general 154:18	36:21 37:2 39:17
16:18 70:14,14	follows 119:5	free 198:2 217:21	158:15 159:22	43:20 46:6 47:21
71:9 74:6 75:1	follow-up 150:15	222:2	191:19	50:9 59:10 66:14

70:21 71:5 72:3 83:19 92:7 100:5 100:16 117:16 118:8 132:3 139:11 141:9 142:20 149:10 153:14 156:3,6,16 168:7,16 173:16 175:16 177:21 180:17 181:6 182:2 184:12 190:12 197:16 199:13,14 200:17 201:6,21 202:12 209:7 213:7 220:17 221:11 goal 54:2 75:15 99:3 102:8 156:15 171:11 goals 53:15 120:3 120:10 171:18 218:10 goes 56:21 57:1 90:8 117:14 131:22 142:12 150:8 210:12 215:7,9 going 18:15 19:18 28:22 29:4,5,7,7 29:19 30:8,12 32:3,7 33:7 44:2,4 44:12 47:6 54:12 54:13,15 55:4 58:8 63:11 71:5,7 72:9 76:22 77:4 81:10 92:4,11 94:6 99:1,21 100:10,16 109:17 112:14 127:13 130:4 137:16 139:13 142:9 143:18 152:6,9,15 155:13 156:3 157:11 158:17 162:9 167:12 171:20 174:17 181:8 182:3 189:3	189:13,17 195:8,9 197:5 198:13,21 199:3,5,10,11,17 199:19 201:16,17 201:20,21 205:2 206:19 207:6,8 208:22 209:6 211:10 212:2,4 213:14,16 214:16 214:18 216:19 219:5 gold 105:3 good 4:3 13:1 16:10 16:21 39:3 45:6 57:9 58:14 60:17 62:2 75:15 82:15 94:7 95:15 117:12 135:18 136:3,6 139:22 152:22 167:14 168:16 183:16 194:10 201:3,22 217:3 gotten 78:5 186:10 206:6 government 188:16 222:12 grace 151:7 grade 125:21 126:1 180:5 grading 95:16 graft 8:22 GRALING 1:18 grant 174:21 graphs 176:5 great 19:10 38:15 67:21 87:7 122:3 183:6 200:8 203:17 greater 25:4 65:8 69:17 104:7 Greenville 2:2 Ground 189:22 group 10:20 11:21 17:16,22 21:6 24:9 25:21 42:22 49:7,12 56:2 68:8 72:17 86:22 92:22	93:5 101:6,7 103:7 106:11 113:22 120:5 145:12,17 156:21 164:17 166:6 168:2 171:18,18 175:4 178:12 184:8 197:9 210:9 222:2 groups 64:12 66:10 121:4 138:11 161:2 163:18 206:17 219:13,16 219:18 growing 77:16 guess 21:5 33:5 43:14 146:5 161:4 196:13 201:22 219:12 guidances 178:19 guide 58:19,21 guideline 68:22 95:14,20,21 105:14 106:21 116:17 118:8,13 119:2,10 125:5,9 180:5 guidelines 105:9 107:1,4,6,13,18 108:21 109:5,7,17 109:18,21 117:6 117:22 118:19 119:4 120:6 122:22 123:3,6,14 125:20 126:3 128:6 138:8,9,18 139:3,7 140:22 141:11,19,21 142:3 guy 96:13 217:9 guys 13:6 98:17 141:4 156:9 166:4 179:3,21 180:2 187:12 201:22 GYN 103:12,22	half 59:9 64:5 131:5,7 Hall 204:15 Halpern 1:19 30:14 36:1,2 41:20 80:1 81:2 84:17 160:19 163:20 182:6,19 200:18 209:2 210:11 213:15 217:4 Han 2:18 5:22 11:3 11:3,7,13 13:9,15 hand 26:22 46:7 127:3 handle 30:10 handling 30:4 happen 95:2 127:20 213:14 happened 22:19 happening 60:20 happens 7:22 60:21 140:16 163:4 188:4 195:1 218:8 happy 5:20 8:1 19:16 85:15 94:17 147:2 180:3 hard 32:7 38:13 45:19 60:20 61:3 96:10 98:7 177:14 180:11 185:3 harder 91:18 215:12 harmonization 16:14,20 49:14 56:11,14 58:8,15 106:1 178:18 205:10,22 213:13 harmonization/c... 49:21 harmonize 67:11 120:6 157:4 harmonized 56:11 203:15 harsh 77:4 hash 212:1 hate 57:6 Hayden 1:19	HCAHPS 93:12,14 head 208:8,9 health 1:13,15,22 25:20 27:11 31:7 31:7 32:10 34:8 54:17 176:1 181:10 182:22 212:8 hear 36:16 121:22 150:15 heard 13:20 51:20 110:19 127:17 129:16 152:19 190:11 hearing 85:14,16 heartening 104:12 Helen 2:8 45:11 152:18 158:22 178:5 212:19 213:1 help 36:10 44:12 55:1 89:14 187:12 218:13 helpful 44:11 69:21 173:15,18,22 176:10,11 helps 187:16 hematocrit 170:21 hematoma 124:22 hematomas 108:10 hemoglobin 81:19 189:10 heparin 117:2,3 118:10 Hershey 1:16 hesitate 170:12 heterogeneity 76:5 83:15 Hi 11:3 hierarchy 193:9 high 17:15 26:13 39:16 64:19 65:3 74:22 102:11 103:11 107:21 109:8,10 114:20 115:2 129:12 132:6 139:1
H				

183:12 187:14,15 210:7 higher 63:19 85:21 85:22 108:11,18 120:20 206:6 highest 138:10,13 140:8 193:11 highlighted 73:9 hill 211:14 Hilton 1:9 hint 54:3 hip 109:9 HIPAA 215:16 hips 104:1 140:11 historical 202:22 historically 65:6 history 38:16 hit 50:7,20,21 76:21 170:6 215:6 215:8 hoc 141:1 hold 168:3,4 212:10 holding 52:12 Holdings 1:20 home 18:16 35:16 35:21 36:20 38:19 39:1 43:20 honest 39:22 honestly 170:8 hope 20:1 34:3 70:20 139:5 170:1 183:16 191:19 212:1 hopeful 203:19 hopefully 109:20 156:9 167:5 189:4 203:15 212:5,20 hoping 186:20 horizon 194:6 horrible 42:7 horse 205:16 hospital 1:18 2:2 6:22 24:6 28:20 29:7 30:1 34:17 36:7 42:16,17 43:3,6 47:2 48:18	52:11 53:10 71:15 73:22 87:15 89:6 89:19 90:9 91:5 93:17 104:7 122:18 123:1 127:5 128:8 133:1 133:5 134:21 135:6,13 136:2 138:3 151:11 180:21 183:22 199:18 hospitalization 56:20 169:14 hospitalized 78:15 86:14 102:10 hospitals 5:8 7:12 7:21 24:13 35:5 43:17 96:2 116:12 130:13 139:14 152:1 161:2 163:15,16 170:14 184:8 195:22 198:10 199:12 hosting 211:16 hour 79:20 221:11 hourly 74:13 91:16 hours 7:19 74:20 90:11,18,19 92:2 94:13,19 95:9 96:18 99:8,11 100:20 101:17,18 102:5,6,15 104:7 132:20 134:14,22 135:3 HSN 205:12 huge 26:17 41:13 41:19 74:22 104:16 176:17 177:5,16 184:8 196:21 207:15 211:14 213:12 human 182:9 husband 28:20 hyperglycemia 71:18 80:10 85:21 86:3 hypoglycemia	73:20,21 77:14,18 78:3 88:17 98:2,6 99:4 <hr/> I <hr/> ICD 126:11 ICU 83:18 ICUs 80:13 idea 133:22 184:1 ideal 208:3 ideally 59:12 91:2 ideas 87:7 221:19 222:1 identification 163:2 identified 10:6 27:13 65:4 192:18 192:20 218:17 identifiers 215:14 identify 64:22 68:10 203:7 212:18 identifying 33:1 ignored 114:22 II 220:10,18 ill 75:19 80:10 Illinois 2:4 illness 112:3 imaging 216:7,8 IMI 68:22 immediate 76:22 134:9 136:4 148:8 immediately 99:20 139:13 immunosuppress... 66:10 impact 4:17,21 50:5 79:16 81:1 127:13 149:13 179:20 181:10 182:21 192:1,6 207:20 208:13 impacted 176:1 impacts 133:5 implant 57:2,4,5 108:12,14,15,15 implantable 58:3	implants 57:6,12 59:6,12 implement 10:14 60:3 implementation 178:22 190:17 implemented 87:1 176:9 implementing 76:19 177:4 implications 92:22 195:22 importance 8:19 14:11 17:18 21:19 50:4 53:21 56:4 66:16 72:19,19 97:1 142:22 149:12 150:10 164:4,8,9 169:18 169:19 170:4 179:8 important 4:7,22 5:1,12 9:3 17:20 24:10 27:5 34:7,9 36:7 45:6 48:3 54:8,18 58:11 66:6 69:15 94:2 95:5 106:20,21 109:16 116:12 128:22 131:3 150:5 157:10 162:21 163:1 168:19 170:11 176:20 177:8,12 180:9 181:4 182:12,18 183:2 191:12 192:4,9 195:14,17 207:21 211:9 220:20 imported 174:10 174:12 impractical 60:2 impressed 186:8 improve 8:22 186:4 improved 79:1 88:2 improvement	29:22 30:8 47:8 65:19 70:15 83:2 130:19 147:3 160:13 162:20 166:15 188:2 improvements 47:12 inaccuracies 24:15 inappropriate 202:15 incentive 153:2 incidence 65:17 Incidentally 215:12 incision 114:1,6 incisional 63:16 incisions 126:17 127:3 129:13 include 38:19 63:15 126:12 163:7 173:21 181:10 included 32:5 36:3 38:6 120:21 129:20 137:12 142:10 144:6 includes 63:16 including 48:12 170:17 incomplete 118:4 inconsistencies 180:8 inconsistent 180:10 incorporate 186:12 incorporated 125:4 incorporating 162:3 incorrectly 151:6 increase 22:18 73:22 78:19 91:10 208:22 increased 73:15,18 131:5 increasing 19:7 86:2 135:16 increasingly 105:4 index 169:13 indicate 52:20
---	--	---	---	---

