

THE NATIONAL QUALITY FORUM

+ + + + +

MEETING OF THE CHILD HEALTH STEERING COMMITTEE

+ + + + +

FRIDAY

NOVEMBER 13, 2009

+ + + + +

The Child Health Steering
Committee met in the Ambassador Room of the
Hilton Washington Embassy Row, 2015
Massachusetts Avenue, N.W., Washington, D.C.,
at 10:00 a.m., Charles Homer and Marina L.
Weiss, Co-Chairs, presiding.

PRESENT:

CHARLES HOMER, MD, Co-Chair
MARINA L. WEISS, PhD, Co-Chair
DAVID R. CLARKE, MD
SHARRON L. DOCHERTY, PhD, CPNP (AC/PC)
KATHY J. JENKINS, MD, MPH
ALLAN S. LIEBERTHAL, MD, FAAP

THOMAS McINERNY, MD
MARLENE R. MILLER, MD, MSc
LEE PARTRIDGE
JANE PERKINS, JD, MPH (via telephone)
DONNA PERSAUD, MD
GOUTHAM RAO, MD
ELLEN SCHWALENSTOCKER, PhD, MBA

BONNIE ZIMA, MD, MPH

NQF STAFF PRESENT:

IAN CORBRIDGE
MELISSA MARINELARENA
ASHLEY MORSELL
EMMA NOCHOMOVITZ

REVA WINKLER, STAFF
BONNIE ZELL, STAFF

C O N T E N T S

Welcome and Introductions, 5

Review of Day 1 and Discussion:

Framework for Measuring

Child Health Outcomes

Discussion: Measure evaluation 121

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

2 9:08 a.m.

3 CO-CHAIR HOMER: So now I can say
4 it again with the microphone. Good morning,
5 everyone.

6 PARTICIPANTS: Good morning.

7 CO-CHAIR WEISS: And good morning.
8 Delighted to see all of you looking so ready
9 to go.

10 CO-CHAIR HOMER: So I'm sorry.
11 Reva, you said something about --

12 DR. WINKLER: We want to have the
13 operator open the lines to see if anyone is on
14 the call.

15 THE OPERATOR: All lines are open.

16 DR. WINKLER: All lines are open.
17 Is anyone on the line?

18 MS. PERKINS: Jane Perkins. I'm
19 here. Hello. Good morning, everybody.

20 DR. WINKLER: Hi, Jane. Thanks
21 for joining us again.

22 MS. PERKINS: Thank you for having

1 me.

2 CO-CHAIR HOMER: So it sounds like
3 there was some enjoyable evening activities.
4 It sounds like Kramer's Books was a good place
5 for dinner. Perhaps we'll make a note of that
6 for future meetings.

7 So we have a good day today. Reva
8 also tells me that the staff was extremely
9 productive and has a lot to share with us
10 today. So we're looking forward to that.

11 So with that it says "Welcome,
12 Introductions, Brief Review of Day 1." Do you
13 want me to review Day 1 or will you be
14 reviewing it? Go ahead.

15 DR. WINKLER: As always happens,
16 Day 2's agenda always gets shuffled based on
17 what happens on Day 1, and so this morning
18 we've pulled together some of the things
19 you've talked about, brought in some of the
20 information you were asking, and we'll go over
21 that minutes, and that's sort of a review of
22 yesterday.

1 We've also drafted up some
2 language for the call for measures for you to
3 look at based on your conversation yesterday,
4 and then we're going to need some input from
5 you all on who to target this call to to help
6 us distribute it appropriately.

7 Then I've also got a draft of a
8 potential framework for you to take a look at
9 and think about and opine upon. And so the
10 last thing we'd like to do is go over NQF
11 standard evaluation criteria. You received it
12 in your materials, but you will be evaluating
13 measures, and so just as an introduction and
14 also when you're thinking about measures that
15 might be out there to submit, realizing that
16 they will be judged against these criteria and
17 kind of knowing what the lay of the land is
18 might be helpful in targeting and looking for
19 measures out there to get submitted into the
20 project.

21 And then we'll just talk about
22 where we go from here. Quite possibly we'll

1 be done around lunchtime, and luckily the
2 weather seems to have improved from when you
3 came in so that hopefully traveling out won't
4 be as uncomfortable as it was when you
5 arrived.

6 But that's what our plan for this
7 morning is, and I'm hoping for everybody to
8 react. We're looking for your input
9 significantly because it will help kind of
10 determine where we got next and how we guide
11 the work that we're going to do.

12 So there were a couple of things
13 that you were talking about yesterday,
14 information we wanted to get to bring back
15 that you talked about, but we didn't have
16 details on. And so one of them was you were
17 talking about the CHIPRA core measures, and
18 what I did is I pulled the set of 25, the
19 recommended set off the AHRQ website, and I
20 did two things. I highlighted those that are
21 NQF endorsed measures, and I also assigned
22 those that I thought were outcome measures.

1 And you can see that some of them
2 are certainly NQF endorsed measures. Not that
3 many of them are outcome measures, and we
4 could probably have a discussion on whether on
5 the assignment of outcome or not, but you can
6 see where we are. There aren't that many
7 outcome measures, and most of them that are
8 are already in queue as endorsed measures.

9 So you can kind of see that the
10 work NQF does plays a significant role in this
11 sort of things. The two outcomes measures,
12 and again, are they outcome measures; are they
13 ER visits sort of in general I assume; and
14 then the asthma patients greater than a year
15 of age with more than one asthma ED visit.
16 That seems to be the only outcome measure in
17 there.

18 But there are several others, and
19 they are already within NQF's portfolio. So
20 that's just a bit of a follow-up.

21 Question, comment?

22 DR. LIEBERTHAL: Whose measure was

1 the asthma greater than one year with an ED
2 visit?

3 DR. WINKLER: Don't know right off
4 the top of my head. I didn't capture that.
5 It's on our website. We can go back and find
6 out.

7 DR. LIEBERTHAL: The NCQA,
8 virtually every criteria for asthma or measure
9 for asthma starts at five years because under
10 five years it's very difficult to know what to
11 call asthma. There are so many other
12 conditions, and it's a very different disease
13 under five years of age than over five years
14 of age. So I have a problem with that as a
15 measure.

16 DR. WINKLER: Right. Well, just
17 because we were talking about it, I thought
18 I'd actually just bring the list and show
19 where we've intersected. As far as I'm aware,
20 all of the measures, and they're all process
21 measures that NQF has endorsed. They are as
22 you say. The NCQA started five years kind of

1 measure.

2 So that was one thing that we did
3 to kind of follow up on what you were talking
4 about. Another one that we were looking
5 around for, you know, the top 20 for children,
6 not easy to find, but we did find this is sort
7 of a summary article that AHRQ put out from,
8 you know, all of the data they crunch. It's
9 amazing. They don't do a top 20 diagnosis for
10 children. You can't find it anywhere, but we
11 did find the top five most costly conditions
12 in children in the annual cause. I believe
13 this is 2006 cost data.

14 And so, you know, there it is:
15 depression and asthma, trauma, acute -- that's
16 bronchitis, but isn't that misspelled? Yes.
17 Okay. I was going to say I tried to read it
18 and it didn't work for me. And then acute
19 infectious disease.

20 So those are the big ones on
21 overall cost basis. Face validity, does that
22 sound right to you all?

1 DR. RAO: Did you look at the --
2 yes, there's the National Ambulatory Medical
3 Care Survey. Did you have a chance to look at
4 that?

5 DR. WINKLER: I did, and answering
6 this question, isn't it in that published
7 data? If I ran the data myself, I could
8 probably answer the question, but I wasn't
9 doing that last night. I was just looking at
10 the published kind of reports, and there just
11 wasn't a list of, you know, by age, top
12 diagnoses, or any of those sorts of ways. The
13 raw data is there and we could probably
14 generate it, but not last night.

15 So those are the big ones. The
16 other thing that is useful that comes from
17 AHRQ that I looked at was the hospital
18 discharges. So you can cut this either by
19 volume or by cost. This happens to be the one
20 by volume, and this is, again, 2006 data. I
21 think that's the most recent, and so this is
22 overall for all children, and so as Charlie

1 mentioned, the most common is newborn, not
2 exactly a surprise here.

3 But these are broken down into age
4 bands, and so you've got the lesson, the
5 infants, if you will, and so we do have the
6 major diagnoses from hospitalization, and so
7 the one to four, but we're seeing pneumonia,
8 asthma, bronchitis. You know, the respiratory
9 thing is playing a significant role.
10 Dehydration and viral syndrome plays a
11 significant role. School age, same thing.
12 Appendicitis sneaks its way up there, and arm
13 fracture, one of my favorites. I like that.

14 And then I guess the pre-
15 adolescent, appendicitis, you know, hits the
16 top followed by affective or mood disorder.
17 So we're starting to see mental health. So
18 it's really an evolution over time.

19 And then for adolescents that
20 becomes the big one, and then maternal
21 complications and childbirth.

22 So this is one way of looking at

1 the hospitalization. So you know, this data
2 is here. In terms of the ambulatory care,
3 we'll see if we can mine that out, but I
4 couldn't exactly get it real quick. I don't
5 carry the SAZ program on my computer, even if
6 I remembered how to use it.

7 So you know, if anybody runs
8 across that kind of general data around kids
9 trying to figure out, you know, we were
10 talking about slicing and dicing it through
11 both cost and volume prevalence or incidence.
12 It would be great if you could share.

13 Kathy, do you have a question?

14 DR. JENKINS: Now, the other lines
15 of course is severity or outcome, and I know
16 that CHCA has generated a list of the top
17 mortality diagnoses that I can probably --

18 DR. WINKLER: Okay. So that's the
19 other one. So essentially volume, cost and
20 severity are the various ways to slice and
21 dice it. It would be nice if we could pull
22 together the data to be able to have those

1 lists, particularly to see where they
2 intersect.

3 DR. ZIMA: For ambulatory care you
4 might want to look at the NAMCS.

5 DR. WINKLER: Yes, we did.

6 DR. ZIMA: And you didn't --

7 DR. WINKLER: Well, the thing is
8 they give you the raw data. So we could
9 probably pull it out, but they're actually
10 published tables, which was really all I had
11 time to look at last night, didn't lay it out
12 quite the way to answer the question.

13 DR. ZIMA: Yes, and that's tricky,
14 too, because the analysis isn't the child.
15 It's not has base visit, and then when you
16 look at the details, there's some exclusion
17 criteria. It's not perfect.

18 DR. WINKLER: Right. It's around
19 how many visits. If you've got a sick child
20 who's coming in for multiple visits, it counts
21 multiple times rather than one. So data
22 problems always an issue.

1 So anyway, we've kind of pulled
2 these things together to kind of follow up on
3 your conversations. Is there anything else
4 along this realm, and especially data kind of
5 things you'd like to see if we could gather up
6 that would be helpful in performing or
7 thinking.

8 DR. RAO: Does anyone know in
9 terms of the attribution of cost to
10 depression, is that mostly in-patient
11 hospitalization that's the cost?

12 DR. WINKLER: Yes. Well, that's
13 with this, but the previous one that we had up
14 on the top dollar cost, I think it was
15 combined, but -- and I think, again, the data
16 from AHRQ, and it was a summary report, and so
17 I think that if you delve into the data, we
18 can break it down, but again, it's the kind of
19 thing that these were their summary reports,
20 and that was the easiest to grab, but we can
21 probably get that data, you know, by
22 developing different --

1 DR. RAO: It's probably a small
2 number of children who are stimulating a lot
3 of columns.

4 DR. WINKLER: Right.

5 CO-CHAIR WEISS: Reva, can you
6 send that to us electronically?

7 DR. WINKLER: Sure, yes. These
8 are new things we've just discovered. We'll
9 be happy to package them up and send them
10 along. We can share the, but we can see if we
11 can dig in some of the data and get it broken
12 down a little bit more. We can probably
13 contact somebody over at AHRQ and see if they
14 can get it to us.

15 So those were the sort of follow-
16 up on what you discussed.

17 DR. McINERNEY: Does Kaiser keep
18 some data like this?

19 DR. LIEBERTHAL: Not that I'm
20 aware of. We can get the data on what we see
21 the problem may be that the precise coding may
22 be inaccurate. So we're not -- we've only

1 been coding for about two years, and most of
2 the doctors are not very good at it. So I
3 don't know how accurate the data would be, but
4 it would be interesting to search our
5 database, which does have this information.

6 I'll give you an example on the
7 coding, is a search for all patients diagnosed
8 as cystic fibrosis, and looking to see if
9 there are any that are out there that haven't
10 been referred to the CF Center, and we've got
11 a couple of hundred, and over half of them are
12 things like fibrocystic disease of the breast
13 or something like that.

14 CO-CHAIR HOMER: Oh, my goodness.
15 Given the sponsor, it might be worth checking
16 with CMS as to their expenditures by
17 condition, if we could get that.

18 DR. WINKLER: Yes. That's always
19 a real interesting query.

20 DR. McINERNEY: Well, you know, for
21 Medicaid, you need to check with 50 different
22 Medicaid programs.

1 MS. PERKINS: I don't know if they
2 still do it, but some years back Robert Wood
3 Johnson published data on ambulatory sensitive
4 hospital stays, and I think it was for kids.

5 DR. WINKLER: Right. Commonwealth
6 produced data, too.

7 MS. PARTRIDGE: Actually with
8 respect to CMS, they have invested a
9 substantial amount of money in merging all of
10 the data that the claims take. Remember it's
11 admin. It's coming off paid claims, and
12 they've merged it, however, so there is
13 something of a national database. I suspect
14 there's nothing more recent than 2006, but I
15 think Mathematica may be sitting on some of
16 that and could do the analysis, and I'll be
17 glad to ask my former colleague, Jim Verdier
18 who used to run Indiana Medicaid if that,
19 indeed, is there and we can share.

20 DR. WINKLER: Yes, that would be
21 great.

22 DR. LIEBERTHAL: Does NHANES

1 collect that sort of data?

2 DR. WINKLER: I don't know.

3 That's something -- I think they collect some
4 of this kind of stuff, but maybe not in the
5 exactly the way we're asking the question.

6 That's something Bonnie might be able to help
7 us with.

8 Do you know if NHANES collects the
9 kind of childhood diagnoses?

10 We can find out.

11 DR. McINERNEY: The only other, I
12 would wonder if somebody like UHC, United
13 Healthcare which has, you know, huge numbers
14 of patients, and that's commercial but you
15 could probably extrapolate if they would
16 release it. I don't know whether they
17 consider it proprietary.

18 DR. WINKLER: They tend to.

19 DR. McINERNEY: Yes.

20 DR. WINKLER: Yes, in
21 conversations.

22 CO-CHAIR WEISS: Let me just say

1 that we have worked with Thompson Healthcare
2 in the past, and they have an aggregate
3 database of about ten million lives. It's all
4 from the private sector side, and they have
5 been very cooperative in helping us with
6 certain codes and so on. So it's another
7 possibility.

8 DR. WINKLER: Yes, okay. All good
9 options. So we'll see what we can pursue to
10 come up with that kind of information.

11 The next thing in terms of follow-
12 up is the rather lengthy discussion we had
13 around -- oops, this isn't what I meant to get
14 -- around the call for measures. Now, somehow
15 I am struggling with myself here. I pulled
16 the wrong file.

17 But I drafted a -- sort of
18 redrafted that list that you talked about
19 yesterday. Where did it go? Draft call.
20 Here it is. Thank you, finally.

21 In terms of the bullets we went
22 over and so I want to share what I kind of

1 drafted up if I can get it on the right
2 computer. Bear with me just a second.

3 So just for Marina's point,
4 outcomes up at the top of the page. This is
5 sort of boilerplate background, but here is
6 where we're really talking about what we were
7 working with yesterday, and how is it to point
8 to C? Not that easy? Yes, that's what I was
9 just about to do. That's where I was going.
10 Come on. I want to zoom. I'm trying to get
11 150.

12 Yes, well, that will do it. Okay.
13 So this is actually the meat of the call that
14 we did, and so a couple of -- you know, I
15 tried to change it in response to what you
16 were talking about yesterday, and this is
17 where, you know, continue to help working on
18 this. The first bullet I just allocated to
19 functioning because we talked a lot about
20 functioning, both child and family, including
21 maintenance or improvement as well as
22 attaining optimal functioning. So all of

1 those, I think were elements that you were --
2 that were highly desirable, and so I made them
3 as explicit as possible, and I separated out
4 what had previously been with that bullet,
5 symptom improvement or relief. We didn't talk
6 very much about that, and then added a bullet
7 on growth and development to include physical,
8 cognitive and social, all of those things.

9 And I think we said the physical
10 fitness kind of thing, developmental
11 milestones, that kind of rolled into that
12 area.

13 Then that one bullet that you had
14 trouble that seems kind of messy, I broke out
15 patient or parent reported outcomes, such as
16 health status or health related quality of
17 life because we do see those.

18 CO-CHAIR WEISS: Let me just ask.
19 I think Allan made the point yesterday or
20 someone did that in the patient or parent
21 reported arena we needed to use some sort of
22 objective structured measurement tool so that

1 it's not just casual.

2 DR. WINKLER: Right, okay. Report
3 outcome tools for -- what's the word?
4 Standardized, that's the word. Health status
5 or health related quality of life assessment?

6 DR. McINERNEY: Would that include
7 something like the PAN symptom checklist?

8 DR. WINKLER: Possibly.

9 DR. McINERNEY: All right, and then
10 the ADHD like the Vanderbilt?

11 DR. WINKLER: Yes, yes. Well, I
12 think it depends. Remember there are other
13 specifications beyond the tool. When do you
14 use it? Who do you give it to? How do you
15 interpret the results? How do you use those
16 results to assess quality?

17 So there are other elements
18 besides the exact tool that would create the
19 measure, but then so anything else on that?
20 Okay.

21 Do you want cognitive? Do you
22 want emotion? Works for me.

1 DR. SCHWALENSTOCKER: Could I ask
2 one question about the one above that?

3 DR. WINKLER: Sure.

4 DR. SCHWALENSTOCKER: Physical
5 fitness seems to me to go better with the
6 first one than the growth and development, but
7 maybe I'm --

8 DR. WINKLER: I don't care.

9 DR. SCHWALENSTOCKER: Well, I
10 defer to the physicians in the room, but --

11 DR. WINKLER: You were the one
12 that kind of had the physical fitness thing
13 yesterday. So I put it in because you talked
14 about it.

15 Where would you put what?

16 The first bullet there.

17 DR. RAO: I intended physical
18 fitness to be under the first bullet.

19 DR. WINKLER: Oh, okay. That was
20 me. Sorry. I can fix that.

21 CO-CHAIR HOMER: So moving to a
22 different bullet, the compliance with

1 treatment, I'm not really comfortable with
2 that as an outcome.

3 DR. WINKLER: Well, this was sort
4 of what you were talking about on that one
5 bullet you didn't like about knowledge, self-
6 management, yaddy-yadda-dah, and the words you
7 tossed out were kind of compliance with
8 treatment, you know, behavioral change doing
9 something.

10 DR. JENKINS: Is it adherence?

11 DR. WINKLER: Okay. Adherence,
12 compliance.

13 DR. LIEBERTHAL: Adherence is more
14 PC now -- but I think that is an outcome
15 because if you can measure adherence based on
16 your intervention, then you measured -- it may
17 be an intermediate outcome, but it is an
18 outcome because the treatments from many of
19 these things have proven successful, and the
20 failure is the appearance.

21 DR. McINERNY: I think some
22 examples might be seatbelt use, bicycle helmet

1 use, as an intermediate outcome.

2 DR. WINKLER: How about medication
3 adherence?

4 DR. LIEBERTHAL: Why are you less
5 comfortable with it, Charlie?

6 CO-CHAIR HOMER: I guess it's an
7 intermediate outcome. I just tend not to
8 think of that. I mean, I think of adherence
9 as a step along the process to improved
10 outcomes. So, you know, it's part of the
11 treatment. You're not writing whether you
12 prescribe. It's not a process here.

13 We would put it in here and see.
14 I think we'll get back a bunch of measures of
15 adherence. I think the question is whether we
16 really consider that to be a quote, outcome
17 measure.

18 DR. WINKLER: We actually have
19 endorsed a fair number of medication adherence
20 measures fairly recently in a medication
21 management project. So --

22 CO-CHAIR HOMER: Do you view that

1 as the outcome?

2 DR. WINKLER: We didn't really
3 have to say it was an outcome in our process,
4 but that was sort of a --

5 CO-CHAIR HOMER: So maybe we're
6 splitting hairs.

7 DR. WINKLER: Yes, I do think that
8 there is a vagueness to it, and it sort of
9 depends on your point of view, but --

10 DR. JENKINS: I do agree that it's
11 intermediate. So it's an intermediate in one
12 of the others. I'm wondering if there isn't
13 a way to say that intermediate clinical
14 outcomes with definite links to clinical
15 outcomes, to clinical outcomes, will be
16 considered and put them all together, and
17 adherence would be part of that for me.

18 CO-CHAIR HOMER: I mean, I
19 differentiate, for example, the outcome of
20 counseling about or legislation to change
21 seatbelt use. Whether you are smoking, for
22 example, it's an outcome to me of whether the

1 person stops smoking or not.

2 DR. WINKLER: Yes, it's decision
3 weight.

4 CO-CHAIR HOMER: Right, which is
5 the behavioral change.

6 DR. WINKLER: Right.

7 DR. JENKINS: Or adherence. I
8 mean, that is adherence to counsel.

9 DR. WINKLER: Okay, or adherence
10 to whatever therapy you recommend.

11 DR. RAO: Reva, what kind of
12 measures are you getting for medication
13 compliance? Are they like co-counts or --

14 DR. WINKLER: Yes, it's medication
15 possession ratios, is sort of the most common
16 one, and actually they landed on sort of a
17 standard definition for medication or for
18 medication possession ratio.

19 DR. RAO: These are for adults
20 with heart failure, things like that?

21 DR. WINKLER: Actually across the
22 board, and some of them actually could apply

1 to kids. I have to go back and look at the
2 actual specs, but you know, it was statins.
3 It was some of the mental health meds or
4 schizophrenic medications actually, as well
5 as, you know, the beta blocker, you know, the
6 usual stuff.

7 DR. ZIMA: This is just a
8 wordsmithing, but I think I'm again back on
9 thinking about what Charlie is struggling
10 with. Maybe it's adherence with treatment,
11 comma, behavioral intervention, not
12 necessarily change, just to have two nouns
13 there, and that we think goes to the point
14 about counseling.