indicated 8:17 40:14	initially 4:16 85:9 86:21 89:16 144:3 148:2 175:6	110:19 153:22 158:18 181:7 184:18 187:4 194:3 203:3 205:4 206:22 216:18	15:16 26:17 27:7 27:18 29:3 30:15 34:6,8 36:7 43:10 43:11,15 44:6,15 46:16 53:18 56:14 70:3 71:16 72:18 77:9,14 80:9 96:4 96:7 105:15 106:1 112:2 117:21 120:18 123:10 127:15 135:8,14 145:4 149:2 151:9 152:18 159:6 162:6 170:5,11 172:2,7,18,19 183:15 185:20 187:3 188:8 189:19 196:11 199:10 205:9,10 205:11 208:21 209:6 210:18	Jane 2:18 5:22 11:2 11:3 13:5,19 January 178:20 jargon 173:6 JCH 164:3 169:18 170:9 Jessica 2:10,20 36:15 218:13 220:1 job 29:18 John 1:21 209:22 JOHNSON 2:21 89:11 130:4 136:18 137:11 John's 208:8 join 11:8 joined 206:16 joining 11:14 joint 72:9 108:5 135:17 151:18 183:19,20 192:3 joints 57:18 joking 221:6 judge 182:19 jump 221:13 justification 169:12 justified 162:20
indicator 77:11 154:2,3	initiative 9:4 29:22 79:9	interests 121:16 internal 66:11 157:14 209:15 215:3 internally 147:8 215:10 internist 42:10 interoperable 167:5 interprets 142:16 interrupt 101:21 intervention 55:21 interventional 62:10 interventions 65:17 103:16 intolerance 38:12 38:16 intolerant 40:3 Intracranial 107:22 intra-abdominal 62:17 introduce 5:15 6:17 33:17 100:17 introduced 6:1 16:9 55:14 68:6 71:10 76:8 invalid 185:17 invite 72:22 73:4 invite-only 211:16 involved 47:19 57:22 58:11 involves 215:9 involving 55:20 in-hospital 17:10 irrigate 63:5 irrigation 63:4 isolated 8:12 55:18 77:11 issue 9:14,20 10:5 12:2 13:21 15:16	issues 10:18 15:5 16:3 21:2 25:1,8 29:1 33:11,19 34:16 40:22 47:5 51:11 52:4,10 53:9 58:22 72:21 73:1 74:1 80:22 85:6 97:15 101:2 101:9 105:18 110:1 119:20 120:12 121:21 122:5,7 125:4 126:4 131:1 139:17 144:11 148:11 155:10 167:15 171:12 172:10 179:2,16 186:16 187:6 190:7 199:21 211:7 218:17 item 3:2 51:4 items 168:14 IV 73:18	J JAMES 1:14
individually 163:3 individuals 100:12 160:21 161:2 infallible 185:5 infection 55:13,20 56:9,19 57:16 63:18 64:7 65:11 71:17 72:2 79:12 79:17 85:3,21 86:3 197:14 209:21 210:1,8 infections 6:6 60:8 60:13,22 61:6 63:15 65:18 67:15 88:13 95:1 104:14 108:11,12 195:6 infection/mediast... 62:22 influenced 179:17 information 9:5,8 9:11 10:5 26:8 34:20 35:1 59:13 117:16,19 154:12 174:2,10 176:3 212:9 218:15 infrequently 62:5 infusions 85:17 Ingenix 2:20 6:8,10 23:13 24:7,21 25:11 31:16 33:12 33:19 35:7 36:13 36:16 51:20 52:17 164:4 inherent 32:6 37:8 53:3	instances 165:12 Institute 1:17 institution 28:15 77:17 159:14 197:1 198:15 institutions 30:10 43:11 52:13 65:9 65:9,12 74:21 78:5 198:1 203:22 207:15 208:11 209:14 211:8 214:21 institution's 113:22 instructions 173:5 insufficient 191:22 insulin 73:15,18,19 74:8 75:17 76:3 77:20 80:15,15 83:9 85:17 86:6 87:1 134:8 integrated 32:11 integrity 121:20 intended 31:21 111:1 intensity 178:3 intensive 74:12,14 75:17 77:20 80:15 82:11 86:6 208:10 interactico 72:7 interest 172:15 interested 5:4 212:10 interesting 81:16	issue 9:14,20 10:5 12:2 13:21 15:16	issues 10:18 15:5 16:3 21:2 25:1,8 29:1 33:11,19 34:16 40:22 47:5 51:11 52:4,10 53:9 58:22 72:21 73:1 74:1 80:22 85:6 97:15 101:2 101:9 105:18 110:1 119:20 120:12 121:21 122:5,7 125:4 126:4 131:1 139:17 144:11 148:11 155:10 167:15 171:12 172:10 179:2,16 186:16 187:6 190:7 199:21 211:7 218:17 item 3:2 51:4 items 168:14 IV 73:18	J JAMES 1:14
				K keep 18:22 19:18 20:10 54:19 74:9 74:13 91:6 131:5 132:15 157:6 163:10 178:2 209:19 211:17 keeping 18:18 20:2 KENNEDY 1:20 kept 88:14 key 142:5 158:6 keys 82:14 kick 168:22 kidding 45:4 killed 191:20 kind 31:12 46:11 47:12 82:3 92:8 115:9 121:18 157:8 161:19

162:8 174:5 176:3 179:1 180:14 184:1 194:8 200:2 207:19 213:8 221:9 kinds 32:18 Kleinpell 1:21 8:3 8:4,6 12:5 68:6,8 69:20 70:2,9 73:8 77:6 80:8 95:8 154:17 175:15 188:3 knee 112:11 knees 104:1 know 8:19 11:13 13:2 14:2 16:12 18:22 19:4 21:13 22:15 25:3 29:16 31:3,15 32:13,16 33:15 37:21 39:1 39:13 40:18 41:6 42:8 43:4,20 45:19 46:6 48:8 56:15,16 57:10 58:6,10,17,19 59:12 60:14,16 61:10,19 64:8 68:15 74:8,9,12 74:19 77:1 78:17 81:18 84:9 85:14 90:17,20 91:2 92:2 94:10,19 105:22 106:4 110:9 114:9 115:6 117:7,8,13,18,21 118:6 119:14,18 123:2 125:13 130:21 131:16 135:12,22 136:6 137:5 142:18 148:3 152:5 155:4 170:8 171:2 173:13 176:7,14 177:2,9,13 178:5 181:17 183:5,8 184:1,14 185:8,18 193:5 194:5 195:8	196:5,18 197:8 198:13 199:16 200:7,16 201:13 203:18 204:9 205:8,19 207:4 208:7 209:13,18 209:20 210:2,8 213:17 217:12 219:15 220:19 221:12 knowing 45:5 157:10 known 45:14 52:22 82:20 83:3 85:20 110:15 knows 13:12,14 70:21 152:19 Kottke 183:4 KRISTIN 2:8 <hr/> L <hr/> lab 91:13 128:2 labor 74:12,14 208:10 labs 84:20 lacks 44:19 lamplight 167:12 language 144:9,10 145:5 169:2 173:11,13,20 lap 131:17 137:3 laparoscope 113:16 laparoscope 126:17 127:10 133:11 laparoscopic 104:4 114:3,4,7,13,19 115:14 118:21 120:13,14,19 126:5,7,15,20 127:6 128:18 129:6,9,11 130:12 132:5,11,13,15 144:5,7 laparoscopically 113:19 133:7 137:5 laparoscopy 114:8	142:7 large 20:16 25:21 105:19 121:8 214:21 216:6 largely 122:13 lastly 15:3 22:9 46:14 97:13 121:10 late 60:8 61:6 92:7 Latham 88:6 Latham's 88:18 laudable 53:16 99:3 120:4 launching 122:4 LDL 46:11 54:17 LDLs 46:9 leadership 222:6 leads 60:19 leak 62:19 leaks 131:8 Leapfrog 161:13 162:4,5 163:21 learn 52:8 138:20 210:14 learned 4:15,17 67:11,14 78:7 learning 128:1 leave 33:7 90:6,7 124:4 leaves 164:11 leaving 144:12 left 132:9 146:16 171:14 172:1 216:13 legacy 185:8 length 132:21 136:21 lengthy 11:12 letter 141:20,20 let's 14:9 15:15 21:17 23:5 50:2 55:6 68:5 70:21 87:7,8 99:15 142:20 144:13 145:19 149:10 159:14,18 164:6 217:14	level 19:1,4 29:8 34:17 37:19 41:5 41:10 42:16,17,20 42:22 43:3 52:12 52:12 77:12 83:5 107:13 119:8 125:21 140:5,18 157:18,20 162:16 163:13 164:22 173:17 199:2,2,3 202:2 208:13 215:13 levels 73:12 78:19 81:19 liberal 86:16 88:15 Lieberman 135:16 life 183:8 light 82:15 limit 86:10 189:10 limited 7:11 Lincoln 1:9 line 33:14 68:1 130:22 195:5 217:19 lines 33:18 link 65:20 193:12 213:19 lipid 17:3,22 35:15 lipid-lowering 17:6 23:12,16 35:18 36:20 38:20 48:5 48:14,18 52:21 Lipitor 28:11,20 36:19 38:18 list 36:21 37:2 89:8 124:1 126:11 156:10 158:21 166:5,11 168:8,18 173:4 listed 12:16,17 40:11 115:21 169:10 literature 45:14 61:4 73:20 77:10 79:21 107:10,12 111:12 125:11 131:2 136:1	174:22 175:5,9,16 175:17,19 177:6 177:16 186:9 little 4:21 24:20 33:15 49:14 52:1 62:3 64:13 92:8 93:5 99:20 106:17 112:1,15 121:19 129:5 165:21 168:12,18 169:21 188:13 200:4,22 201:1 207:14 210:6 218:5 lived 85:12 lively 72:16 lives 29:13 living 200:20 local 202:2 locally 215:15 lock 198:14 logic 45:1,10 logistically 76:19 logistics 99:7 long 119:17 129:4 136:15 150:21 173:15 194:9 longer 32:21 57:2 114:7 185:14 186:2 longitudinal 194:15 look 23:16 26:21 28:2 32:12 40:9 46:8 53:18 54:8 64:10,16 84:11 87:9,17,19 90:17 90:22 91:1,3 95:8 97:19 101:6 128:6 129:1,10 130:5,7 139:21 140:5,18 148:5 156:16 174:9 177:2 184:1 187:22 205:15 210:22 214:4,11 218:18 looked 18:9 19:5 26:13 28:14 44:8
--	---	--	---	--

88:7 103:16	love 59:12	mandated 196:8	16:22 17:2,13,17	117:12,17 118:14
174:19 175:12	low 27:1,22 35:22	mandates 170:13	17:18,21 18:4,18	118:14,15 120:16
177:5	45:3,14,16 64:15	manual 136:22	20:2,9 21:1,4,18	120:22 121:2
looking 23:10,21	65:1 91:7 117:2	138:4 141:10	21:19,21 22:1,3,6	122:17 123:9,12
26:6 28:5 32:8,20	118:10 119:15	MARCH 1:6	22:9 23:2,3,7,9,10	123:22 126:1,10
41:17 64:2 66:11	123:19	marched 91:11	23:15 24:4,10	126:19 127:19
77:9 82:14 128:3	lower 54:17 83:11	mark 64:10 170:7	25:6,12,19 26:5	128:14 130:2
131:12 133:9	178:3 210:10	marker 83:20	26:12,21 27:3,17	131:22 132:5,8,19
167:11 179:15	lowering 17:3	market 196:15,16	28:4 30:6 31:1,14	133:3 134:19
194:13 195:10	35:16 71:16	match 42:17	31:21 32:5 33:17	138:14 139:8,19
210:15 211:15	lunch 155:12	materials 64:4	34:22 35:9,10,11	139:20 140:1,9
220:18		matter 71:2 78:20	35:12,17 36:3	141:1,2 142:2,21
looks 17:3 19:10	M	155:16 177:17	37:6,9,12,18 38:1	142:22 143:4,6,9
53:16 56:18 110:3	main 29:3,18 74:18	186:3 222:13	38:2 39:6,8 42:15	143:12,15 144:10
122:17 123:13	76:7 80:2 96:14	matters 200:5	42:18 43:16,22	144:14,18,21
134:12 147:12	107:3 110:1	maturation 181:14	44:7,8,9 47:5,20	145:2,3,8,13,14
loosening 77:2	maintain 153:4	181:19	48:1,3,11,16,22	146:3 147:12
loses 151:17	183:2	mature 185:14,22	49:2,8,10,20 50:3	148:4 149:9,11,12
losing 153:10	maintenance 1:3	Mayo 201:8	50:4,10,11,15,19	149:17,19 150:5
lost 137:21	4:14 8:11,15	Mayor 1:14	51:9,14,15,15	150:10 151:19
lot 4:22 20:18 26:2	16:22 71:9 155:1	mean 9:17 26:13	52:9 53:13,15	154:8,19 155:1
27:11,22 28:1	155:7 157:16	39:14 40:17 41:6	54:2,7 55:7,12,12	157:14,16,17
30:5,7 32:21	158:11 174:20	45:16 61:6,7 75:7	55:15,16 56:3,13	158:10,11,11,20
33:10 34:11,22	175:2 177:22	84:19 91:2 94:17	57:1,16 59:20	160:3,3,6,7,17
37:10 44:18 51:12	178:6,7 179:11	99:19 113:18	60:4 64:2 66:15	161:11,12 162:1,5
51:15 52:16 59:17	180:14 181:9	114:18 117:21	66:16,18,19,22	163:21 164:1,12
64:9,17 75:16	182:9	150:1,3,7,8,20	67:3,19 68:5,13	165:3 166:14
76:5,10,13,18	major 18:1 23:20	160:14,16 164:19	68:14,16 70:6	169:2 173:12
85:16 88:3 103:5	25:20 43:11 51:11	164:21 176:4,19	71:13,16 72:5,6,8	176:1,8,19,20
103:10,14 113:8	97:15 102:19	177:8 183:9,14	72:9,13,17 73:2,6	178:21 179:7,9,11
122:7 123:7	103:21 104:2	185:11 189:8	74:10 75:17,22	179:13,16 180:11
131:14,16 136:6	120:1 126:6	197:20 198:4	76:3 77:4 78:1,22	182:3 183:20
136:14,16 147:19	144:11 145:11	201:12 214:2	79:9 80:21 81:9	184:19 185:1,9,10
154:10 167:12	216:4 218:16	221:7	81:12 82:4,13	185:12,17,21,22
173:15 174:20	majority 20:12	means 34:2 64:5	83:1,8 84:3,7,14	185:22 189:10
176:3,4,17 179:2	60:9 140:17	84:9 108:13	85:9,13 86:6,21	191:6 193:18
180:9 183:15	making 54:10	149:15 150:9	89:13 90:4,11	194:16 205:12,13
186:12 187:8	129:13,17 155:9	195:21	91:8,12,22 92:12	220:6
191:20 192:19	157:9 200:1	meant 84:16	93:8,16,21 95:21	measured 13:22
198:9 207:19	mammary 66:11	measure 3:7,8,10	96:22 97:1,3,5,7	34:4 188:13
208:22 210:3	157:14	3:11,12,13,14 6:9	97:10,13 98:4,11	192:22
211:14 212:4	managed 61:18	6:14,15 7:11 8:3,3	100:2,16 101:11	measurement
214:21 217:10	62:1	8:6,7,8,11 9:3,17	101:13,15,19	37:20 91:6 94:13
218:3	management 77:15	10:1,4,7,10,14,16	102:8,8,13 103:6	94:15 95:3 97:18
lots 87:6 94:9,21	211:1,2 214:3	12:7 13:18 14:11	105:13,17 109:12	98:19 110:12
189:17 216:20	manager 214:10	14:12,14,16,19,22	109:16 111:4,9	157:18,20 162:17
loud 219:14	managing 42:11	15:3,9,12 16:4,7	115:15 116:3,5	179:18 183:14