15 DR. WINKLER: I guess one of the
16 things I'm thinking about with, you know, the
17 behavioral intervention, the outcome, is as a
18 result of your counseling did they do
19 anything. Did they change something?

20 CO-CHAIR HOMER: I think the
21 heading is behavioral change. That's the
22 lead.

1 DR. WINKLER: Okay.

2 CO-CHAIR HOMER: And then

3 adherence which he meant is actually part of
4 the example, medication adherence. I think
5 that probably captures it.

6 DR. McINERNEY: You could maybe use
7 another example. You could put in smoking
8 cessation.

9 DR. WINKLER: Happy? Does that
10 work?

11 Donna, please.

12 DR. PERSAUD: I know Kathy said
13 this, and I don't know if we adjusted the
14 document to reflect that, whether either in
15 the introductory or in these bullets we
16 specify that we're primarily searching for
17 outcomes measures, but if they are processed
18 or intermediate, those are acceptable
19 submission as long as you show clear linkage
20 to a specific outcome measure.

21 DR. WINKLER: Yes, I think
22 actually really we don't want to open the door

1 to process measures because that's essentially
2 what the rest of the NQF portfolio is, but
3 intermediate outcomes, and I think that's why
4 we are trying to get this list of bullets
5 right, to describe what we mean by outcomes,
6 because, again, the term may mean different
7 things to different people.

8 So what are we including in this
9 project as being the outcomes of interest or
10 desirable outcomes? What's the breadth, but
11 what are the limits?

12 So I would be uncomfortable, you
13 know, saying that we're accepting process
14 measures because that's really not what we're
15 trying to do. Intermediate outcomes, which is
16 why it's one of the bullets, is perfectly
17 reasonable.

18 Right, but at this point what
19 Melissa is bringing up is we've seen lots of
20 measures around smoking cessation counseling,
21 and we're trying to be sure that the measure
22 we have is one measure applicable to everybody

1 as opposed to multiple little ones, but
2 harmonized, you know, looking to see if the
3 smoking cessation measures we have actually
4 including children.

5 As it turns out, the endorsed set
6 right now has two measures, one for adult, one
7 for children. They're identical, but there
8 are two. So merging.

9 So to the degree we have some of
10 these sort of cross-cutting, generic things
11 that really aren't, you know, population
12 specific, we don't want multiple little
13 measures for all of the different populations.
14 We like one measure that would apply to
15 everyone.

16 CO-CHAIR HOMER: I mean, the
17 relevant pediatric measure which maybe would
18 come in here is actually going to be
19 initiation or lack thereof of smoking. So
20 actually that would be something I'd be
21 interested in getting in this call because
22 that's --

1 DR. WINKLER: Prevention would be
2 even better.

3 Lee, you've been patiently --

4 MS. PARTRIDGE: Sorry. I'm
5 sitting here struggling with patient or family
6 experience with care because in the NPP work
7 we see that as having three dimensions. One
8 is the experience. Are you satisfied with the
9 care that you receive, been your experience
10 with whomever, your health plan, your
11 physician, your hospitals, your home health
12 agency?

13 But the other two are shared
14 decision making, which is sort of part of the
15 knowledge concept, I think, that we were
16 flirting with yesterday. To the extent that
17 you have a family very much involved in trying
18 to decide how you're going to handle the
19 condition or treatment of your child, and then
20 the third, of course, is developing family and
21 patient capacity for assuming more management
22 of their own care.

1 And it seems to me we need
2 somewhere in here to reach out to the
3 prospective developers and senders and say,
4 "We would like to have something around
5 measurement of parent and patient involvement
6 in their care," not just a passive "did you
7 adhere to the treatment plan," but "were you
8 involved in developing the treatment plan?"

9 Development, developing the
10 treatment plan is a process measure. It's not
11 an outcome measure.

12 DR. WINKLER: Right.

13 DR. JENKINS: Lee, I was thinking
14 maybe that second half of what I think you're
15 alluding to, which is the whole shift that we
16 talked about yesterday to a chronic disease
17 management model where for a portfolio of
18 patients, clinicians are actively managing
19 patients whether they're in their viewpoint or
20 not that day.

21 And to your same point, the
22 families are also part of that story, and I'm

1 not sure if that's all wrapped into the
2 clinical outcomes at the end or somehow moving
3 toward that different type of management model
4 should be more explicit. Is that part of what
5 you're thinking?

6 DR. WINKLER: Are there
7 intermediate outcomes that you're thinking of,
8 Lee? Because ultimately the end is, you know,
9 did they do well for whatever you're being
10 treated for, but are there intermediate
11 outcomes, such as for the shared decision
12 making. The parent-family perception that
13 they had a lot to say in the decision making
14 process, is that an intermediate outcome in
15 this kind of situation?

16 DR. LIEBERTHAL: I think it is.

17 DR. WINKLER: Okay.

18 CO-CHAIR HOMER: So I think the
19 way to do it if we wanted to would just be to
20 put a parenthesis after the patient or family
21 experience with care and list those three
22 dimensions that you mentioned, which could be,

1 you know, ratings, comma, shared decision
2 making, comma, and --

3 DR. WINKLER: So one is
4 satisfaction, right?

5 DR. JENKINS: The other one is
6 value, value from the perspective of patients
7 and families, which is another new paradigm.

8 DR. SCHWALENSTOCKER: And then
9 there's the efficacy, talk about patient
10 efficacy or family efficacy in making the
11 illness, kind of getting it to your chronic
12 care.

13 CO-CHAIR HOMER: I think the
14 capacity for self-management, does that
15 capture that concept?

16 I guess the only question I'd have
17 and I guess we'll find out when we call, I
18 mean, CAHPS is already an endorsed measure --

19 DR. WINKLER: It is.

20 CO-CHAIR HOMER: -- including the
21 pediatric CAHPS survey. So I'd be surprised
22 if we'd get anything better. I mean, there

1 might be narrower measures.

2 DR. WINKLER: I was going to say
3 aren't there some disease specific survey type
4 tools --

5 CO-CHAIR HOMER: DR. RAO: Yes,
6 there are.

7 DR. WINKLER: -- looking at some
8 of these elements? So you know, whether we
9 want to break them down and have a library of
10 these little things --

11 CO-CHAIR HOMER: There are.

12 DR. WINKLER: Yes. That would
13 potentially capture some of those.

14 DR. ZIMA: This is a minor point,
15 but I'm responding again to I think the AHRQ,
16 and if no health is going to be here, maybe a
17 few more triggers in there about mental
18 health. So symptom improvement, really for
19 example, pain control, asthma control, you
20 pepper in there something, either decreased
21 hyperactivity or decreased oppressive
22 symptoms, something that has a mental health

1 to kind of trigger that we're going to be open
2 to mental health outcomes as well. So symptom
3 would be improved hyperactivity, reduction in
4 depressive symptoms, something like that.

5 DR. McINERNY: I'm blocking on the
6 names, but the two folks from Crotched
7 Mountain have the medical home survey.

8 Carl Cooley, right and McAllister.
9 You're right.

10 I don't know as we need to put it
11 in there, but for smoking cessation there have
12 been some efforts to try and get parents of
13 kids who have things like cystic fibrosis or
14 asthma to stop -- get the parents to stop
15 smoking. So far I think most of those efforts
16 have not been terribly successful, but I think
17 it is an important outcome for the kids if you
18 can get the parents to stop smoking, and I
19 don't know if we need to actually specify
20 that, but it would be interesting to see if
21 anybody comes up with that as a measure,
22 outcome measure.

1 DR. RAO: The whole issue of
2 environmental health is the home environment,
3 especially with respect to obesity. The built
4 environment plays a role, but how you define
5 outcomes and measures for that sort of thing.

6 DR. WINKLER: Yes, I mean, aren't
7 those really the process?

8 DR. RAO: Yes, they are process.

9 DR. WINKLER: The structure or
10 processes that contribute in the outcome is
11 normal weight or, you know, good breathing.

12 DR. ZIMA: Could we also add under
13 behavioral change another example, reduced
14 high risk behaviors? I think that would
15 capture this concept of delayed use, substance
16 abuse, driving, all of that.

17 DR. WINKLER: Reduced high risk
18 behavior, yes. Okay.

19 DR. JENKINS: Charlie, do you
20 think your transition to adulthood is in the
21 first one? Is it there well enough?

22 DR. WINKLER: Isn't growth and

1 development transition to adulthood?

2 DR. JENKINS: My boss says that
3 everyone should become a taxpayer. That's his
4 goal.

5 (Laughter.)

6 DR. WINKLER: Well, very
7 pragmatic. Productive, tax paying.

8 DR. ZIMA: Just a boilerplate.
9 Again, you're going to be putting in some type
10 of comment that when you refer to it as
11 parent, that you're referring to any sort of
12 primary caregiver.

13 DR. WINKLER: Right. Yes, I mean,
14 should it be caregiver versus parent? It just
15 seems for children, I mean, it's --

16 DR. ZIMA: You know, I find if
17 it's in the introductory paragraph that
18 hereafter, you know, primary caregiver is
19 referred to as "parent," it saves text, but
20 then you know, you have Grandma, you have the
21 foster parents, you've got --

22 DR. WINKLER: Yes, you've got all

1 the others.

2 DR. ZIMA: -- the social workers in
3 there.

4 DR. WINKLER: I'm not sure exactly
5 where it goes right at the moment, but we can
6 add it, yes, right, exactly.

7 DR. McINERNEY: Where do we put
8 something like disease reduction? So that,
9 you know, if you counsel lessons on safe sex,
10 that we have less sexually transmitted
11 illness.

12 DR. WINKLER: Isn't that an
13 interesting one? Because where's the data
14 that collects them and it doesn't happen? I
15 mean, it's almost a negative.

16 We tend to monitor the incidence
17 of, you know, various conditions.

18 CO-CHAIR HOMER: I think that
19 would be included in some of the community
20 health indicators.

21 DR. WINKLER: Right, but it's
22 still an outcome, is the lack of, the absence

1 of bad things.

2 MS. PARTRIDGE: Wouldn't that also
3 be true, say, of community data like suicide?
4 I mean, that it seems to me is a partner with
5 do you screen and counsel for depression.

6 DR. WINKLER: Well, one of the
7 things I was thinking about was this whole
8 issue around immunization. You know, the
9 rates are such a proxy for disease prevention,
10 but that paired with sort of the big picture,
11 you know, community incidence of immunization
12 preventable diseases gives you that picture.
13 It's one of the things --

14 CO-CHAIR WEISS: Well, it
15 certainly could be in a category of
16 population-wide measures, community as it
17 compared one to the other or say it's a
18 compared one to the other.

19 DR. JENKINS: Maybe we could have
20 a whole bullet on like population health, one
21 little circle.

22 DR. WINKLER: Hold on, hold on.

1 Because I struggled with trying to figure out
2 how to, again -- I created it as sort of a
3 second one rather than bury it as its own
4 bullet. I went down, "additionally care and
5 soliciting measures to assess populations
6 including," and I had to put something down so
7 you can change it, but I was thinking about
8 the conversation you had around, you know,
9 entire providersp populations rather than
10 those who just walk through the door.