206:7 207:3	219:4 220:5,10,17	142:21 143:4,9,12	metrics 141:13	moment 18:6 44:19
measures 3:5,18	measure's 72:18	143:16 144:14	212:15	100:10 152:9
4:5,14 5:9,16,18	measuring 42:21	149:11 160:12	MI 180:22	moments 5:15
5:21,22 6:2,17 7:1	46:3 51:19 60:18	198:18 199:8	Michigan 1:13,14	money 214:7
7:2,7,14,22 10:8	91:16 99:10	203:9	1:15	month 32:18
10:12 16:12 18:8	170:20	meeting 101:4	midnight 96:14	148:10 153:20,20
21:7,8 24:16	mechanical 105:10	150:22 164:8	mid-nineties 26:14	215:7
25:16 27:3 44:17	109:4 117:4 124:8	167:22 168:5	Mike 131:15	months 32:20
46:18 47:7,13	124:15 125:1	173:14 174:3	milligram 110:10	45:18 56:21 58:21
49:13 54:19 59:10	140:12	211:15,17,18,21	110:13	61:7,7,7 141:9,10
65:15,20 67:8	MedAssets 2:1	212:3 213:13	million 24:1,1	moot 164:2
68:18 71:6,9 92:1	mediastinal 55:21	217:22 218:11	133:18	morbidity 36:10
93:7,10,17 95:22	61:5 104:14	219:8,11,17 221:3	mind 53:4 54:19	66:4 68:21 69:6
99:14 100:14	197:13,15 209:21	meetings 218:9	131:5 157:6	82:22 102:19
101:7 121:3,12	210:1	meets 101:6 110:12	163:11 164:15	104:13
122:9 126:3	mediastinum 63:6	143:7 148:10	169:16 178:5	morning 4:3 16:10
127:12,14 133:14	medical 1:16,19,21	173:12	200:11	78:17 84:19
136:20 146:6,10	1:23 2:14,22 6:21	Melinda 2:9 118:2	mindful 5:3,12	135:10 152:14
146:20,22 147:4	164:14 193:22	141:14 158:1	mindset 20:5	Morris 1:10,13 3:4
147:10,20,22	194:14	164:2 167:1 221:7	mine 212:14	4:3 6:7 8:2 10:17
148:12,16,18	Medicare 44:2	member 24:1	minimal 127:13	13:5,16 14:7
150:7 151:7,10,15	146:21	152:10,16 217:15	147:5	16:16 18:3 21:2
151:16 152:1,3,18	medication 8:5,8	members 4:9 31:10	minimally 22:5	25:7 32:1 33:10
152:21 153:1,4,7	8:14 20:5 35:16	84:12 105:8	50:13,17 51:6	34:10 36:12,17
153:11,12 154:20	35:18 36:20 38:8	Member/Public	97:6,9,12 143:8	37:1 39:5,12
154:20 155:6	38:10,13,17,21	3:16,20	minimize 103:3,9	40:17,21 42:13
156:5,8,10,12,21	39:1 41:15 48:5	memory 137:9	Minnesota 183:5	45:11 47:15,21
157:3,5 161:9,16	48:18 52:21 53:22	menial 207:19	minor 59:19	49:4 50:1 54:9
161:21 164:3,18	54:4,14,16 68:12	mention 106:9	122:16 133:6	55:6 58:22 60:11
165:9,12,14,20	110:5	137:17 181:9	141:8	65:22 66:13 68:3
166:4,8,10,21	medications 38:5	mentioned 23:9	minority 138:16	70:19 71:5 85:6
167:6,9,16 168:2	40:4 42:11 69:1,2	36:8 49:13 54:21	minutes 11:14 23:1	92:10,16,21 93:4
168:2,6,9 169:5	69:9	70:3 91:3 92:6	104:6	94:1 95:4 96:19
169:18 171:17	medicine 172:9	125:8 159:3	mired 194:9	100:15 101:11,20
172:3 177:3,7,20	186:1	167:11 178:14	missed 112:6	106:16 110:2,18
178:13 179:11	MEDPAC 216:18	193:7	missing 84:6,14	111:5 112:17
180:16,20,21	meds 22:21	mentioning 216:13	89:3,10 132:4	119:19 128:16,20
181:9,21 183:20	meet 14:11,15,20	merit 94:4	mission 191:3	136:17 137:15
183:22 184:15	15:1,4 16:4 21:18	message 170:2,2	mitigated 95:7	139:16 142:19
186:21 187:4,9	21:21 22:3,6,10	171:3 191:19	mobilization 109:3	145:10,19 146:4
190:15,16 191:21	23:4 50:3,10,15	met 1:9 9:18 12:7	model 205:5	148:14 149:8
192:5 193:4,10,11	50:19 51:9 55:8	70:7	214:19	150:4 152:8 155:8
193:16 194:4	66:15,18,22 67:3	method 19:13	modeling 196:21	156:3 158:9 161:3
196:3 203:2,8	67:19 73:17 74:2	51:22 182:16	models 46:22	163:9,22 165:18
204:13,14,16	96:22 97:3,7,10	methodology 64:19	209:17	168:10 182:11
206:13,15 213:10	97:14 98:11 99:22	metric 11:20 63:20	molecular 117:2	183:17 190:20
216:10,10 218:22	101:1 105:12	66:5 124:9 127:21	118:10 119:14,15	192:8 194:11

195:15 207:11 211:10 217:13 221:2,15 222:10 mortality 17:10 24:4 36:11 66:4 68:21 69:13,14 73:22 85:22 102:21 161:6 210:16,16 Morton 1:21 25:10 30:22 33:5 76:12 91:20 99:1 114:17 128:16,19 129:5 130:18 132:1 136:5 137:7 181:8 199:9 mousetrap 162:7 move 14:9 21:17 46:21 47:16 50:2 55:7,11 96:20 101:12 138:7 142:20 144:13,17 147:22 149:10,19 162:3 167:4 183:1 183:13 188:11 193:14 200:4 208:20 213:8 moved 80:18 200:2 moving 82:3 168:10 176:8 200:2 221:9 multiple 94:5 171:8 173:5 208:2,7 214:22 multi-institutional 159:21 multi-specialty 201:14 MURPHY 2:9 49:18 101:5 158:4 167:18 171:7 174:1 178:4 190:11 218:12 220:12 221:5 muscle 55:20	name 6:19 named 23:13 narrow 187:11 nation 138:14 national 1:1 19:1,3 86:10,17 88:22 125:6 158:15 171:10 208:13 215:13 nationally 126:21 130:15 133:17 146:20 184:5 natural 112:8 nature 28:10 182:9 near 21:9,10 128:2 near-zeros 64:17 necessarily 26:3 42:8 74:5 75:7 83:12,12 119:12 156:18 187:18 197:22 necessary 145:14 need 4:11,20 5:2,7 11:19 25:1 45:7 46:4,18 66:12 69:9 89:17 97:17 103:6 119:17 142:9 144:4,8 146:14 159:9 174:15 178:2 180:17 182:8 183:19 190:8,8 194:9 195:2 200:9 210:6 211:5 215:4 217:7 219:15 needed 121:8 needle 176:9 183:1 183:13 needs 11:17 44:8 45:2,8 46:19 110:6 142:14 170:7,22 191:13 191:13 Neither 46:11 neuroaxial 124:11 124:11,13 never 39:20 63:8	86:8 131:1 new 62:7 95:13 105:5 141:11 145:7 148:4,12 158:19 179:3,12 194:6 207:21,21 newer 179:6 nice 77:22 185:11 208:3 NICHOLAS 2:1 night 75:3,12 95:12 160:20 nightmare 30:9 nights 133:1 134:16,21 138:3 nine 50:8,17 95:12 98:12 143:10 Nineteen 67:1,4 nineties 26:13 Ninety-eight 45:20 noise 28:1 30:5 35:8 53:3,6 183:14,15 non 71:18 nonoperative 61:19 nonoperatively 62:1 Noon 83:19 normal 81:20 North 2:2 note 13:19 70:17 118:20 158:7 171:20 noted 9:8 10:7 68:13 121:3 notice 50:22 92:19 154:20 noticed 36:2 111:11 notion 170:10 172:11 novo 167:7 NQF 2:6 3:16,20 14:11,15,20 15:1 15:4 16:5 21:18 21:22 22:3,6,10 23:4 50:3,10,15	50:19 51:9 55:8 56:10 66:15,18,22 67:3,20 97:1,4,8 97:10,14 98:12 126:19 142:21 143:5,9,12,16 144:14 146:8 149:11 150:11 151:6,22 152:10 152:16 153:11 156:14 174:9 177:2 178:8 186:7 186:15 190:4,15 191:3,12 193:16 196:13 199:4 202:20 206:3 215:22 217:15 220:16 221:3 NQF's 192:10 NSQIP 176:18 198:8,17 200:3 201:14,19 202:10 204:16,19,22 215:8,8 number 8:7 60:7 60:12 61:15 78:9 78:10,15 88:4,16 88:18,19 94:19 95:17 96:9 99:4 101:14 102:21 103:15 104:15,17 118:15 121:8 125:8 130:10 135:17 183:9 numbers 25:3 60:21 61:3 65:2 98:7 104:19 133:17 140:4 191:7 218:16 numerator 12:14 12:17,21 13:7 15:22 38:6,19 55:22 61:21 70:13 71:20 84:10 103:18 116:2 118:16 142:14,15 173:3	numerators 17:5 nurse 2:5 214:16 nursing 18:15 N.W 1:10 <hr/> O <hr/> O 200:4,19 201:2 217:1 obese 115:2 obesity 119:1 obligated 188:16 obligation 43:22 obtain 34:22 obviously 18:21 42:22 53:19 106:20 115:3 120:20 179:18 183:2 207:17 212:10 214:6 215:10 occur 19:6 60:8,9 60:15 62:18 67:15 67:16,17 131:6 219:8 occurred 62:12 occurring 61:5 odds 139:14 offering 219:5 officially 138:2,3 offline 203:5 Oft 112:6 oftentimes 28:17 114:11 154:22 oh 6:15 18:19 40:15 102:2 110:21 172:11 175:12 217:2 221:13 okay 10:20 11:5 13:16 16:4 34:10 36:12 37:3 40:15 47:15 59:1 66:13 67:19 70:9,19 85:7 92:10 96:21 98:10 137:1,13 142:19 144:13 145:19 158:9 159:11 166:6
<hr/> N <hr/>				