11 We were talking about populations
12 that are sensitive to disparities, you know,
13 however you want to slice and dice it, and
14 then the third bullet was the one I have no
15 clue exactly. I just threw something there,
16 was the community concept that I think is what
17 you're starting to talk about, and again I
18 just did not know quite how to --

19 DR. ZIMA: I sometimes use
20 communities in which health care, dah, dah,
21 dah.

22 DR. WINKLER: Right.

1 DR. ZIMA: Sometimes we use the
2 words "child-serving care sectors."

3 DR. WINKLER: Okay.

4 DR. ZIMA: And then that
5 encompasses education, child welfare, juvenile
6 justice --

7 DR. WINKLER: Child --

8 DR. ZIMA: Child, hyphen, serving
9 care sectors."

10 DR. WINKLER: -- care sectors,
11 rather than communities.

12 CO-CHAIR HOMER: Rather than
13 "others."

14 DR. McINERNEY: You know, there are
15 these now improvement partnerships where there
16 are groups of pediatricians, often academy
17 chapters, that work with the state Medicaid
18 folks, and there was a great website, Webinar
19 on that recently led by the folks from Vermont
20 and how several states have significantly
21 improved immunization rates and other
22 conditions by working together, the

1 pediatricians in the chapter working with the
2 Medicaid folks at least for the Medicaid
3 populations.

4 CO-CHAIR HOMER: Agreed on both
5 points, but I think what we're trying to get
6 here are measures of population health
7 basically, measures of community health
8 indicators in which health care may have joint
9 accountability with other child-serving
10 whatever the word you used.

11 DR. WINKLER: Okay.

12 CO-CHAIR HOMER: Other child-
13 serving programs, but we're trying to find --
14 again, this would be, for example, the
15 prevalence of sexually transmitted diseases in
16 a population or the prevalence of smoking or
17 the prevalence of suicide, which are
18 conditions that we think are -- so those are
19 population health indicators.

20 DR. JENKINS: I would use that
21 term. I think we're trying to trigger a more
22 epidemiological mind frame of infant mortality

1 or whatever, and I don't know if it should be
2 in the header here or just in one of the bars,
3 but to me that's the trigger language of
4 population health indicator.

5 DR. PERSAUD: Soliciting measures,
6 such as "population health indicators,
7 including" or "measures which are population
8 indexed."

9 DR. WINKLER: I guess the one
10 thing I would then ask, then does the first
11 bullet make sense for what we were talking
12 about?

13 CO-CHAIR HOMER: Well, give an
14 example from the first -- what's missing in
15 your first bullet is you're still talking
16 about largely a clinical population, provide
17 a professional practice population. So, for
18 example, if you're looking at your patients
19 with asthma in a clinical population like at
20 Kaiser, that's where you're interested in --
21 that would still look at, for example, rates
22 of hospitalization or --

1 CO-CHAIR HOMER: Right, but the
2 denominator would be your entire population,
3 not just who you had an encounter with, sort
4 of the more health plannish maze where you
5 look at the total members with X as opposed to
6 the counters with X that you get off of
7 traditional claims.

8 CO-CHAIR HOMER: But isn't that
9 what we're going to get up above?

10 DR. PERSAUD: I think we're
11 getting into higher bullets. We probably
12 don't need that first bullet in the second
13 section.

14 DR. WINKLER: Okay.

15 DR. RAO: Reva, I think it would
16 be nice to be much more explicit about this
17 very sensitive population, "disparity" defined
18 by race or ethnicity or geographic location or
19 heart disease status, whatever else we think
20 is important.

21 DR. WINKLER: What does do you
22 want to put?

1 DR. RAO: Geographic, rural versus
2 urban, for example.

3 DR. WINKLER: See what a lousy
4 typist I am. Well, do you want to just remove
5 this altogether?

6 DR. PERSAUD: I think we can.
7 We're going to get that in the top.

8 DR. WINKLER: Do you think you
9 will? That's the thing I wasn't sure without
10 being explicit.

11 DR. JENKINS: My suggestion had
12 been to in the top section put population
13 health indicators

14 DR. WINKLER: You're right. Of
15 the second one, right?

16 DR. JENKINS: Well, that was
17 before I knew you had the second session, but
18 will that work?

19 CO-CHAIR HOMER: You're just
20 suggesting having a bullet in there that says
21 population health indicators.

22 DR. WINKLER: Oh, I see what

1 you're saying, rather than a second section.

2 Okay.

3 DR. PERSAUD: That would be fine.

4 DR. WINKLER: Yes, we could do
5 this. So what you're saying is population
6 health indicators, such as. Yes? Okay.

7 DR. JENKINS: Such as infant
8 mortality rates, percentage of suicides, the
9 types of things people are -- what?

10 CO-CHAIR WEISS: STDs.

11 DR. WINKLER: Yes, STDs, infant
12 mortality, et cetera.

13 PARTICIPANT: Suicide.

14 DR. WINKLER: Suicide, yes. Okay.
15 Let me do this. We'll put it up front.

16 DR. McINERNY: And the currently
17 correct nomenclature is STIs.

18 DR. WINKLER: Yes, right,
19 whatever.

20 PARTICIPANT: Sexually transmitted
21 infections.

22 DR. WINKLER: So you don't want to

1 be explicit about, you know, provider
2 population denominators or disparities?

3 DR. JENKINS: I would definitely
4 be explicit about what Bonnie was referring
5 to, the concept of specific ones with co-
6 accountability are okay when the health care
7 is only one of the accountable individuals.

8 DR. WINKLER: Is that under the
9 population health indicator?

10 CO-CHAIR HOMER: Yes.

11 DR. JENKINS: Yes.

12 DR. WINKLER: So we want to get
13 rid of this one and this one. No.

14 DR. PERSAUD: Well, we need
15 disparities and the joint accountability
16 concept in there. Those are the two things.

17 DR. WINKLER: Okay. This one goes
18 away. So is this one essentially -- I mean,
19 obviously wordsmithing to get the format
20 right, but essentially are we talking about
21 these kinds of things as well?

22 DR. JENKINS: What may work is to

1 have a second bullet that says something about
2 populations of specific diseases as opposed to
3 the population overall.

4 DR. WINKLER: Okay, all right.
5 Got it. So you're saying populations of
6 specific disease states, whatever.

7 DR. JENKINS: And disparity
8 sensitive measures.

9 CO-CHAIR HOMER: I'm not sure what
10 that first bullet is getting at. I'm sorry.
11 And, again, it's very hard to write by
12 committee.

13 DR. WINKLER: Yes, that's fine.

14 CO-CHAIR HOMER: But I'm thinking
15 you've got the bullet that says population
16 health indicators, such as blank. We have the
17 subheading that say something along the way of
18 your bottom bullet, which is, you know, this
19 includes or this should include, you know,
20 those conditions which are -- in which health
21 care has joint accountability with other child
22 serving sectors.

1 DR. WINKLER: Charlie wants to put
2 this instead of others, right? Bonnie, you
3 want to leave communities and put?

4 DR. ZIMA: I'm a little quiet
5 because I'm struggling a little bit with how
6 that last idea about contact and other care
7 sectors relates to some of our earlier service
8 utilization discussion, and that was on your
9 page ahead of that because we hadn't --

10 DR. WINKLER: We had not finished
11 the entire list of these. So did you want to
12 maybe --

13 DR. RAO: Let me get back to the
14 disease states. I'm not sure what Kathy
15 intended, but I was thinking more like
16 disabled children and deaf children and
17 mentally challenged children. So I think
18 specific --

19 DR. JENKINS: Or children with
20 special health care needs. It's just that the
21 denominator didn't necessarily need to be all
22 children, let's say, in the State of

1 Massachusetts. It could be where some of your
2 prior bullets were going to. That's all I was
3 looking for, Charlie, was to say your
4 denominator doesn't necessarily need to be all
5 children.

6 DR. WINKLER: But it could also be
7 not only the groups you were mentioning but
8 all of the children with asthma or all of
9 children with diabetes or all children with
10 whatever. Okay. Are we capturing where you
11 want to go?

12 DR. McINERNEY: Could we roll back
13 then to the top? I'm still a little concerned
14 that where we try and assess how physicians
15 are caring for all patient sin their practice,
16 is that somewhere?

17 DR. WINKLER: That was what I was
18 trying to get with that first bullet. It is
19 a clinical population, but the one assigned or
20 belonging to a provider.

21 DR. JENKINS: That's also what I
22 was trying to get at with the chronic disease

1 management. It's really about the
2 denominator, what you include in the
3 denominator for your accountability.

4 DR. McINERNY: If we get to the
5 specific directions and the specifications, is
6 that where we can put that?

7 DR. WINKLER: Because this is it.
8 This is it.

9 DR. McINERNY: That's it.

10 DR. JENKINS: They do have the
11 sentences above though, the direction ones
12 about the locus, the unit of analysis, and
13 it's conceivable we could just add a
14 clarifying sentence there at the very
15 beginning.

16 CO-CHAIR HOMER: Yes, because I
17 guess the reason I'm maybe having a little
18 trouble here is that any measure needs to
19 define a numerator and a denominator.

20 DR. WINKLER: Right.

21 CO-CHAIR HOMER: So if somebody
22 says, for example, your asthma hospitalization

1 rate, they're going to have to say how are you
2 defining -- if they're giving us the
3 specification, it's going to have to be some
4 indicator of what the numerator and what the
5 denominator is, and the denominator presumably
6 is going to have to reflect some universe, and
7 that universe has to be either the universe of
8 patients that are -- I mean it could be a
9 visit based universe, one of the patients that
10 I happen to have seen.

11 DR. WINKLER: Well, our experience
12 in seeing measures like this is measures that
13 tend to be at health plan levels tend to be
14 membership based, whereas measures that tend
15 to be at clinician levels, tend to be visit
16 based.

17 CO-CHAIR HOMER: I would then
18 include in the top part, say we are
19 particularly interested, you know, for all of
20 these measures, we're particularly interested
21 in measures based on an entire population,
22 including populations within a clinical

1 practice as well as within a plan or within a
2 geographic community, something like that.

3 DR. WINKLER: Have to figure out
4 how to wordsmith that in.

5 CO-CHAIR HOMER: Because I mean, I
6 think, again, when we jump ahead to the
7 reviewing part on the important area, if it
8 was just a visit based, you know, of the
9 patients that I happen to see with asthma this
10 year, you know, I manage to put them on
11 inhaled steroids. I would sort of deem that
12 as less important, but maybe that's too
13 technical.

14 DR. WINKLER: Well, it's just my
15 experience so far with measures, particularly
16 in the ambulatory care sector are much more
17 that than the population based.

18 CO-CHAIR HOMER: But I think
19 that's more processes than --

20 DR. WINKLER: No, it's not.

21 CO-CHAIR HOMER: So I think if we
22 specify it up front.

1 DR. WINKLER: Okay. I can't even
2 begin to think about how to do it, but I've
3 made myself the two notes to change the up
4 front to include the explanation on caregiver
5 and that we are particularly interested around
6 the entire population of a plan or practice or
7 whatever.

8 DR. McINERNEY: Now, for example,
9 Peter Slides in Rochester improved the
10 immunization rate of the children in the inner
11 city of Rochester by going and going recall
12 and outreach so that they look at all of the
13 patients in the practices that they were
14 studying and they sent outreach workers out to
15 those that hadn't come in. And that's how you
16 got it from 70 percent to 90 percent.