168:14 182:20 183:7,11 200:8 217:18 219:17,19 221:2 Oklahoma 2:14,21 6:20 old 30:17 34:13 older 8:12 23:11 27:9 30:19 37:5 37:10,16 55:17 once 4:8 50:21 90:21 143:1 182:16 195:10 215:7 220:3 oncologic 113:7 oncology 113:17 216:16 ones 41:21 96:16 131:15 146:11 165:10 169:1 174:19 175:2 180:17 203:2 ongoing 193:1 194:12 onus 163:16 Opelka 203:5 open 15:8 33:18 61:19 114:14 131:15 197:12 219:18 operate 83:4 201:1 operated 81:21 operating 97:21 operation 62:6,14 82:10 140:20 148:7 216:22 217:3 operations 86:4 126:7,12 130:15 133:7,12,18,19 operative 6:6 55:21 opinion 106:2 145:20,21 opportunities 62:9 165:20 opportunity 33:13 65:19 119:22	130:19 156:6 168:6 181:2 190:17 217:15 220:22 221:21 opposed 78:2 80:3 90:1,11 96:18 159:4 167:8 194:5 option 138:17 optional 155:4 orange 208:14 oranges 75:14 76:11 order 12:20 19:8 22:20,21 59:22 92:9 98:5 100:16 105:18 185:15 199:8 ordered 101:16,22 102:13 144:20 147:12 149:1 ordering 145:8 146:2 172:13,19 organ 63:16 organization 79:5,8 organizations 56:7 207:17 208:7 organizing 215:10 originally 126:18 148:20 orthopedic 103:13 103:22 105:7 107:5 108:3,12 110:15 111:13,18 111:19 120:7 121:14 123:11 124:17,19 135:15 138:8,13 139:6,18 140:7 ought 181:10 outcome 52:14 54:12,13,15 81:21 104:16 146:11 149:14 191:18 192:7,16,17 193:4 193:20 194:17,19 194:21 195:11 204:16 210:13	outcomes 17:21 45:6 186:19 191:17 192:11,14 193:1,10,12 194:7 194:13 195:13 206:13 outdated 175:18 outlier 64:20 outliers 64:13,14 64:14 65:4 outset 85:13 outside 24:20 26:3 111:20 125:15 overall 36:10 80:2 81:4 93:19 102:8 164:10 210:15 220:16 overlap 147:19 overnight 135:17 overuse 216:10,20 overview 156:7 overwhelmingly 139:18 over-adjustment 211:5 ownership 216:16 owning 29:20 ox 186:14 oximetry 184:16 oxygenation 171:1 o'clock 75:3,11	paper 39:19 167:10 174:14 213:2 papers 212:7,22 213:16 paperwork 72:4 paragraph 173:20 pardon 163:15 part 7:6 20:4 53:19 58:7,14 64:3 68:13 76:17 146:8 170:21 173:21 184:6 188:6 208:6 210:19 partially 14:18 15:2 22:2 50:13 50:17 51:6 66:21 67:2,5 97:6,9,12 143:7,11,14 participant 204:22 participate 159:21 201:13,14 participates 159:15 participating 202:4 participation 158:12,14 195:21 196:7,8 particular 4:15 15:9 21:11 27:18 27:19 31:4,11 56:13,17 59:18 63:20 66:5 91:7 91:22 110:20 120:10,17 157:17 167:3 190:22 207:10 216:9 particularly 34:18 41:14 50:5 52:6 72:22 85:18 105:5 121:7 128:18 152:10 157:1 158:17 162:1 parts 191:3 pass 43:16 83:21 124:9,15 125:2 127:19 139:12 141:15 150:11,12 150:13 159:16	164:3,19,21 169:19 174:1 180:15 190:6 passed 204:1,14 passes 142:13 passing 123:8 137:21 passive 214:15 paste 181:16 pasted 176:5 181:18 patency 8:22 path 189:18 193:14 212:3,6 pathways 135:9 patient 9:16 12:6 24:12 29:10 38:10 46:1,7 48:17 53:18 54:4 61:22 70:6 73:11,13,22 75:1 78:16 82:9 83:18 84:13,18 90:12 95:11 97:20 102:9,11,17 111:14 122:19,21 123:4,9,18 124:8 125:2 128:7 132:20 149:2 171:11,18 172:6 172:18 192:7 201:1,4 206:14 210:7 patients 7:9,12,16 7:17 8:11 9:9 10:2 17:5,7,8 18:9 18:15 19:3 20:13 23:11 24:6,21 25:2,6 27:8 28:5 29:14 30:1,18 34:12,18 35:14 37:5,9,11,16 38:5 38:20 43:19 44:1 52:5,20 53:21 54:16 55:17 61:5 66:10 71:11,14,19 71:20 72:1 73:15 74:14 75:19 77:9
---	--	--	--	--

78:6,18 80:11,14 82:5,20 85:1,5,16 85:18,22 86:14 87:4 88:8,10,13 100:18 101:15,22 102:9,19,22 103:4 103:12,19 104:4,5 104:6,8,15,16,17 109:10 113:17 114:20 118:20 120:19 121:16 123:15 125:13,16 126:6 130:20 131:21 132:9 134:13 135:5,10 135:19 136:9 138:18 144:18,22 146:21 148:6 164:14 184:17 195:8 200:7 205:19 210:9,14 217:6 patient's 42:11 PAULA 1:18 pause 120:5 pay 169:6 197:17 214:4 paying 201:17 payment 92:12 189:12 PCI 205:6,7 PE 107:8,11,15 112:2,5 116:1 131:7 pelvic 103:12 Penn 1:16 people 20:3 26:18 26:20 27:12 28:15 30:20 31:3,19 33:8 36:6 37:7 38:1,11,22 40:3 43:8 45:17,17 55:1 63:4,6,6 64:22 66:11 72:18 76:14,18 82:2 83:3,9,22 87:6 88:20 105:2 110:9	121:17 159:7 160:17 172:14 177:3 197:13 200:21 212:19 218:7 221:8 Pepco 1:20 percent 8:11 9:10 9:10 17:14,17 19:10,11,17 20:13 25:2,4 26:15,15 26:18,19,22 29:14 31:10,11 33:8 34:12 39:10,11,16 44:1,20 45:4,16 45:21 60:15 62:15 64:5,14 65:10,13 72:14 79:11 104:18,18 108:16 126:22 129:11 135:5,12 146:1 147:1,4,6 176:21 181:1 187:21 196:15 202:10,11 202:13 205:18 206:1,2 percentage 30:18 36:5 37:4 55:17 81:9 133:20 percentagewise 61:10 percutaneous 61:18 62:10 percutaneously 63:8 perfect 54:5 88:2 195:6 208:21 perform 13:6 204:13 performance 9:6,9 50:5 93:18 100:1 122:17,20 123:12 123:21 124:9 126:1,2 127:21 128:14 132:19 133:2,14 138:14 140:8 141:13 146:20,22 149:13	153:4 171:17 179:17 181:1 184:13 188:6 performed 29:8 102:15 113:15 215:21 perfusion 171:1 period 65:11 76:2 77:1,3 81:14 87:8 90:17 119:13 134:10 147:15 149:5 151:7 152:5 169:15 178:22 periodically 100:1 100:13 154:8 perioperative 115:21,22 134:1,6 134:9 147:14 149:4 perioperatively 85:2,17 permissible 47:18 person 75:10 91:21 93:6,7 101:6 169:22 196:22 218:10 personal 51:4 personally 46:5 163:6 170:8 222:5 person's 197:9 perspective 79:15 82:8 perspectives 153:22 persuasive 165:15 pertaining 142:6 pertinent 112:13 PEs 108:20 Peter 1:16 175:10 pharmacologic 123:16 124:13 140:10 pharmacy 23:15,22 24:6,15 25:22 27:15,16 28:6 30:4 31:2,4,10,13 32:4,16,17 33:6	35:2 47:2 52:6 phase 56:11 219:19 220:10,15,18 phenomenon 201:5 phone 6:1,11,13 11:1 23:14 31:17 33:17 89:4 145:17 152:11 156:19 phrase 159:17 physician 37:19 38:7 40:4 41:5,10 42:20,22 52:12 105:14 107:6,13 163:18 172:18 216:15 physicians 42:7 53:20 105:1 122:14 163:17 pick 46:18 47:4 49:15 87:18 183:21 picked 94:13 picking 91:18,19 94:18 197:20 202:15,19 208:11 picture 29:17 piece 154:11 172:13 216:15 pieces 59:13 174:14 pile 42:3 177:22 piling 43:15 place 62:13 209:3 placed 62:4 places 197:5 plain 173:12,19 plan 5:5 25:20 27:11 31:7,8 32:10 43:4,5 51:21 52:2 219:12 planning 128:13 plant 166:19 platelet 6:5 109:2 123:19 platform 204:21 205:9 Plavix 9:17 12:4,6 15:11 70:6	play 206:19 221:17 plea 153:3 208:19 please 5:3 45:22 51:2 163:10 217:20 222:2 plus 53:7 105:10 pneumonia 184:17 point 16:20 18:17 24:22 27:21 28:14 29:13 51:21 54:21 57:9 58:14 59:8 59:10,14 60:3 63:12 70:20 73:7 74:16,17,21 77:14 80:2 82:11 84:15 89:2,7 90:9 91:1 94:3,6,13 99:18 112:12,22 117:7 140:22 141:6 146:7 150:10,14 150:17 155:9 158:3 159:2 161:19 164:3 169:17 174:18 178:10 182:12 192:9 195:5 196:13 199:22 201:10 204:9 pointed 30:20 101:14 164:2 184:9 192:19 points 4:7 27:21 76:1 81:5 86:5 120:1 142:6,9 151:4 160:17 165:5 195:17 199:10 policy 89:3 141:2 poor 18:21 148:19 poorly 73:6 76:9 78:21 83:7 population 19:3 30:17 37:13,15 77:15 83:2,15 115:7,10 131:4 132:7 port 114:12
--	---	---	---	---

portion 116:19	111:12 200:14	pressures 85:18	problem 41:13,19	179:6 207:21,22
Portland 87:1	Prager 2:13 5:17	presumably 42:18	42:14 78:7,8,16	proliferate 198:22
posed 191:21	5:20 10:22 11:5	presume 6:3	100:8 107:10	promote 9:1
poses 43:5	11:11,16 12:10	pretty 15:19 21:4	113:16 115:18	proper 192:17
position 112:14	13:1,13 14:6 19:1	24:3 32:17 53:7	125:20,22 185:18	properties 14:16
174:13 199:6	59:3 61:1 62:2	53:10 55:22 60:17	192:2 194:12	22:1 50:12 66:20
positive 15:7 33:4	65:22 66:2,7	85:15 92:7 103:19	203:11 208:6	97:5 143:6
44:17,18	pragmatic 82:12	104:3 118:7 120:8	problematic	prophylactic
positives 15:8	predictable 170:15	135:18 160:3	108:13	136:16
possibility 98:1	predictor 161:12	187:9 189:5	problems 27:2	prophylaxis 3:5
165:7,8	predominantly	213:21 216:11	74:18	7:14,16,18 100:19
possible 35:20 53:5	30:16	221:5	procedural 23:18	101:16 102:5
146:11	preference 46:5	prevalence 65:8	procedure 33:9	106:13 107:1,15
possibly 95:10	preop 36:4 111:9	prevent 107:7	104:5 118:9	107:16 109:4,5
post 6:5 189:1	preoperative 69:3	preventable 18:13	120:20 137:9	115:1,4 116:4,14
216:15	82:5 136:15	18:13,14,19 21:15	217:12	119:3,13,16
postoperative 7:10	preoperatively	preventing 108:19	procedures 103:20	122:13,21 123:13
20:5 71:11 77:3	20:20	prevention 9:1	104:2 107:22	123:16 124:8,13
82:22 84:5 95:15	prepare 121:9	20:17	112:20 113:3,15	124:16 125:1
100:7 108:8,11,12	preparing 219:16	previous 17:2	117:9 118:21	126:8,9,13 127:19
postoperatively	prescribe 69:9	23:10 24:4 25:19	132:11,13 137:3	128:3,7,11,12
55:19 56:21 87:4	111:13	35:11 49:9 134:4	proceed 50:9 205:3	130:20 131:21
88:11 108:2,3	prescribed 26:19	145:2 181:18	process 20:8 65:20	132:3 133:5 134:8
128:9 134:14	38:8 54:15	previously 68:4	69:16 71:16 93:10	135:20 136:3,11
148:5	prescribing 26:11	192:9	133:9 140:21	140:6,11,12
post-discharge	54:13	primarily 41:8	146:10 150:21	144:19 145:1
45:15	prescription 18:20	67:16	151:1,16,18	147:11 148:7
post-op 71:15,22	26:11 28:7,21	prior 23:17 24:7	153:15 187:21	149:1,7 185:16
potential 54:21	29:10 35:15 38:18	36:6,9,20 38:21	188:15 191:20	proportion 87:9,17
115:3 123:8	39:2 41:15 43:20	72:1 100:20	192:16 193:3,11	130:17
171:14 199:20	46:2 48:14,14	101:17 102:5	193:16,18 194:8	proposal 17:12
216:17	53:22	priority 193:11,13	195:2,14 198:3	190:12
potentially 16:15	prescriptions 28:16	privately 210:22	214:5 215:19	proposed 7:6 56:9
33:9 47:7,9 51:1	30:2 34:19 43:19	privilege 172:14	processes 181:15	92:15,19 93:11,13
51:17 53:1 67:7	53:17	probably 12:19	186:13 192:11,12	93:22 151:8
108:15 125:17	present 1:12 2:6,12	15:21 20:12 21:12	192:18,20,21	proprietary 5:10
139:17 162:2	4:9 14:2 16:13,17	22:19 40:8 44:2	194:15 195:3	pros 116:9
182:15 190:9	16:19 56:6 85:7,8	45:21 55:1 64:18	processing 84:8	prostate 216:16
205:8	118:22 145:15	65:7 75:16 85:10	product 31:9,12	prostatectomies
powerful 107:12	211:6	98:6,16 120:21	profession 172:10	114:13,14
PQRI 9:4	presentation 174:5	121:15 129:7,19	profound 144:2	prostates 113:5
practical 59:13	presented 171:6	135:10 137:21	Program 151:12	114:10
83:12	presenting 175:14	141:3 158:17	programs 153:2	protect 112:10
practice 42:5 76:14	presiding 1:10	162:10 168:15	project 3:21 162:11	protection 112:8,8
159:21 192:6	press 14:17,17 50:7	193:4,19 206:1,2	216:6,11 218:4	protocols 87:1
205:20	pressure 199:12	212:12 218:2	projected 121:13	prove 79:13
practices 64:9	214:6	219:1	projects 178:20	proven 131:2

provide 202:9 218:20,22 220:9	purposes 91:6 95:3 127:4 165:1 211:2	84:3,21 93:3 100:22 106:22	147:4 187:11	183:9,12
provided 9:5 116:16	push 143:1,2 206:12,15	109:16 112:18 122:8 134:12	ranged 9:9	really 6:19 9:18
provider 25:21 37:19 110:4	pushed 86:7,8	146:5 148:15 159:12 160:15,18	ranges 31:9 80:16	10:15 15:18 17:22
providers 40:18 53:1	put 44:9 58:20 63:3 63:4 66:8 91:17	161:22 162:9 167:13 176:6	ranging 147:3	20:2 21:6,8 23:21
provides 10:5 207:2	95:17 114:2 125:1 125:16 139:13	177:1 182:21 186:7 187:4 205:2	rare 99:5 127:9	26:18 27:1 29:15
proximate 146:13	150:18 154:7 163:14 165:9	206:21,22 207:7 215:18	rarely 127:11	29:22 30:7 34:8
public 5:4,5 29:6 30:9,12 34:7,15	172:3 187:15 189:9 191:16	questionable 101:3	rarer 114:15	38:13,14 43:1
37:17,18 41:4,9	204:20 219:10	questions 8:1 10:19	rate 26:14 27:22	44:11,17 45:3,5
44:13 46:19 57:22	putting 41:22 42:1 42:1 173:19	11:17,18 15:8 17:16 35:6,13	35:22 45:3,14	46:3,9,12,17,21
63:13 92:20	P-R-O-C-E-E-D-... 4:1	51:17 52:15 68:4 68:9,10 133:22	55:13 64:4,22	47:8 48:1 51:18
117:14 142:13	p.m 156:2 217:17 222:14	168:1 179:5 184:22 211:19	79:12 99:4 108:11	52:14 54:2 56:2
150:18 152:10	<hr/> Q <hr/>	218:3	108:17 146:22	61:15 70:4 72:16
154:6 165:9,14	QA-10 40:12	quibble 99:6	147:6 161:6 195:9	74:8 75:18 77:8
176:11 188:12	quality 1:1,17,23 2:14,22 4:5 6:21	quick 130:5,8 186:6	197:15 209:21	79:1 80:5,12 81:1
189:2 204:3,6,18	19:5 21:8 29:12 29:22 30:8 46:20	quickly 86:5 113:14 168:11	210:1,2,8,16,17	81:7 83:1 84:1,15
210:21 211:6,12	130:19 151:11 154:3 160:12	214:1	rates 44:7 45:16	86:5 96:6 99:10
211:18 212:8	162:20 166:15,18 167:17 180:6	quiet 217:22	63:18,19 65:11,13	105:22 109:15
213:14 217:16	186:4 199:8 201:4 211:1,2 212:8	quite 45:1 61:15 72:2 86:15 113:5	79:17 85:21 133:5	110:22 128:5
publicly 7:4 42:16 222:5	214:3,10	143:17 144:2 146:17 147:20,20	140:8 146:20	129:14 131:8
publish 213:18	quantitative 183:11	163:7 221:21	211:3	139:3 143:18,19
published 42:15 79:21 88:6 107:5	quantity 180:7	quote 185:10	ratio 200:20 201:3 217:1	145:3,17 146:12
122:15 128:10	query 219:1	<hr/> R <hr/>	rationalization 169:12	146:14,14 147:2
pull 151:19 201:17	question 11:20 12:4,12,19 13:2,4	races 147:7	ratios 200:4	148:6,21 156:6
pulled 118:18 153:8	13:21 15:18,20 18:12 19:17,21,22	racial 147:5	raw 211:3	160:11 162:7
pulmonary 103:2 111:22 112:16	22:14 25:5,10 31:1 34:9,12 35:4	radiation 216:16	reactions 28:11	164:2 166:22
125:10,17	40:1 41:3 49:13 51:12 53:2 61:17	radiologic 216:8	read 34:1 36:22	168:3 170:22
pulse 184:16 186:14	62:3 69:19 82:16	radiology 62:11	48:4 114:18	173:6 176:3,6
purchasing 7:7 92:19 93:22 106:9		rail 216:7	117:15 121:9	177:1,9,17 180:9
151:9		raised 9:21 37:4 73:1 97:16 122:8	206:9	180:11 182:12
purely 104:4 111:3 113:10 114:3		179:3	ratio 200:20 201:3 217:1	183:14 184:14
115:13 131:14		range 74:14 81:20 82:21 86:15 88:21	rationale 102:18 197:4	185:3,13,14 186:2
137:4			rationalization 169:12	187:14,15 188:8
purpose 160:12 215:4 219:3			ratios 200:4	190:4 191:5
			raw 211:3	192:10,22 193:13
			reactions 28:11	193:15 194:18
			read 34:1 36:22 48:4 114:18	195:13,17 196:20
			117:15 121:9 206:9	200:5 203:6
			readdress 165:21	205:10 207:20
			readily 121:2	208:15,17,22
			reading 57:16	213:5 216:18,18
			readings 80:3,6	217:22 218:4
			readmissions 47:10	221:16
			readmit 24:5	reason 19:9 35:21
			real 25:17 29:11 32:22 33:4 54:11	62:1 66:6 110:4
			65:19 75:14	114:10 125:3
			104:21 130:5,7,18	129:1,2 199:6
			131:3 192:6,9	reasonable 83:19
			201:5 210:17	
			reality 46:17 87:11 150:6 180:15	

86:16 88:18 94:20 95:10 96:17 100:5 104:8,20 105:11 106:13 120:9 161:17 reasons 104:9 111:11 123:20 125:7 139:17,22 185:10 195:13 reassess 165:16 recap 3:3 4:6 22:13 34:11 51:10 67:6 119:20 120:1 143:18 receive 7:17 166:11 169:4 received 7:18 17:6 21:12,14 100:18 102:1,3,4 112:21 166:5 receiving 166:7 169:22 recognize 59:3 123:15 recognizing 163:2 170:20 recommend 119:2 141:16 162:12 165:10,10 recommendation 86:11 88:22 118:8 141:15 142:1 151:1 175:21 recommendations 86:17 95:16 105:8 105:20 119:11 122:15 125:21 126:2 140:7 142:2 142:8 219:5 recommended 7:15 20:15 61:20 68:22 77:8 86:15 122:12 123:14 126:14 144:19,22 147:11 149:1,6 150:19 151:2 152:6 165:12,14	recommends 118:13 119:9 reconciliation 54:4 reconsider 99:18 150:17 165:6 reconvene 219:13 record 71:3,4 155:17 173:14 222:14 recording 54:14 recover 82:10 rectify 73:12 recurrence 125:14 recurrent 125:17 191:8 redo 198:17 reduce 65:17 108:20 reduction 79:11 reendorsement 7:3 153:14 reference 163:8 references 154:21 155:2 175:17 referring 114:8 173:7 reflect 210:17 refrains 191:9 refused 189:9 regard 15:13 21:3 35:13 53:12 68:4 92:12 regarding 20:17 39:6 49:7 52:4 60:21 regardless 80:13 regional 19:4 20:7 22:16 Register 189:1 registries 159:7 197:7 203:14 registry 60:17 159:15 160:18 195:21 196:9,9 202:5 205:5,7 214:14 215:5 reimbursement	63:13 reimplanting 108:15 reinfection 108:17 reinforce 14:2 reinforced 171:9 171:13 reinstated 164:20 reiterating 169:17 rejected 84:8 89:5 89:16 90:8 Rejects 89:12 related 3:18 35:6 56:14 70:11 102:22 156:5,8,10 156:13,22,22 164:11,12 165:19 167:20 168:1 182:13 196:3 218:21 219:3 relationship 161:9 relative 88:1 relatively 99:5 released 8:16 relevant 146:3 186:3 reliability 179:13 reliable 154:3 170:15 remain 5:12 154:14 remaining 145:4 remains 17:20 remark 217:2 remember 160:19 removing 108:14 127:10 133:10 RENAE 2:2 rendered 76:16 renewal 174:21 reopen 63:3 reopening 63:1 reorganization 171:17 repeat 92:16 93:2 repeatedly 168:17 168:20 195:18 replacements	135:18 report 14:12 21:19 42:21 50:4 66:16 97:2 142:22 146:9 149:12 150:10 167:17 177:22 180:2 193:8 197:15 215:7,9 216:19 reported 7:4 17:15 40:5 42:16,19 63:18,20 65:10,13 reporting 5:5,6 29:6 30:9,13 34:15 37:17,18 41:4,9 44:13 57:22 63:13 68:14 151:12 154:6 204:4,6,18 210:21 211:18 212:8 213:14 215:1 reports 61:4,13 178:15 206:11 215:5 repositories 215:3 representative 36:13 71:8 representatives 22:17 represented 141:7 represents 30:16 reprocess 198:18 request 100:5 139:12 161:15 require 17:19 170:14 required 117:10 151:10 182:17 204:3 requirement 49:18 175:20 requirements 179:10 requires 180:4 requiring 55:21 resection 161:6,7 resident 41:16,22	42:1 residents 209:18 resides 42:14 resolve 167:22 resource 207:18 resources 121:19 207:16 214:7 respect 10:15 68:11 112:9 respects 26:4 48:2 49:3 60:4 respond 10:21 31:17 36:13,19 59:2 72:21 99:16 99:20 119:22 122:4 203:22 responds 33:20 responses 122:1 220:8 responsibility 53:20 172:16,20 responsible 29:4,20 41:21 42:9 43:9 163:3 170:15 rest 81:6 217:22 result 85:3 results 64:11 117:17 220:4 resurrected 153:13 rethink 43:17 retired 182:15 183:20,22 184:16 185:11 retirees 27:9 retooled 72:10 retrofitting 167:9 returning 18:8 review 8:16 11:12 98:17 100:13 111:12 141:1 155:2 reviewed 212:16 reviewers 70:3 reviewing 148:11 154:20 176:12 178:2 revised 8:17
--	--	---	--	---