17 MS. PARTRIDGE: And that same is
18 true of the medical home discussions where you
19 assume that a physician or practice has the
20 capacity to know how many children are
21 diagnosed with X.

22 DR. WINKLER: Isn't that one of

1 the major characteristics of the medical home
2 because you know who's at your house?

3 (Laughter.)

4 DR. WINKLER: Who lives at your
5 house?

6 DR. JENKINS: It's true in a
7 subspecialty realm, too, about management of
8 congestive heart failure and diabetes. It's
9 all of the patients in your portfolio of
10 accountability, not just the ones you have in
11 the -- the concept is fine.

12 DR. WINKLER: Yes. We'll figure
13 how to work it. We need to think about that
14 one a little bit and redo the front.

15 There were a couple of these
16 bullets, especially this last one. Allan was
17 particularly uncomfortable with the term
18 "service utilization," but I couldn't come up
19 with anything better. So I just modified it
20 by saying health care services because it
21 seems that maybe health care utilization as a
22 concept, I think, is fairly well understood.

1 But otherwise I'm open to
2 suggestions. Allan, you were the one that
3 was --

4 DR. LIEBERTHAL: I'm putting
5 health care services in. I think it clarifies
6 it as what you mean by service.

7 DR. WINKLER: Right, okay, and
8 then the examples of the readmission.

9 CO-CHAIR HOMER: The changing
10 condition. I'm sorry. Health -- I don't
11 understand that changing condition phrase.

12 DR. WINKLER: Well, I think the
13 idea of deterioration or complications.

14 CO-CHAIR HOMER: I'm sorry. So
15 change in condition refers to defining patient
16 outcomes in that phrase?

17 DR. WINKLER: Yes, un-huh.
18 Although perhaps we don't need just health
19 care services utilization and then just
20 example; get rid of the rest of it.

21 CO-CHAIR HOMER: Yes.

22 DR. WINKLER: Is that sufficient?

1 CO-CHAIR HOMER: That's what I
2 would think.

3 DR. JENKINS: Or just say when it
4 represents a change in patient condition. The
5 alternative thing to do here is to make it be
6 unplanned readmissions, unplanned ED or
7 something like that.

8 CO-CHAIR HOMER: Yes. I agree
9 with Kathy's point. I think you could still
10 say as a practice for a change in condition.
11 I just don't think you needed to elaborate on
12 what -- or a change in --

13 DR. JENKINS: A change in status.

14 CO-CHAIR HOMER: -- a change in
15 status, yes.

16 DR. ZIMA: Just a question because
17 I'm trying to meld that one with the concept
18 of, you know, where do we put outcomes like
19 reducing out of hold placement, reducing, you
20 know, recidivism, things like that.

21 DR. JENKINS: Maybe I always
22 thought in the population health just to

1 trigger it.

2 DR. WINKLER: Bonnie, your

3 microphone.

4 Where do you want to put it?

5 DR. ZIMA: Again, maybe it's --

6 I'm just thinking out loud with the rest of

7 the group. Change that third bullet to

8 content to other child-serving care sectors.

9 That may share accountability, such as school,
10 child welfare, juvenile justice.

11 I think what we're trying to do is
12 focus on health care utilization for the
13 majority of the outcomes, but at the same
14 time, communicate some type of openness to
15 these population based estimates. So it would
16 be contact with other child serving care
17 sectors, and then take out slash, communities
18 in which responsibility may be shared.

19 And then, for example, schools,
20 comma, child welfare, comma, juvenile justice,
21 and then I think this is really splitting
22 hairs, but the issue of substance abuse

1 facilities. Sometimes, you know, it's lumped
2 with mental health. Sometimes NIDA treats it
3 differently. I think I'd like some of the
4 policy experts to maybe help me with that one.

5 I think that says it.

6 DR. McINERNEY: Under the
7 population health indicators, would you want
8 to put in child abuse or is that getting too
9 specific?

10 You can measure child abuse rates.
11 I mean, those numbers are available.

12 CO-CHAIR HOMER: Such as reports
13 of child abuse.

14 DR. WINKLER: You want to go up?
15 Is that what you're saying?

16 DR. JENKINS: Just as a general
17 concept related to what you're struggling
18 with, Bonnie, I want to be sure that we are
19 including prevention, the absence of, all of
20 the absence of including recidivism and things
21 like that, but are we sure we have them?

22 CO-CHAIR HOMER: That was partly

1 what we meant by these population health
2 indicators. So maybe that doesn't capture it.
3 So, for example, the rates of STDs or the
4 rates of child abuse.

5 DR. JENKINS: Well, you were
6 saying before non-conversion to smokers.

7 DR. ZIMA: Yes. I think this
8 discussion is saying should we have a separate
9 bullet just on safety, you know, which would
10 encompass things like child abuse. It's like
11 patient protection. I don't know if that
12 would be a population based.

13 DR. RAO: Safety opens up a whole
14 new world of bicycle helmet use, seat belts.

15 DR. ZIMA: Yes.

16 DR. McINERNEY: There is, you know,
17 David Olds home visiting nurses. His outcomes
18 seem to be pretty solid. That program does
19 reduce child abuse and actually 20 years later
20 his kids seem to be graduating from high
21 school more frequently, those who didn't have
22 the service, but --

1 CO-CHAIR HOMER: Well, should we
2 just use that as the specific example under
3 the population health indicators, for example?

4 DR. WINKLER: Which one, high
5 school graduation rate?

6 CO-CHAIR HOMER: No, rates of
7 abuse reported, rates of child abuse.

8 DR. WINKLER: Up here?

9 CO-CHAIR HOMER: Yes.

10 DR. WINKLER: We might. Someone
11 mentioned it. Bonnie, I think.

12 DR. ZIMA: I thought substance
13 abuse fit in very well with high risk
14 behaviors. I didn't comment.

15 DR. WINKLER: Yes, that's
16 typically where it goes.

17 So essentially what all of these
18 bullets do is define the types of outcome
19 measures that are highly desirable to use for
20 some type of accountability for health care
21 for children. Do they all fit? Are we
22 missing anything?

1 CO-CHAIR HOMER: I think they fit.
2 I think we need to do some wordsmithing on
3 some of the bullets, but we can do that
4 offline if you want.

5 DR. WINKLER: Sure. Have we
6 thought about everything, all of the big ones?
7 Anybody got anything that doesn't -- okay.
8 What we'll do is I'll just send this all to
9 you all and feel free. Use that red line.

10 DR. CLARKE: It seems to me that
11 we've missed the bottom couple of bullets.

12 DR. WINKLER: Not talked about
13 them? We talked about the health care
14 services utilization. Clinical morbidity from
15 a disease progression?

16 DR. CLARKE: Well, I think that's
17 pretty --

18 CO-CHAIR HOMER: Yes your
19 microphone, please.

20 DR. CLARKE: One of the issues
21 that we run into, you know, how you said, my
22 experience is in acute hospital care, and one

1 of the issues that we run into is that as
2 mortality rates drop, if you only look at
3 mortality, you're ignoring 96 percent of the
4 patients you treat in terms of their outcomes,
5 and there's a lot of things that happen in
6 acute hospitalized patients besides mortality,
7 and so I think we need to put the appropriate
8 emphasis on the measurement of morbidity.

9 As I said yesterday, it's not that
10 easy, and you really end up it's very
11 subjective and you really end up using some
12 sort of surrogate, and you know, I would be
13 very interested in seeing what people can come
14 up with to actually put some objectivity into
15 the assessment of, you know, both in hospital
16 and post hospital morbidity.

17 CO-CHAIR HOMER: Well, it says
18 clinical morbidity. Should we take out the
19 "from disease progression" or should we --

20 DR. JENKINS: Well, you also have
21 health care acquired hours in event of
22 complication right after it. So between the

1 two you have morbidity from the disease and
2 then you have morbidity from the health care.
3 So I'm not sure what's missing.

4 CO-CHAIR HOMER: David?

5 DR. CLARKE: Well, I just think
6 you ought to probably add morbidity to the
7 second bullet there because that is more --

8 DR. WINKLER: Which one, survival
9 or where?

10 DR. CLARKE: No, to the adverse
11 event.

12 DR. WINKLER: But what about this
13 one?

14 CO-CHAIR HOMER: The one above
15 says morbidity.

16 DR. CLARKE: Well, there's that
17 morbidity, but to me that's more of an
18 ambulatory care thing. What you're talking
19 about when you talk about morbidity in
20 hospitals usually is related to your health
21 care interventions.

22 CO-CHAIR HOMER: Again, is that

1 different from an adverse event?

2 DR. WINKLER: Yes, I think what he
3 is talking about, there's the -- are you
4 talking about the difference between -- for
5 every procedure there are a certain level of,
6 you know, not so perfect outcomes, morbidity
7 associated with that regardless of who does it
8 or how it happened and different from the more
9 error based patient safety kinds of things.

10 DR. CLARKE: Well, I like to say
11 there's no such thing as zero morbidity when
12 you talk about any kind of an intervention.

13 DR. WINKLER: Right.

14 DR. CLARKE: No such thing. It
15 might only be inconvenience, but it's not zero
16 ever, and sometimes, you know, if you want to
17 talk about mortality, that represents 100
18 percent morbidity in my view.

19 DR. WINKLER: right.

20 CO-CHAIR HOMER: I'm not
21 disagreeing. I'm just trying to come up with
22 what words we should be adding beyond clinical

1 morbidity from disease progression and health
2 care acquired adverse events or complications.

3 So just help me. If there's --

4 DR. DOCHERTY: Could you add to or
5 broaden the clinical morbidity bullet to
6 morbidity from disease progression or
7 treatment or intervention or treatment, or
8 disease treatment?

9 DR. McINERNEY: You maybe want to
10 put it in, for example, line related
11 infections or something like that.

12 DR. WINKLER: Those are adverse
13 events. Those come under health care acquired
14 adverse events. I can guarantee you.

15 DR. JENKINS: I think what they
16 are maybe alluding to is something like no
17 logical outcomes after congenital heart
18 surgery. You know, where does that fit in
19 where it's not explicitly that there was a
20 complication or an adverse event?

21 DR. WINKLER: Is a known risk.

22 DR. JENKINS: But on the other

1 hand, that's a very important indicator. It
2 similarly would be, you know, the technical
3 outcome from a congenital heart operation, and
4 the ongoing clinical status of the patient as
5 a result from variation there.

6 I thought it was captured
7 personally by clinical morbidity and then also
8 spelling out the health care acquired issues
9 so that if I were thinking of a measure and I
10 said does my measure fit in, I would have said
11 yes and put it under one of those two, but
12 maybe you're looking for something more
13 specific than that.

14 DR. DOCHERTY: I see it sitting
15 there like I think in the population I work
16 with, the bone marrow transplant, the grafters
17 are supposed to be their measures. We measure
18 graphers and hosts. It's just part of that
19 morbidity that occurs because they're getting
20 their treatment.

21 CO-CHAIR HOMER: So I think that's
22 good. I think we're adding an intervention

1 and giving an example. Both are examples of
2 grafts versus hosts and neurologic impairment.

3 DR. RAO: Why are those not
4 adverse events? What's the defining
5 character?

6 DR. CLARKE: They are adverse
7 events, but you know, I guess my point is one
8 of emphasis. You know, the RFP sort of venue,
9 we seem to really sort of dissected and
10 concentrated on the out patient and so forth,
11 and I agree that that population winds up with
12 most of it, but when you talk about the areas
13 most likely to produce controversy, those are
14 your high risk subspecialties, and we've
15 already seen that in cardiac surgery around
16 the world.

17 You know, it also happens in other
18 areas of acute hospital care. You know,
19 trauma is a good example. Neurosurgery is a
20 good example, and so forth, and I just think
21 we ought to be a little bit more expansive in
22 describing the requests in this area in

1 addition to the ambulatory area.

2 CO-CHAIR HOMER: So do you think,
3 for example, rates of BPD, bronchopulmonary
4 dysplasia, would be something we'd expect to
5 get in this?

6 DR. JENKINS: In answer to the
7 question about the difference between clinical
8 status outcome and adverse events, using
9 cardiac surgery as an example, would be you
10 could measure the rates of stroke after
11 congenital heart surgery as an adverse event
12 or you could take a population of children and
13 measure their neurological outcomes by
14 neurological assessment tool at five years of
15 age, and they're both actually relevant to our
16 field, understanding the variation in the
17 neurological outcomes may partially be
18 explainable by something that's truly been
19 counted as an adverse event in other cases not
20 explainable by that.

21 DR. McINERNY: And one of the
22 problems is that things that were accepted at

1 one point as sort of untoward outcomes that
2 couldn't be avoided, such as line-related
3 infections and ventilator acquired pneumonia,
4 it turns out, well, they really could be
5 prevented if you did the right thing.

6 And so, you know, that's a
7 significant morbidity that we could prevent if
8 we do things correctly, and we should measure
9 those.

10 MS. PARTRIDGE: Reva, I'm a member
11 -- well, when we were first talking five years
12 ago with possible measures in the child area,
13 that the pediatric cancer community had quite
14 a bit to contribute, and I wonder if the
15 clinical morbidity, if we might have a cancer
16 example in there. That's not my world, but I
17 suspect there are not adverse events, but
18 normally occurring.

19 DR. JENKINS: Like rates of
20 relapse.

21 CO-CHAIR WEISS: Perhaps some of
22 the adverse side effects of the drug

1 interventions, neuropathy, for example.

2 DR. DOCHERTY: Or neutropenia is
3 common.

4 DR. RAO: Just to play devil's
5 advocate, I mean, how are those preventable or
6 how can we improve the quality with respect to
7 febrile neutropenia, for example? That's just
8 going to happen randomly in response to --

9 DR. JENKINS: I think that's the
10 point, is that some of it is going to need
11 risk adjustment. Some of it is going to be
12 practicing the state of the art where we are,
13 and some of it is going to be something that
14 was viewed as unpreventable. We're trying to
15 focus attention on it. Suddenly neurological
16 outcomes, surgery and --

17 CO-CHAIR HOMER: I mean, there may
18 be, for example -- well, there are -- the use
19 of variety of drugs to stimulate neutrophil in
20 this case, and different places may be better
21 or less good at using those prophylactically.
22 So that's -- or your choice of therapeutic

1 agents, things like that. So it would be
2 reasonable to look at that kind of
3 variability.

4 DR. JENKINS: And advocacy for
5 better devices, better treatments, better
6 drugs, better drugs for children, et cetera.

7 DR. ZIMA: This is just a question
8 that's I think echoing some of the concerns
9 about prevention. Where do we put things like
10 reducing risk of fetal alcohol syndrome,
11 substance abuse in pregnant women, HIV testing
12 early.

13 MS. PARTRIDGE: HIV testing is in
14 the perinatal.

15 DR. WINKLER: Right, but aren't
16 those process measures though?

17 I mean that's what we're really
18 trying to focus in on the outcomes here.

19 CO-CHAIR HOMER: I mean, I would
20 hope that, for example, let's say fetal
21 alcohol, somebody may propose that as one of
22 our population health measures, that is, the

1 rate of fetal alcohol syndrome, assuming you
2 could actually diagnose it reliably in a
3 population or we might end up dealing with
4 that, but that it would seem to me would be a
5 reasonable population health indicator that
6 someone could propose, and we could review and
7 decide whether that -- so I think it should be
8 captured under what we've already defined.

9 And I agree that I think HIV
10 testing is a process.

11 DR. McINERNEY: And for HIV we can
12 look at congenital HIV infection rates which
13 have fallen off dramatically obviously,
14 thankfully.

15 DR. ZIMA: Acknowledging the HIV,
16 then maybe that would be one in the
17 parentheses under population health indicator,
18 just, again, to kind of raise awareness that
19 we're -- raise congenital HIV.

20 DR. WINKLER: Okay.

21 CO-CHAIR HOMER: The use of the
22 term "rates." All of these are going to be

1 rates.

2 DR. WINKLER: Right.

3 CO-CHAIR HOMER: So we might drop
4 that.

5 DR. WINKLER: Right, or put it up
6 front, "rates of," da-da-da-da.

7 Okay. Like I say, I think you've
8 had a chance to kind of work this through, but
9 think about it some more and think of what
10 your colleagues have had to say. Again, the
11 plan is save and send, and yes. So what we'll
12 do is we'll get it out to you.

13 We're scheduled for a break at
14 10:30. Do you want to do so? Does everyone
15 need to refill their coffee?

16 CO-CHAIR HOMER: Does anybody need
17 to check out or anything like that.

18 DR. WINKLER: That's a good point.
19 There are people looking to check out? Okay.
20 Now would be a good time to.

21 CO-CHAIR HOMER: So we'll
22 reconvene in 15 minutes.

1 DR. WINKLER: Yes, and if you're
2 not back, we know where you are. So we'll --

3 CO-CHAIR HOMER: We'll wait.

4 DR. WINKLER: -- we'll wait for
5 you.

6 (Whereupon, the above-entitled
7 matter went off the record at
8 10:26 a.m. and resumed at 10:54
9 a.m.)

10 CO-CHAIR HOMER: So I thought this
11 morning's conversation was extremely
12 productive, and I'm very happy with where we
13 came out. Again, we've had a few
14 miscellaneous comments, but does anyone have
15 any major additions or changes, reflections
16 during the break?

17 Again, we'll get the chance to see
18 this because Reva is going to save and send it
19 out to us with the time line for when we can
20 review it and give it back to her.

21 DR. WINKLER: Yes. I mean,
22 essentially where this document is going to go

1 after this so we'll need to get it to you and
2 get feedback is the call for measures sort of
3 has a two-step process. As Ellen, I think,
4 brought up, sort of announcing to the world at
5 large that the call for measures will be
6 coming, we issue a call for the intent to
7 submit measures or something that has got a
8 goofy title, in my personal opinion, but
9 nonetheless, that's going to go out in
10 December.

11 We send it to all of our usual
12 folks. We'll send it to you, and you are
13 encouraged, not just welcomed, encouraged to
14 send it on to anyone within your world that
15 you think would find it useful.

16 So that's the intent. It's sort
17 of an announcement in advance to kind of say
18 this is going to happen.

19 The actual call for measures is a
20 30-day call, and that will get up right after
21 the first of the year. We want to avoid, you
22 know, people feeling pushed because the 30

1 days includes all of the holidays. So it's
2 going to go right after.

3 And it is 30 days, and we will
4 make the announcement. We will send it out to
5 you. Also the submission is fairly formal and
6 structured in an electronic format, and we're
7 going to kind of show you what happens, but by
8 doing that, it puts it into a spreadsheet that
9 then we can manipulate that data.

10 When it was in old Word documents
11 or by hand, you know, that was just an awful
12 lot of staff work to manage all of that data,
13 and Kathy has had experience with filling out
14 one of our forms, and it's not an
15 insignificant amount of information. I mean,
16 it's rather pages of detailed stuff, and to
17 the degree that the submitter answers it or
18 doesn't answer it is one of the things you'll
19 be doing in your evaluation.

20 We're going to talk about the
21 evaluation criteria a little bit because I
22 know David had some questions about are they

1 required to do this, that and the other thing,
2 and so I'll show you what we're going to be
3 evaluating them on.

4 But we do need to have people use
5 that form submission process. Work-arounds
6 don't work for us on that particular one. You
7 know, it's a relatively new technical thing
8 for us, and we've been ironing out technical
9 bugs. So anybody who is making a good attempt
10 will work with them.

11 But you know, we need to have them
12 use the process. So we'll be able to send you
13 out a link to go to this website, submit here,
14 and send them out.

15 So that's the plan. So the
16 question I would ask you up front --

17 CO-CHAIR HOMER: Tom has a
18 question.

19 DR. McINERNEY: When you send out
20 the call for measures, will you let us know to
21 which organizations you are sending it so that
22 if we think about an organization and you've

1 already sent it to them, we don't have to --
2 DR. WINKLER: Yes, but by the same
3 token I would suggest that if you --
4 particularly with these organizations you have
5 personal contact, it's one thing to
6 anonymously come from NQF. It's another to
7 come with your name and recommendation on it,
8 you know. In the electronic world duplicates
9 aren't the worst thing that ever happened, but
10 if it's coming with sort of your name behind
11 it, that may carry a little bit more
12 attention. Your E-mail address under sender
13 may prompt someone to open it up rather than
14 ours.

15 So in that respect that may be of
16 a benefit. I'm not sure duplicates are a
17 problem, but at the same time, one of the
18 things we would like to do is get some input
19 from all of you on who we need to specifically
20 start sending these out, both the intent and
21 then ultimately the call, and I know Charlie
22 was offering up some suggestions to start

1 with, but just get some ideas and maybe see
2 how together as a group what's your thinking
3 in terms of where you think who would be
4 interested or particularly respond.

5 Who has got measures out there?
6 Who is doing work in this space, focused on
7 children? Who, you know, is likely to be
8 interested in participating?

9 You know, because children is not
10 something -- NQF lists tend to have a small
11 amount of children, but your world is all
12 kids. So you're hooked in with them far more
13 than we are.

14 DR. McINERNY: Well, it's disease
15 specific, such as the Cystic Fibrosis
16 Foundation, the Pediatric Oncology Group,
17 Vermont Oxford Network.

18 DR. WINKLER: We know them well.

19 DR. McINERNY: They come to mind
20 immediately. Unfortunately, there aren't as
21 many of these as we should have for children's
22 conditions. There are just some forming. A

1 new one is inflammatory bowel disease group
2 has a collaborative. I don't know if they
3 have measures, outcome measures.

4 CO-CHAIR HOMER: They do.

5 DR. McINERNY: They do?

6 CO-CHAIR HOMER: Well, they have
7 measures. I don't know if they're outcome
8 measures, but they definitely -- I think they
9 do.

10 DR. McINERNY: Yes.

11 CO-CHAIR HOMER: So I had
12 suggested again through the American Board of
13 Pediatrics for several years has convened a
14 group of the pediatric subspecialty group. So
15 I think through ABP we could get access to all
16 of the pediatric subspecialty, medical
17 subspecialty groups anyway. I think that's
18 more medical than -- I don't think the
19 surgical groups are as part of that same
20 group. Maybe they are, but I think that would
21 be one way to get pretty much all of the
22 pediatric medical subspecialties, and that

1 would be through Paul Miles and Mimi Schaeffer
2 at the ABP.