revision 109:18	210:1,4,7,16,20	sampling 205:9	score 10:8,11 15:13	seek 189:2 193:10
revisional 131:15	risks 124:1 211:4	sandbox 221:18	68:15,17 72:13	seeking 190:15
revisions 122:16	risk-adjusted	satisfied 43:21 48:4	93:19	seen 4:16 19:6,12
revisit 98:16 101:2	68:20,21	48:16	scored 93:17	20:1 61:8 62:21
revisiting 182:16	RIVENBURGH	satisfy 107:2	scores 69:14	63:8 73:14 77:19
re-operation 209:9	1:22	save 156:18 183:8	186:10,12,16	147:3 214:20
re-reviewed 142:4	road 153:8 216:20	saw 64:8 79:11	script 24:8,12	segment 131:3
re-vote 99:17	ROBERT 1:14	149:5 198:14	se 177:15	139:13
Richard 1:17 2:13	robotic 114:13	saying 29:15,17,21	search 175:17	selecting 197:8
200:1	Rochester 201:10	45:21 49:1 81:3,3	SEARS 2:1 43:14	self-reported 24:16
rid 132:10 144:7	ROGERS 1:22	111:19 112:5	206:18 207:5	send 14:17 50:8,21
200:5	100:21 111:21	118:12 134:15	second 4:4 7:17	90:6 143:2 168:8
RIEHLE 2:20	162:14 169:20	154:7 177:2	12:2 14:14 16:19	197:17,18 209:15
36:15,18 37:3	172:5 215:17	183:11 197:5	26:9 48:9 74:7	213:1,19 220:3,5
39:9,13 40:6,15	222:4	198:6 202:7 209:7	101:21 125:19	220:10
40:20 41:6 48:20	role 120:14 206:18	209:22 210:4,7	134:11 147:12	sense 97:16 136:16
right 6:8 8:4 12:5	room 1:9 86:2	219:14	148:2 149:3	147:9 185:9
12:10 13:15,18	97:21 141:22	says 15:2 21:20	157:15,21 165:8	187:14 189:22
28:15,16 46:20	188:2 211:22	22:2,5 50:12,13	168:5 178:12	198:3 200:22
57:4 77:13 83:22	221:8	51:6 66:20 67:21	193:13 206:20	202:3 203:14
92:20 102:1	rosy 29:17	75:16 78:12 84:7	secondary 9:1	215:15
114:18 115:16	rotting 217:10	135:2,2,5 141:16	20:17	sensitive 43:12,12
117:11 122:2	roughly 131:8	141:21 143:3,8	secondly 4:20	sensitivity 12:15
132:18 133:8,15	routinely 126:14	176:18 177:6,17	15:10	sent 89:6,15 96:10
152:8 154:15	rule 92:15 93:12,14	202:9,11 209:15	Secretary 188:21	159:11 160:20
166:4 168:14	151:8 189:12	219:9	section 175:4	separate 49:17
179:22 181:12	ruled 37:9	scale 28:9	190:22	148:18 160:17
197:9 198:15,20	Rulemaking 92:19	scary 112:15	see 5:17 15:15	separately 63:22
199:1 206:4	run 25:14,16 26:1	schedule 11:10	19:13 27:21 39:21	sequencing 167:19
212:12 215:14	27:4,8 129:4	70:20	48:3 51:2 68:5	series 47:11
217:13 218:19	207:8	scheduled 217:17	70:22 74:3 76:13	serious 29:11
rigid 131:20	running 11:9	science 18:1 61:16	82:9 87:19 100:8	166:16
rigor 178:7	Rush 1:21	78:12 83:10 91:11	112:21 118:3	serum 7:10 71:12
risk 43:6 71:17	rushing 76:14	94:7 96:5 106:2	133:18 140:18	serve 46:19
77:15 86:3 98:8	Ruth 1:21 73:1	202:19 205:15,18	147:2 153:21	serves 54:2
102:11 103:3,11	Ruth's 174:18	scientific 9:22 10:2	155:14 157:7,14	service 216:2
104:17 107:18,19		14:15 21:22 50:11	163:4 164:6	services 32:19
108:21 109:8,10	S	56:4 66:19 94:4	166:16 168:6	215:20
114:21 115:3	safe 83:12	97:4 143:5 154:21	179:21 180:3	set 86:9 90:17
118:22 120:20	safety 171:11,18	scientifically	181:19 182:1	94:19 99:4 101:8
123:9 124:3,7,20	172:6,18 186:20	152:22 153:7,10	194:2 200:14	112:6 113:7 139:7
125:16 129:12	Saigal 1:23 27:20	153:15 185:17	205:4 206:7 208:6	151:19 154:1
131:5 132:6 139:1	40:1 44:5 112:17	SCIP 90:13 92:1	208:15 216:9,14	188:6 198:19
140:14 162:6	112:18	99:13 150:7	217:15 220:22	199:19 219:10
167:15 196:21	sample 9:8 13:3	176:16 177:15	222:3	sets 19:8 22:20
198:9 200:10	184:5	181:21 187:18	seed 166:20	setting 31:7 74:4
209:7,8,9,10	sampled 146:21	scope 106:5	seeing 194:5 199:1	91:5 135:21

settings 74:4	simple 15:19 17:5 22:21 169:1,8 209:19	sniff 44:21	speak 5:8 13:5 31:16 33:22 49:6 61:2 100:3 113:21 221:21	stage 193:18
seven 23:17 24:5 35:19 50:12 51:6 75:3 128:4	simplest 132:12	soapbox 47:14	societies 105:6,19	stakes 206:5
Shahian 2:15 11:1 13:12 20:11 47:17 47:18,22 48:21 59:16 61:12 62:16 63:21 65:5 67:22 68:2,19 70:1,8,17	simplified 173:11	societies 2:13,15,18 8:9 86:11 199:2	society 2:13,15,18 8:9 86:11 199:2	stand 185:19 214:11
share 38:4 180:3 196:15,16 213:5	simply 48:17 60:2 87:22 112:3 123:3 127:9 129:4 133:10 152:17	Society's 112:14	speaks 9:19 12:8 50:5 54:10 70:4	standard 8:21 186:14 198:19,19 208:20
shared 46:22 184:7	single 46:15 127:18 133:4 136:15 157:2 208:4 216:11	socioeconomic 32:6 54:22	special 169:6	standardization 69:16 212:15 213:6,7,12
shelf 153:8 182:15	SIP 79:9	solo 222:9	specialist 170:18	standardize 79:19
Shield 2:3	SIPERSTEIN 2:1 53:14 57:15 175:22 185:7 207:13	solution 207:9	specialties 159:20 194:3,6	standardized 22:20
short 113:11 115:9 115:11 136:4 191:6	sitting 212:14	somebody 27:14 30:20 36:8 38:15 47:19 81:20 89:4 89:9,21 136:1 167:10 170:21 183:3 194:19 195:10 197:18	specialty 159:5 199:16	standards 105:3 188:17,21 208:2
shot 123:17	sit 201:8 202:17 206:10 211:22	somewhat 30:9 93:9	specific 118:7,7 119:8 133:17 159:5 160:9,9,13 160:18	standpoint 112:16 158:7
show 41:17 64:11 104:10	site 56:9 63:12,15 63:17 79:12 88:12 95:1 112:10 201:9	soon 39:20 213:4	specifically 9:12 36:19 37:6 98:2 118:20 135:1 147:13 149:13 153:21 188:20	stands 58:10
showing 84:1	situation 109:8	soonest 218:14	specification 59:19 116:3	Stanford 1:21 132:2
shown 75:18 78:10 133:4	situations 97:20 121:17 138:16	sophistication 198:11	specifications 25:13 37:22 49:20 62:7 122:12 141:12 158:6 167:6 174:4 203:8 203:16	staple 130:22
shrift 191:6	six 32:19 45:18 50:16 61:7 96:11 113:2 141:10 143:6 212:7	sorry 6:16 11:14 18:5 102:3 164:4 196:9	specified 119:7	staples 58:16,17,20
sick 61:22 217:6,11	Sixteen 97:2 144:15	sort 15:8 40:8 83:21 85:10 103:21 104:1 105:3,3 121:13 141:16 154:14 156:7 168:22 169:8 180:20 182:17 185:4 187:5 188:3 195:19 201:15 209:21 211:17 213:9 216:17	specifies 35:17	Starry 131:16
sicker 200:8 201:2	skip 6:12 46:8 74:19	sorts 29:1 87:7 157:5	specify 119:11 199:7	start 5:19,20 6:11 18:6 22:11 82:3,8 122:6 128:20 166:20 181:22 188:1 200:16
side 15:7 32:9 53:7 59:14 155:5 156:11,11 193:20	skipping 194:8	sounded 52:1	specimen 114:6	started 6:2 28:21 71:6 79:8 146:19 148:22 156:4 194:1 195:10 201:7
sides 32:22	slight 70:15	sounds 16:21 52:19 52:21 121:14 181:16	spectrum 103:21	starting 86:21
sign 112:4 184:19	slightly 67:13 120:11	source 26:7	spend 207:15	starts 53:18
signal 183:15	slip 179:2	South 58:1	spending 215:22	state 1:16 58:1 199:2 201:15
significance 80:21 108:1	slippage 20:10	space 63:17 108:7	spent 59:17 113:2	statement 56:1 62:15 100:9
significant 56:3 66:4 79:3 80:9 103:15 104:12 108:10 109:14,15 115:18 162:16	small 28:8 44:10 60:7,12 61:15 65:2 104:15 133:20 187:11		spirit 140:1	States 7:13
silly 121:18	smoking 152:1,3		spread 213:20	static 181:16
similar 16:12 17:1 23:10 24:3 25:18 54:7 108:22 147:20 207:16 211:21 219:10	smoldering 60:7,13		SSIs 205:11	statin 45:22 46:10 48:13
Similarly 124:17			St 1:22	statins 35:15,20 45:15,18
			staff 2:6 156:14 174:9 209:19	statistician 197:2
			Stafford 2:2 41:2 41:11 54:20 77:18 81:8 84:21 171:13	stay 104:6 113:11 132:21 133:13

136:2,21 148:8 205:17 stayed 134:13 staying 98:4 113:8 stays 135:6,17 136:4 Steed 2:2 30:11 55:13,14,15 57:3 57:11,20 58:19 63:10 66:3 79:4 80:7 175:8 213:1 222:8 Steering 1:4,9 4:5,8 46:15 97:17 98:16 118:1 121:7 150:19 152:17 165:15 166:12 189:14 220:19 221:3 stent 113:4 step 47:7,13 53:17 187:5 203:20 steps 212:18 218:3 Steps/Timeline 3:21 sternal 55:12,19 57:5,11,17 58:2 60:7,22 62:21 65:11,18 67:14 79:12 85:3 sternum 63:1 Steve 71:10 206:10 STEVEN 1:18 steward 8:8 17:1 23:13 72:5 154:19 196:13 sticker 112:4 stop 84:8 128:22 stopping 129:4 story 76:1 136:13 straightforward 131:17 stratified 160:15 strict 127:2 130:12 strike 158:1 strikes 47:22 48:21 striking 183:10	strokes 219:20 strong 10:3 193:12 stronger 188:20 strongly 22:18 163:7 struck 170:19 structure 74:18 172:2 structured 170:14 struggle 187:17 STS 5:17,22 11:17 14:3 17:1 18:7,9 18:22 19:3 21:7 22:17 24:17 26:2 26:12,21 29:16 30:6 32:21 39:7 42:18 44:8 51:15 59:2 67:10,11 95:13 159:22 160:2,3 186:11,18 191:9 196:7,8 198:3,14,16 201:13,17 202:8,9 204:4,10,13 209:8 215:6,7 stuck 89:1 184:21 213:8 studies 28:4 117:1 study 11:21 77:21 88:5,18 102:20 128:10 133:3 stuff 18:19 138:16 175:3 194:8 212:1 subcriteria 190:5 subgroup 9:21 10:6 subgroups 9:14 subject 190:21 submission 148:4 179:3 submissions 181:18 submit 128:15 174:22 197:16 203:10,16 204:10 204:12,19,21 205:6 submitted 8:15 122:10 173:1	203:2 212:13 submitting 207:16 subpopulation 106:14 subscribing 207:5 subset 107:9 substantial 147:3 164:15 substantially 49:9 120:15 subtle 109:14 succinct 176:7 sudden 186:13 suffer 208:1 suffice 119:8 sugar 78:19 79:7 86:19 87:19 88:1 89:22 90:5,18 99:3 sugars 85:19 88:10 88:14 100:8 suggest 128:6 174:6 suggested 87:6 171:15 suggestion 171:9 suite 102:17 summarizes 53:11 summary 43:7 176:1 218:14 superb 222:6 superficial 63:16 63:22 supersede 146:14 superseded 145:22 supervise 113:22 supplanted 185:13 185:21 support 79:2 80:2 83:10,10 94:8 103:11 197:7 207:3 supported 106:12 supporting 6:22 supportive 171:4 supports 79:21 82:19	suppose 90:15 supposed 134:20 138:2 202:16 209:14 sure 8:6 11:22 12:4 13:2,20 16:10 23:8 25:3,4 34:2 39:14,21 40:6 45:7,9 47:21 57:13 58:7 59:5 61:1 68:8 69:21 70:1 84:16 93:18 106:19 113:5 114:17 130:5 148:6 216:7 218:19 surgeon 48:10,10 111:13 124:18,19 217:6 surgeons 2:13,16 2:19 8:9 48:12 56:8,16 57:14 58:4,9 61:17 105:7 107:5 109:2 111:18,19 120:7 121:15 138:8,13 138:17 139:6,13 139:18 140:8 159:18 160:1 surgeries 36:11 103:22 107:20 130:7 217:7 surgery 1:3 7:11,20 20:19 28:16 31:5 36:9 56:20 60:13 62:18 66:9 71:20 74:22 77:8 80:14 80:19 85:22 87:2 87:5 88:8 99:8 100:18,20 101:17 101:18 102:6,22 103:12,13,13,22 104:1,5 111:14 120:13,15 126:5 130:1,10,22 131:7 132:6 134:5 136:1 136:13 144:18,22	147:15,16,17 158:10,13,15 159:19 168:8 193:19,19 201:19 208:15 221:8 surgical 4:4 7:16 42:12 56:9 63:12 63:15,17 73:11,13 78:15 79:12 88:12 95:1 102:17 103:12,20 104:2 112:10 113:17 125:15 164:14 166:4 194:12 204:15 221:12 surprised 39:15 surveillance 57:21 154:9,13 survival 161:12 suspect 39:14 91:15 suspecting 14:3 sustain 112:9 sutures 57:19 swinging 210:5 symptomatic 107:8 107:11,15 108:20 112:2 125:10 synopsis 148:14 system 1:13,15 2:2 20:4 32:11 34:14 42:10 54:5 91:14 92:13 121:11,15 121:18 139:21 143:21 151:15 167:7 200:20 202:8 systematic 158:12 158:14 systems 185:4 199:13 S-E-S-S-I-O-N 156:1
<hr/> T <hr/>				
T 1:19 table 136:8				