3 I also had suggested as you said
4 many of the disease specific groups with the
5 CF being the leading group in this field, but
6 again, I think there are a lot of those. I
7 was trying to think how to get access to them.
8 One I thought was the CDC's National Center
9 for Birth Defects and Developmental
10 Disabilities probably has a pretty good list.
11 CDC has the National Partnership Group that
12 also probably has that, and there's the
13 National Association of Rare Diseases or
14 something like that here in Washington that
15 would probably also have a list of many of
16 those groups like autism.

17 I think so each of those sort of
18 consumer or parent oriented groups should be
19 informed, some of who will either have
20 measures or will be working with clinician
21 groups that, you know, their medical advisory
22 panels will often be a relevant group.

1 DR. LIEBERTHAL: I have two
2 questions. One is PCPI requires that their
3 measures have an evidence based guideline to
4 support them. Does NQF have that?

5 DR. WINKLER: No. We'll look at
6 the criteria. That is certainly one good
7 supporting element for a measure, but it does
8 not have to necessarily be imbedded in a
9 guideline.

10 A lot of discussion areas or topic
11 areas don't have a lot of guidelines or
12 another interesting problem. We've got
13 conflicting guidelines among various groups.
14 So that's always fund.

15 But, no, evidence based, yes. You
16 know, studies in the literature, good body of
17 knowledge, but it doesn't have to have been
18 made its way to a guideline per se, though
19 that's a very common route to take. That
20 isn't a requirement.

21 DR. LIEBERTHAL: Also, I would
22 anticipate that one of the areas where you

1 will get multiple submissions is asthma, and
2 is it NQF's policy to approve multiple
3 measures in a field, or what do you do then?
4 Do you pick the one that is best? Do you try
5 to get the groups together to come to some
6 consensus?

7 DR. WINKLER: All of those have
8 actually been part of the work we do. It
9 depends on what they are, but in general our
10 focus is standardization. So multiple
11 measures of the same thing don't meeting that
12 goal. So we're trying to find best in class.

13 Sometimes, you know, it often is a
14 matter of just choosing one based on the
15 evaluation criteria, and so that's the most
16 common way. We've actually had experience of
17 getting two measure developers to mutually
18 change their measures, to line it up. You
19 know, that may not be the easiest relationship
20 going forward. Who really owns it? Both want
21 to retain credit for owning it, and then the
22 ongoing stewardship may not be the easiest

1 road to take, but we've done all of those.

2 So it really just depends on what
3 we're talking about, and outcome measures
4 we'll have to see because a lot of the risk
5 adjustment issues really tend to be unique to
6 that particular measure because it depends on
7 how they do the adjustment and what their
8 study population is for developing, you know,
9 the risk factors and things like that.

10 So I think we just have to take it
11 as it comes.

12 CO-CHAIR HOMER: Kathy.

13 DR. JENKINS: I think I have 14
14 pediatric registries in my budget right now.
15 It's amazing that it has been a plethora of
16 them, including there's a new pediatric
17 cardiac anesthesia one. There's a new renal
18 one, and so I can get a list of those to you.

19 Some of them are just all coming.
20 So they're not going to actually have measures
21 yet, and the other one is obviously the
22 subspecialty societies, including you're not

1 going to find things like pediatric EP, but
2 within each of the subspecialty societies and
3 then there's the one level down of the
4 pediatric subspecialty societies.

5 DR. McINERNY: Along those lines
6 would be AAP specialty sections that would
7 have all of the subspecialties, and they might
8 know the measure.

9 CO-CHAIR HOMER: Ellen.

10 DR. SCHWALENSTOCKER: I'm
11 wondering about some of the maybe less usual
12 customer stuff like Academy Health. You know,
13 could we get to -- they may not be widely used
14 and tested, but you know, maybe more
15 developmental.

16 DR. WINKLER: The health services
17 researcher.

18 DR. SCHWALENSTOCKER: Right.

19 DR. WINKLER: A lot of measures
20 start there.

21 DR. SCHWALENSTOCKER: And then
22 there's also -- I don't know if this would be

1 -- this is brainstorming, but AMSPDC, the
2 American Society of Pediatric Department
3 Chairs, or whatever it is.

4 CO-CHAIR HOMER: Medical School
5 Pediatric Department Chairs, yes. NACHRI
6 itself -- well, you're a member. So that will
7 go to all of the member hospitals, QI
8 departments and QA leads.

9 DR. SCHWALENSTOCKER: And I've
10 been thinking about this because we've we
11 recently had a really interesting conversation
12 in our council meeting about reaching the
13 right people in children's hospitals around
14 quality issues and discussion of could you
15 identify the one single person in a children's
16 hospital responsible for quality.

17 Probably not very easily, but what
18 we could do is we could send out our usual
19 call related to this, but ask for it to be
20 broadly disseminated because I'm thinking of
21 the pockets of work that are happening in the
22 clinical departments that we wouldn't normally

1 reach.

2 So maybe we could find a way to do
3 that. Especially with more time, I think we
4 could really work on that.

5 DR. WINKLER: Yes, we should be
6 able to.

7 DR. DOCHERTY: I was wondering,
8 Reva, would NIH send out -- there's just
9 certain institutions at NIH that actually work
10 on developing different measures. I wondered
11 if they would send out. They have their
12 listserves that it goes out to, and then the
13 other group that does some work in measuring
14 some kinds of medical comes as the Society for
15 Research and Child Development. They would
16 probably send it to their E-mail list as well.

17 CO-CHAIR HOMER: Bonnie, there's a
18 mental health child outcomes group, isn't
19 there?

20 DR. ZIMA: Yes. I think a couple
21 of things come to mind, and I think next week
22 when the mental health committee will do some

1 of its double check on my brainstorming, the
2 State Mental Health Directors Association --
3 I kind of feel like different states are maybe
4 experimenting and kind of already applying
5 measures on the states, and they might not be
6 well coordinated.

7 CHADD is a big one for consumer.
8 NAMI, National Alliance for the Mentally Ill.
9 Charlie mentioned Autism Speaks, Bipolar
10 Foundation, and I apologize, but there is a
11 large group advocating for improvement of teen
12 depression and reducing suicide. So some
13 Googling on that.

14 You're already connected with the
15 American Psychiatric Association quality
16 indicator committee. Rob Plovnick is a friend
17 of yours, and Ginger Anthony would be the
18 contact person for the academy in, I think,
19 child and adolescent psychiatry, and there's
20 at least two committee chairs there that would
21 be potential, maybe three.

22 But I think I could defer to

1 Ginger, and Larry Greenhill knows about you,
2 who is the president. So I think you're set.

3 MS. PARTRIDGE: And, Reva, I
4 assume you communicate regularly with the
5 National Association of State Data
6 Organizations. Denise Love?

7 DR. WINKLER: Yes, I was going to
8 say they're a very active member. I get my
9 organizations mixed up. Yes, once you said
10 Denise's name, yes, definitely.

11 MS. PARTRIDGE: Yes, because I
12 know some states do collect certain data.

13 DR. SCHWALENSTOCKER: How about
14 Family Voices? Could they be a dissemination
15 vehicle or measure?

16 MS. PARTRIDGE: Yes. They've also
17 done a lot of work around patient experience
18 and involvement of care, and they've got some
19 tested -- I don't know that they're actually
20 what you would call an outcome measure, but -

21 DR. WINKLER: Another thought,
22 Lee, is the Consumer Council meeting anytime

1 soon? NCARE's Consumer Council and all of the
2 various folks there.

3 MS. PARTRIDGE: Well, its chair is
4 Maureen Corry, of course, and for the
5 maternity community, that's the contact.

6 DR. WINKLER: Yes. It's just that
7 there are some folks in that council that are
8 very -- you know, that have some focus on
9 children.

10 MS. PARTRIDGE: And of course,
11 we're on that council.

12 DR. WINKLER: Yes, I know you are.
13 That's why I brought it up.

14 DR. ZIMA: Do you have a contact
15 in the developmental disabilities services?
16 I'm just thinking again, you know, it gets to
17 be a little idiosyncratic by state, but you
18 know, we're capturing when we talk about
19 development and not achieving milestones, but
20 the huge autism group that may not necessarily
21 be connected with formally health care or
22 Department of Mental Health.

1 DR. LIEBERTHAL: This may be
2 heresy, but what about the insurance
3 companies?

4 DR. WINKLER: Yes, they'll get it
5 automatically. They're very active NQF
6 members, and they have used their membership
7 list for us readily, you know. Rebecca blasts
8 on a regular basis.

9 DR. JENKINS: I assume that all of
10 the pediatric organizations like NACHRI,
11 SAMSA, NICHQ, AHRQ, these groups will
12 automatically be included. Is that true?

13 DR. WINKLER: Yes, I think so. I
14 mean NACHRI and CHC is a member and you know.

15 DR. JENKINS: HQ is here.

16 DR. WINKLER: Yes, we'll get to
17 Charlie. Charlie can't talk. So yes, we do.

18 CO-CHAIR HOMER: -- surgical site.
19 How do we reach out to the different surgical
20 groups?

21 DR. CLARKE: Well, I think most of
22 those specialty societies have, you know, a

1 pediatric or congenital subgroup associated
2 with them. It's usually instead of having
3 surgical group that covers all of the
4 specialties, it's more split up along
5 specialty lines than it is along pediatric
6 lines.

7 DR. JENKINS: Is this the American
8 College of Surgeons though that has a lot of
9 it?

10 DR. CLARKE: Well, they have some.

11 DR. JENKINS: Except for cardiac?

12 DR. CLARKE: Yes, they have
13 obviously pediatric surgery and pediatric
14 surgery has a society, but that's principally
15 general surgery, and it doesn't cover things
16 like cardiac, neurosurgery, urology,
17 orthopedics. Those are pretty much split up
18 along specialty lines.

19 DR. JENKINS: Although there is an
20 idea that the new NSQIP program, the National
21 Surgical Quality Improvement Collaborative,
22 the pediatric component has, I thought,

1 through the American College of Surgeons, made
2 a plan to move into the subspecialty arenas.
3 So whatever their structure is for setting
4 that up would be a good one to tap into.

5 DR. WINKLER: We certainly have
6 worked with NSQIP before, and actually there's
7 a NSQIP measure in the main outcome group to
8 be evaluated.

9 DR. ZIMA: Two more issues.
10 Neurology is not well represented here, and
11 I'm not sure in your database, pediatric
12 neurology, Epilepsy Foundation. I'm thinking
13 again about people who have to care for mental
14 health and developmental delays in children.

15 Also education. I mean, we talked
16 a lot about school performance. I don't know
17 whether special ed. advocates -- I mean, we're
18 getting into kind of waters, but I would
19 imagine the huge special ed. community
20 advocating for children would go along nicely
21 with some of your outcomes.

22 CO-CHAIR WEISS: And, Reva, of

1 course, you can count on us to disseminate --

2 DR. WINKLER: Thank you.

3 CO-CHAIR WEISS: -- whatever you
4 need disseminated throughout the country.

5 DR. LIEBERTHAL: -- and allergists
6 included in your list?

7 DR. WINKLER: They are for the
8 most part. Those societies are members, and
9 so to the degree that the person, our contact
10 that we send to and each association may have
11 two or three that would get the message, would
12 feel, you know, would embrace and maybe send
13 it on to the appropriate, more pediatrically
14 focused group, you know, sort of is always a
15 question.