tables 130:3 176:4	tell 118:16 130:11	that,okay 200:22	219:21 220:1,21	182:2,6,11,18
tackling 166:18	130:16 131:11	then,particularly	think 5:11,21 11:18	183:10 184:22
211:19	132:1 133:16	142:6	12:12,19 15:20	185:1,5 187:3,13
tag 141:16	134:18,18 138:1	therapeutic 110:12	16:14 17:19 20:22	189:21 191:11
take 12:21 13:3	189:20 201:4,7	111:1 119:12	21:4,7 23:20 25:1	192:8 193:3,15
29:16 47:7 58:16	203:21 204:8	therapy 8:20 17:4,6	25:19 26:4,9 27:3	194:1,9,11 195:13
62:13 70:13,22	209:18	17:9,22 20:15	27:18 30:5 31:19	197:21,21 198:11
75:10 79:7 83:14	telling 86:1 124:18	23:12,17 73:19	31:21 34:6,8	199:10 200:1,18
87:7 91:1 94:18	tells 205:15,18	75:17 77:20 80:15	41:19 43:10,16	201:3 203:3,13,17
123:15 151:14	temporary 108:14	83:9 86:7 105:10	44:6,10,16,17	203:19 204:7
172:20 200:8	tend 45:17	109:3	45:8 46:12,18	205:1 206:22
218:18	term 119:17 185:8	THF 181:22	47:6,15 48:17	207:1 210:11,19
takes 133:6 148:12	221:12	thing 5:1 26:6,9	49:1 53:15 54:8	211:12,17,20
talk 6:13 16:19	terms 8:19 9:22	29:2 31:15 43:16	54:18 61:21 62:21	212:4,5,17 213:21
77:1 101:9 106:17	10:4,13 31:18	54:8 64:1 77:22	65:15,18 66:3,6	214:17 217:13
159:9 170:12	33:1 37:17,21	81:3,15 86:18	66:12 72:22 73:8	218:2 219:20
184:7 202:1 218:5	38:11 39:9 41:9	91:20 92:6 94:20	73:14 74:1,2,16	220:16
talked 19:19 20:7	45:21 69:10 70:15	99:13 117:12	77:9,22 78:4 79:6	thinking 82:3
48:8 67:7,8 162:2	74:12 76:18 77:15	118:19 124:10	80:11,21 81:2	102:3 166:20
171:22 215:19	80:22 128:17	125:19 128:21	82:12 85:8 86:15	167:6 168:9
talking 57:18 74:4	139:10 145:5	142:12 145:11	87:11 90:16 91:9	200:16 216:1
104:13 160:5	155:6 164:8	161:17 166:1	92:4 94:11,14,19	thinks 217:2
163:19 172:22	167:18 175:15	167:4 169:9 174:7	95:19 96:4,6 98:3	third 6:9 14:19
174:8 175:11	176:7 179:9	178:4 184:20	98:7,15,17 99:2,9	86:18 135:11
182:7 190:18	185:12 189:20	200:19 214:20	100:4 106:3,20,21	142:12 157:15,19
196:6 199:15	195:16 199:4	217:4 218:13	109:15 114:10	216:7
200:21	209:1 218:9 219:1	220:12	115:6,8,17 117:12	thirdly 5:3 15:12
talks 84:5 116:3,21	terrible 29:18	things 4:12,22	119:1 120:8,14	Thirteen 143:13
tapped 17:17 22:14	Terry 1:22 100:22	12:20 20:8 22:20	121:3 125:12	Thirty 45:16 94:22
target 76:21 131:4	169:16 210:12	33:1 34:11 43:3	128:21 129:2	Thirty-five 44:20
195:11	test 37:6,14 44:21	44:18 47:11 51:19	130:4 132:4	thoracic 2:13,15,18
task 100:12 101:1	46:9 148:12	73:9 85:20 87:10	138:19 139:16	8:9 158:15
146:9 178:15	tested 184:3	87:12,18 94:10,14	140:3,15,16,17	thought 24:9 49:12
193:8	testing 45:8 128:2	94:21 95:5,16	141:14,22 142:12	49:16 70:10 87:3
tasked 197:1	178:17 179:10,11	102:13 109:1	142:14 143:19	161:7 168:19
team 42:4 48:12	179:12,14,15	110:14 114:9	145:1,7 149:21	169:11 191:21
79:15 221:12	thank 4:8 8:2 10:17	122:7 124:2	155:13 156:9	thoughts 39:6
technical 30:22	25:7 47:14 49:4	131:18 139:2	158:16 159:3,6,8	146:18 222:1
84:2 99:21 100:4	54:9 60:11 69:20	141:15 153:2	160:18,21 161:16	three 5:21,21 7:2,4
100:10 117:20	70:10,18 94:1	156:20 157:5	161:21 163:1	7:5 32:19 50:16
125:12 127:16,22	96:19 106:16	168:16,19 170:9	166:5,12 168:15	50:17 61:7 65:13
141:7 148:10	137:15 142:11	172:7 174:11	170:2,12,19 171:7	74:19 88:12
technically 150:14	149:8 155:8 163:9	176:22 178:9	172:1,9,13,17,19	132:22 134:15,20
188:11	Thanks 6:7 50:1	181:13 182:3	173:8 174:20	135:2,6 138:2
technology 214:13	55:6 106:19 122:2	184:2,9,11 189:14	175:20 176:10	141:9 147:6
telephone 2:16,19	152:8 195:15	190:13 200:15,17	177:21 179:21	162:15,18 178:19
2:20,22 6:8 218:9	221:15	201:18 212:19	180:13,15,20	three-site 201:8

thrombo 119:3	194:17	105:4 119:17	67:1,4 68:9,9	undue 90:13 91:10
thromboembolism	timing 98:18 148:2	treatments 21:12	71:22 72:11,12	99:12 191:21
100:19 102:11	149:3,7 177:18	trends 211:3	74:19 76:1 80:3,6	202:1
103:1 105:18	tiny 170:21	trials 103:15	81:4 84:6 88:11	unfortunately 13:9
144:19 145:1	tip 61:14	tricky 98:14	97:5 98:13 100:7	37:13 38:13 39:3
164:7	tissue 108:5	tried 123:22 126:12	126:22 133:1,21	unfractionated
tie 98:15	title 8:7	tries 74:11	134:15,21 135:13	117:3
tight 69:13	titled 71:14	trocars 129:13	138:3 142:5 146:6	uniform 208:20
tightly 77:2	today 5:16,22 7:3	trouble 55:3 78:3	146:19 147:22	uniformity 144:10
time 6:13 7:19 11:8	65:6 166:9 168:21	146:16	148:15,18 149:6	145:5 208:21
14:17 16:14 33:16	185:12 216:15	true 45:21 62:21	149:14 156:11	unintended 98:1
47:16 48:5,15	218:15 220:14	121:10 139:9	157:15 161:10	189:17 210:21
50:7,22 52:3 56:6	told 11:7	214:2	165:3 167:19	Union 1:18
59:11,17 73:11	Tom 183:4	truly 46:12 53:4	180:19 190:13,18	unique 177:10
76:1,22 79:8	Tony 86:22	96:1 191:12	199:9 204:14,15	unit 82:11
81:14 82:11 85:9	top 157:20 185:3	truth 57:7 194:16	206:21 208:8	United 7:13
87:18,20 88:3	topic 156:4 166:13	try 30:10 45:9	215:19	units 172:12
90:12,17,19,21	171:12 172:4	73:16 74:8 87:14	two-day 136:2	University 1:13,14
91:1 92:8 94:6,18	topped 21:9 152:18	123:22 183:10	two-three 220:7	1:15,21,21 2:2
99:9 100:6 101:1	152:22 153:1,16	208:19 210:9	type 140:19 147:17	unknown 34:15
101:5,10,18	154:4 177:21	211:22 220:9	typically 151:6	unrealistically 27:1
109:20 115:1	184:3 185:2 187:9	trying 32:12 42:4		unsuitable 52:20
121:19 125:15	Torchiana 3:4	46:21 48:11 74:2	U	unusual 84:18
136:7 148:12	Tory 89:9 129:21	88:16 104:19	UCLA 1:23	upcoming 196:2
151:14 152:5	134:18	107:7 108:20	ulcer 123:18	update 134:19
155:11 157:10	total 80:4,4 91:3	112:9 146:15	ultimately 203:14	141:8
164:13,20 167:21	93:10,13,14	180:13 181:6	umbrella 24:21	updated 8:18
168:16 169:9,9,10	103:22 104:19	193:13 196:12	171:19	135:16 155:3
169:13,15 178:3,8	totally 19:21 44:14	200:3 205:17	unable 33:16	158:21 175:10,19
179:21 180:16	48:9	tube 18:15	unclear 9:15 24:20	218:21
197:8 199:11	tough 99:20 100:3	tubes 63:4	35:5 49:15 192:15	upgrade 59:19
205:3 207:15,18	tougher 47:13	TUESDAY 1:6	undergoing 8:12	uploaded 208:5
208:10,16 211:3	180:1,14	turn 162:10	33:9 55:18 118:21	upper 116:19 189:9
215:22 218:22	town 203:1	turns 126:21 140:6	120:19	uptake 35:10,11
221:4,16	track 10:14	171:16	underscore 14:8	39:7,8 51:14,15
timeline 95:10	tracking 200:19	tweak 142:2	underscored	urge 212:9
218:4	tragic 103:7 104:15	Twelve 50:8,13	191:13	urologic 113:3,9
timeliness 147:13	transfusion 170:17	Twenty 15:1 16:5	understand 13:4	urology 112:22
timely 33:3 177:12	170:22 171:12	21:19 22:1,4	19:20,20 34:15	usability 10:4
times 4:13 5:12	192:4	66:16,20 67:20	41:3 45:9 46:5	14:20 18:2 22:4
52:16 76:11,14	transfusions	143:2	56:7,10 89:15	50:16 56:4 67:1
86:8 88:12 94:5	170:11,16	Twenty-one 14:12	112:7 137:2 190:9	80:22 97:8 143:10
97:20,21 112:6	treat 63:7	14:20 22:7 23:5	196:12,20 197:4	use 7:4 8:20 19:9
137:22 152:19	treated 10:10 15:13	two 5:18 7:5,13,21	200:10 211:4,7	30:12 31:22 32:8
171:8 174:20	62:20,22 68:16	11:18 27:21 45:12	understanding	37:6 38:1,7 40:2
175:11 178:15	treatment 16:8	56:7 65:13 66:11	12:11 21:11 57:15	52:20 63:6,6
189:6 192:20	21:14 40:13 61:19		Understood 100:15	68:21 72:6 73:15

73:18 88:21 105:8 116:22 117:2 119:2 122:11 124:7,20 127:18 130:13 138:9,21 140:6,7,10,12 152:4,7 159:7 163:15 173:18 179:6 188:17,18 188:21 190:8,10 198:8,16,17 202:7 202:8,14 203:15 204:4 208:10 useful 10:1,5 21:13 44:13 64:2,21 65:4 81:12 139:8 166:14 175:7 219:16 220:15,16 usefulness 72:20 179:7 uses 23:15 107:9 198:3 usually 27:13 62:11 91:21 108:13 173:3,8 utilization 19:7 22:18 utilizing 63:12	value 7:6 30:7 73:2 76:15 83:11 84:11 87:10 89:17 92:18 93:22 106:8 151:9 188:6 valued 222:1 values 81:10 191:2 valves 57:18 Vanderbilt 88:7 Vanderburg 77:21 variability 65:14 77:10 variables 198:7 variants 57:19 variation 22:16 65:8 variety 41:7 97:19 various 4:13 63:5 208:5 vascular 36:9 217:5 vast 20:12 60:9,9 VBP 92:14 93:6 veno 102:11,22 venous 100:19 144:19,22 164:7 veno-dilated 136:9 veno-thrombo 102:5 verbose 217:21 versus 24:16 39:10 39:18 60:1 67:9 67:10 73:12 88:13 95:21 117:2,3 119:8 145:9 160:21 174:4 185:22 196:9 viable 214:19 view 74:17,17 112:22 117:7 157:8 196:13 viewed 217:8 vigilant 190:3 virtue 69:15 visited 214:22 vital 184:19 VIVIENNE 1:19	volume 74:22 161:7 162:3 vote 14:9,10,14,17 14:19 16:3,18 21:17,21 22:12 23:5 41:1 47:16 50:2 51:8 55:7 66:14 96:21 97:3 97:7,15 118:5 138:7 142:20 143:4,15 144:13 149:10 189:21 voted 150:2 189:15 voter 51:1 voting 51:4 118:2 149:16 190:5 218:15 220:4 VPS 92:11 VTE 7:14,15,22 101:16 102:19 116:4,14 118:22 122:9,10 126:7,13 131:20 134:8 136:19 185:16	183:10 185:7 193:5 194:17 198:16,16 203:7 209:20 211:3 220:19 wanted 4:6 63:11 68:10,15 83:2 88:15 121:21 138:6 146:10 163:8 166:19 197:12 213:22 wants 13:17 21:3 22:12 25:9 40:22 59:1 144:12 155:11 195:16 199:16 206:6 warehouse 13:11 89:6,12,17 Washington 1:9,10 216:14 wasn't 53:4 84:16 85:4 103:5 164:9 175:18 193:15 wasteful 121:19,20 watching 194:3 way 25:11 38:15 39:3 47:4 55:4 75:4,6 76:4 81:12 87:22 90:16 111:2 113:6,20 120:9 124:7 127:4 135:5 140:13 147:5 153:6,11 154:10 159:8 161:22 162:4 163:17 170:4,16 171:6 172:2 175:18 176:7 182:19 185:17 197:10,12 197:22 198:13,14 200:16 202:14 206:7 210:5 213:7 215:1 219:14 220:14 221:11 ways 30:3 41:7 120:17 121:18 160:16 163:14	195:12 203:6 208:6 WEBER 2:10 website 213:18 week 54:5 128:9,11 180:19 187:8 220:7 weeks 180:19 206:21 weight 69:12 117:2 118:10 119:15,15 119:15 weighted 10:11 11:19 68:17 93:10 93:12,14 weighting 15:14 69:11,17 weights 93:15 weird 29:1 Welcome 3:3 4:4 went 46:2 71:3,3 91:13 113:14 126:11 155:17 164:7 166:9 174:18 178:19 183:7 212:17 222:14 weren't 37:14 69:21 88:16 West 1:9 we've 89:1 205:11 whichever 128:5 whipples 113:18 wife's 39:2 WILHOIT 2:3 12:12 25:15 31:6 32:9 40:10 44:14 64:1 70:11 84:2 89:14,21 116:2 117:11 118:12 142:11 willing 157:4 willingness 221:17 wind 187:10 window 60:10,19 67:16 winner 49:15
V		W		
VA 1:19 176:18 200:20,22 vac 62:4 vacs 63:6 vague 73:6 76:5 valid 152:3,22 153:7,10,15 154:2 154:2 187:20 validate 51:21 validated 58:1 validation 28:4 44:10 validity 44:20 51:13 valuable 20:20 120:2 193:5 217:14		w 166:9 wait 147:16 waiting 195:19 walk 184:20 Wanda 2:21 89:9 89:11 129:21 196:16 want 14:1,7 16:1,2 36:18,21 45:6 53:11,14 61:2 67:18 76:10,12 77:6 80:9,12 91:5 98:9,21 99:10 102:12 105:22 110:8 119:21 121:16 124:20 138:17 149:9,18 152:11,13 157:6 159:18 163:13,14 167:1,16 174:11 179:19 182:2		

141:18,18 202:15 202:19 winners 197:20 wire 58:21 wireless 91:16 wires 57:5,11,17,18 58:3,17,20 59:6 withdraw 190:17 withdrawn 153:5 woman 188:5 wonder 27:2 30:14 44:22 60:19 wondered 10:9 64:1 wondering 28:3 36:4 79:1 134:2 word 154:15 words 18:10 19:2 33:13 132:22 work 10:19 17:15 17:22 24:9 27:12 28:1 31:1 32:14 49:6,11 54:7 72:17 94:16 96:6 103:6 106:11 110:16,22 121:4 138:15 145:12,16 174:15 179:1 200:9 206:1 207:19 209:19 216:18 219:13,16 219:18 worked 67:11 86:21 141:17 185:2 working 18:6 151:18 154:16 211:18 work-around 109:6 110:20 111:4,6,16 138:22 work-arounds 110:8 world 43:10 44:1 66:9 135:15 193:17 208:3,8 worry 153:9	worse 199:11 worth 45:5 worthy 106:4 wouldn't 41:17 62:14 204:22 wound 6:6 55:13 55:19 60:22 62:4 65:18 67:15 85:3 94:12 108:3 109:7 124:22 138:20 wounds 108:8,9,10 write 53:17 183:19 212:19 writes 215:5 writing 185:15 written 41:16,18 54:2 76:4 115:19 wrong 26:16,16 85:8 148:17 151:13	Z	Zambricki 2:4 33:21 101:12 115:20 118:6 133:21 134:11 137:16 144:20,21 145:16,21 zero 64:22 65:10 zeros 64:17	11:58 155:17 110 77:22 78:2,5 80:17 86:9 95:17 1100 7:12 113 158:13 12 56:21 58:21 60:15 90:18 97:5 175:3 12:00 155:12 12:30 155:13,15 12:33 156:2 120 80:18 13 143:7 14 164:1 140 86:14 88:21 144 3:13 1479 3:10 16:11 23:7 164:5 15 11:14 24:1 33:8 195:7 150 77:7 80:12,19 166:3 150,000 129:7,19 152 3:16 156 3:18 16 3:8 166 3:19 169 9:5 17 149:14 18 8:12 23:11 55:17 164:6 180 57:8 86:14 88:21 95:17 19 55:9 19,000 146:21 190 78:12 1919 1:9 1999 154:22	73:17 76:21 77:7 78:1,9 80:11 86:10 87:19 88:4 88:9,11,14,17 89:2 98:4 2000's 79:10 2001 72:6 2002 154:22 2004 8:16 154:22 2005 146:21 2007 72:7 2008 122:15 2009 95:14 2009-2010 72:14 2010 1:4 8:17 2011 1:6 178:21 2013 7:7,8 190:13 21 14:12,21 16:6 21:20 22:7 23:5 66:17 210 78:11 217 3:20 137:18,22 164:7 218 3:21 137:19,22 222 3:22 23 3:10 23rd 211:16 212:12 213:21 24 7:19 74:20 90:11 90:19 92:2 94:13 95:9 96:17 99:8 99:11 100:19 101:17,18 102:5,6 102:15 104:7 132:9,20 134:14 134:22 135:2 24-hour 87:8 132:16	X	X 81:9 84:7 119:18 159:15	Y	yeah 198:7 year 7:7 59:10,18 60:2 65:1 72:10 129:8 133:19 184:5 206:16 years 8:12 23:11 25:5 30:17,18 34:13 63:9 65:12 72:12 74:10 85:10 113:2 125:14 172:8 175:3 189:8 190:3,19 195:7 206:3 yesterday 4:7,13 5:11 6:1 14:4 20:8 64:9 155:14 159:3,8,11 162:2 166:9 168:21 170:1 171:8,10,14 172:1 203:4 204:1 209:8 210:12	0	0113 158:11 0116 3:7 8:3,4,7 68:5,11 0118 3:8 16:8,11,22 0130 3:11 6:12 55:12 0134 157:16 0217 3:13 122:11 144:18 164:19 0218 3:14 100:17 101:11,13 122:11 145:2 164:11,16 0300 3:12 71:10,14 0371 164:13 0456 158:11 0516 157:17	1	1 1:6 122:10 126:2 144:16 176:16 177:15 1,000 88:8 1.c.9 118:7 1;33 222:14 10 64:13 97:9 98:13 108:16 206:2 10:14 71:3 10:30 70:22 71:1 10:37 71:4 100 9:10 20:13 62:15 104:20 183:7 202:10 101 3:14 11 10:7 136:22 143:10 11:00 96:13	2	2 118:15 122:10 2.a.10 135:1,3 2.a.21 84:4 2:00 96:11 217:17 20 143:2 172:8 202:11 205:18 200 64:6,10 71:21	3	3 14:18 65:10 125:21 144:15 157:19 3:00 75:8,10 30 55:18 56:19 60:9 60:16,18,20 104:6 183:22 205:19
--	--	----------	---	---	---	----------	-------------------------------------	----------	---	----------	---	----------	---	----------	---	----------	--

30-day 60:1 67:16 102:21 169:14	34:13 37:5,8,10 37:11		
30-plus 63:8	65-70 44:1		
30-some-odd 29:14			
31 61:6 95:2	<hr/> 7 <hr/>		
32 26:14 39:10	7 40:12 97:6,12 143:13		
32.8 26:15	70 146:22		
33 26:19	71 3:12		
35 26:22 198:7	75 135:4		
3500 7:20			
360 161:5	<hr/> 8 <hr/>		
361 161:6,10	8 3:7		
363 161:10	80 80:17,18 176:21 202:12 211:14		
<hr/> 4 <hr/>	85 9:10 31:11		
4 3:3 114:5	8586 40:12		
4th 219:9,22			
40 25:4 31:9	<hr/> 9 <hr/>		
4431 137:8	9 84:5 97:11 126:12		
4438 137:8	9:00 1:10 75:9,11		
4439 137:8	9:02 4:2		
456 158:16	9:25 11:8		
48-hour 76:1	90 23:17 36:4 38:21 39:10 72:13 104:18 129:11		
<hr/> 5 <hr/>	90-something 39:16		
5 3:5	92 104:18 147:4		
5th 219:9	94-95 146:1		
50 25:4 79:11 135:12 206:1	95 26:18 45:4 72:13 196:15		
500 81:6	98 17:14,17 19:10 19:10,17 187:21		
53 64:14	98.5 181:1 183:7		
54 64:13,14	99 181:1		
55 3:11			
581 9:9			
<hr/> 6 <hr/>			
6 71:11,15,21 73:2 74:2 79:6 97:9			
6:00 75:4,8 76:15 76:17 77:11 78:16 83:20 86:19 90:11 90:20 91:12 92:6 95:11 96:9,18 99:8 188:5			
60 25:4 33:8			
640 64:12			
65 24:1 25:5 27:9 30:17,18,21 31:19			

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Surgery Endorsement Maintenance 2010
Steering Committee

Before: Arden Morris, Chair

Date: 03-01-11

Place: Washington, DC

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

Neal R Gross

Court Reporter

NEAL R. GROSS

COURT REPORTERS AND TRANSCRIBERS

1323 RHODE ISLAND AVE., N.W.

WASHINGTON, D.C. 20005-3701