16 So if there are any specific
17 people you are thinking about in the
18 emergency care world or the allergy world, you
19 know, we can be more specific in our
20 targeting.

21 Okay. If you've got thoughts
22 along that line, don't hesitate to share, but

1 at the same time, you know, this is one of the
2 benefits of the electronic world, and you
3 know, E-mail files readily and freely
4 throughout the world.

5 So we do need to work as a team to
6 get that message out. So we hope that if
7 there are measures out there, that they can
8 come into the project. We really do have to
9 get the word out and get the appropriate
10 people notified.

11 So okay. In terms of the last
12 topic --

13 CO-CHAIR HOMER: Kathy. Kathy has
14 one more.

15 DR. WINKLER: I'm sorry.

16 DR. JENKINS: No, actually I was
17 going to raise something else, but maybe it
18 was your last topic.

19 I also thought that it would be an
20 important component of this work to look at
21 that other several hundred NQF endorsed
22 measures for that either relevance to the

1 pediatric population or, as importantly, lack
2 of relevance to the pediatric population.

3 How is that activity going to fit
4 in?

5 DR. WINKLER: Not sure at this
6 point. I think we have to talk a little bit
7 more internally about that. That's not
8 exactly a minimal undertaking, and I think it
9 would take a certain amount of staff work up
10 front because some things are real clearly,
11 you know, we can eliminate those off the list.

12 Because having looked through our
13 list of 500-plus measures, for any number of
14 reasons, it's a fairly daunting list to run.
15 But I think that we can certainly think about
16 it a little bit more in terms of how it might
17 feed into this project.

18 So I don't have a real good answer
19 for you at the moment, but certainly something
20 to put on the agenda for us to consider.

21 DR. JENKINS: I think it's very
22 important, and the only thing I'd say is sort

1 of a divide and conquer strategy often works
2 well.

3 DR. WINKLER: All right. One
4 thing Charlie was asking me about, and that
5 was all the conversation we had about
6 framework. Now, where in the world did it go?
7 It's another one of those.

8 What I did was start talking about
9 some of the elements you guys had talked about
10 yesterday in terms of how might we look at a
11 framework, and I took the categories on the
12 left-hand column, which was the bullet list,
13 you know, modified, and we can certainly
14 modify it, and then I took the age ranges that
15 Charlie, you know, offered up, and I popped in
16 the outcome measures from, you know, page 10
17 to just show how this might work.

18 And we can have conversations
19 about, you know, if I put them in the right
20 box or not, but you can see that by doing this
21 kind of thing, we can see where gaps are. We
22 can see where we have measures. We can see,

1 you know, certainly the desirably areas.

2 The biggest question I had was,
3 you know, which ones do we array against each
4 other. So this is age against, you know, our
5 types of outcome measures, but then I also
6 took it to another group, and I went to, you
7 know, the IOM Aims as well as the NPP goals.
8 There's a little bit of overlap and not.

9 So you can start to see where some
10 of these come in. I rated against the
11 bullets, but I also thought, well maybe these
12 need to be arrayed against the ages. Right.
13 Well, I'm trying to do something that's multi-
14 dimensional in a two-dimensional space.

15 So you know, this might be a
16 useful one. I didn't plug them in. I just
17 was sort of building the concept so that
18 having measures for all of these different
19 periods of a child's life and we would want
20 something in each of the boxes probably at
21 each of the elements.

22 So this is one that you think is

1 valuable? Okay.

2 DR. JENKINS: I would have thought
3 the hierarchy is the Institute of Medicine
4 aims and then for each of the acute, chronic
5 and what's the next one? Prevention, and then
6 the ages because some of them will be
7 applicable across all conditions and all ages.

8 DR. WINKLER: Yes, right.

9 DR. JENKINS: And some of them
10 obviously won't.

11 DR. WINKLER: Yes. In building
12 this I had exactly those questions, and you
13 know, I was just trying to kind of get
14 something down for you to react to. So the
15 question is it sounds -- okay. So I took the
16 bullets against both, you know, ages, the NPP,
17 IOM goals, and then the acute, chronic,
18 preventive construct.

19 But the question is: do those go
20 better against ages? Or both?

21 CO-CHAIR HOMER: I think you'll
22 need multiple. I think this one is useful.

1 I think the age against the STEEP is also
2 useful. My guess is you're going to need to
3 do this in a database.

4 DR. WINKLER: Oh, absolutely.

5 CO-CHAIR HOMER: To make sure you
6 have characteristics of each and then look in
7 multiple --

8 DR. WINKLER: Exactly, exactly. I
9 was just trying to think about what are the
10 things -- these are the issues you brought up,
11 and this is very rudimentary, but how would
12 you like to see them related to one another?

13 CO-CHAIR WEISS: I'd also like to
14 see, going back to David's point, in
15 patient/out patient.

16 DR. WINKLER: Okay. And that
17 would be important to compare against what,
18 age?

19 DR. JENKINS: It's not compare
20 against age. It's that a measure may be
21 pertinent across the spectrum of ages. So a
22 measurement may only be pertinent for specific

1 age groups.

2 DR. WINKLER: Right, and that's
3 why I'm --

4 DR. JENKINS: So weight to STDs is
5 not pertinent for infants.

6 DR. WINKLER: Right.

7 DR. JENKINS: Or infant mortality
8 is not pertinent for adolescents.

9 DR. McINERNEY: But I think in
10 patients certainly and out patients, both you
11 would want to run against the IOM six goals.

12 DR. WINKLER: Versus the IOM,
13 okay. I can do that. I can drop that. I can
14 put in patient/out patient down here and drop
15 it against this one.

16 CO-CHAIR HOMER: And without being
17 too much of a splitter, the comparable table
18 that I'm putting together for the other NQF
19 project has out patient broken down into, you
20 know, basically specialty, emergency
21 department, and primary care. So I think
22 that's a reasonable way to frame that.

1 DR. WINKLER: Okay.

2 DR. PERSAUD: Are the NPP the IOM
3 priorities or is that different?

4 DR. WINKLER: They are different,
5 but there's a lot of overlap.

6 DR. PERSAUD: There's overlap?

7 DR. WINKLER: Line 3, effective,
8 safe, timely. Those are the IOM aims, and
9 then the NPP I've got in the line above it.
10 So safety, you know, patient-family
11 engagement, overuse, but the population
12 health, you know, either goes over all of them
13 or it's its own thing, and the same with care
14 coordination. It kind of goes with all of
15 them.

16 DR. PERSAUD: Okay.

17 DR. WINKLER: So, you know, I'm
18 having trouble depicting some of these.

19 DR. PERSAUD: What might be nice
20 in the ultimate document, however we choose to
21 overlay them, is to have bullet asterisks that
22 tell us where a construct fits, whose IOM,

1 whose --

2 DR. WINKLER: Oh, yes, yes. Okay.

3 So anyway, these are the kinds of
4 things that help us do an analysis of what
5 we've got already endorsed, where the new
6 measures may fit if we do, and hopefully
7 they're going to plug some holes, and then
8 clearly the empty spaces provide the gaps.

9 Now, some of these actually don't
10 make a lot of sense, some combinations, and I
11 think some of them will be very, very like,
12 whoa, you've got nothing in this and it's
13 highly important. And so I think it will be
14 an interesting thing to do to kind of come up
15 with an analysis of desirable measures that we
16 don't have, either not endorsed yet or have
17 come into the project, to create that list of
18 this is the stuff that needs to be developed
19 out there, and this is just sort of trying to
20 draft up a tool to help us figure what those
21 things are.

22 DR. JENKINS: The other thing,

1 you'll have to filter the tool in terms of the
2 lends of outcomes because some of them, like
3 I'm thinking overuse, under use, may actually
4 not fit perfectly with the patient outcomes.

5 DR. WINKLER: Right, exactly.

6 DR. JENKINS: So as nice as the
7 framework is. So to filter it down to the
8 core about child health outcomes will be very
9 important.

10 DR. WINKLER: Like I say, this is
11 sort of a first pass, you know, laid down in
12 two dimensions because I wouldn't think of any
13 other way to do it, to share it with you all,
14 but just as a starting point, if you'd like
15 I'll be happy to share it, but ideas from all
16 of you, how do we, you know, make this more
17 appropriate for child health in its next
18 iteration, and I envision this to be somewhat
19 iterative or definitely iterative to see if we
20 can ultimately come up with something that's
21 really a tool to help us understand what we
22 have and what we need.

1 So, again, this is one of those be
2 happy to share it with you and feel free to,
3 you know, come up with all sorts of great
4 ideas. I'm mining your brains.

5 DR. CLARKE: One thing that
6 occurred to me, you mentioned yesterday about
7 sort of blurring the 18-year cutoff, and I'm
8 wondering if we ought to have a group of young
9 adults. I know that at our hospital,
10 Children's Hospital, patients with congenital
11 heart disease are treated usually up to around
12 age 30.

13 DR. WINKLER: Yes, a lot of those.

14 DR. CLARKE: And some other
15 subspecialties do the same thing.

16 DR. WINKLER: Yes, a lot of the
17 congenital stuff.

18 Tom, did you have a question here?

19 DR. McINERNEY: Well, I'd just make
20 a side bet we're going to have more blanks
21 than filled in spaces.

22 DR. WINKLER: Well, and I think

1 that's reflective of the state and just some
2 of the frustration that a lot of folks in the
3 child health world have expressed, that there
4 just aren't a lot of measures for children,
5 and we're not focusing -- you know, the
6 collective "we" -- not focusing on children
7 enough, and that sort of thing. So yes.

8 But sometimes doing this kind of
9 an analysis brings it very clear, sort of
10 crystal clear. There's just a lot of work to
11 be done, and a lot of different kinds of
12 measures than the few that are -- they all
13 tend to cluster in the usual pipes, and are
14 not as expansive and cover a lot of the areas
15 that you all identified, and making that
16 explicit, getting that word out, you know,
17 talking that these are the desirable things,
18 not just, you know, these few narrow outcomes
19 we're used to seeing. It is really where we
20 want to go to have a much more rich
21 measurement portfolio for kids.

22 DR. ZIMA: Yes, it's interesting

1 because we came in thinking we knew our age
2 groups, and I think this last comment would
3 make me feel like my working table would say
4 young adulthood, greater than/equal to 18 to,
5 and I'm not sure what that last number should
6 be.

7 CO-CHAIR WEISS: Well, I don't
8 think there's a right number, but I think it's
9 important that this group come to closure
10 around what we think is a reasonable number.

11 PARTICIPANT: Twenty-one.

12 CO-CHAIR WEISS: Now, are we going
13 to go with the AAP, 21, or are we going to go
14 with what the Medicaid and CHIP programs
15 consider to be children since we're dealing
16 with CMS as the funder? Are we going with
17 what the providers are doing out there, which
18 is a more expansive definition?

19 I just think we need to have a
20 working understanding and have that reflected
21 in the materials that go out.

22 DR. ZIMA: It's a big issue in

1 mental health because when I hear about your
2 patients, I start thinking about all of our
3 psychotic autistic children that would not be
4 appropriate for schizophrenia clinic, and they
5 still have parents involved, and they're 22
6 years old. They're very special, you know, or
7 DDs.

8 CO-CHAIR WEISS: Yes.

9 DR. WINKLER: And one of the
10 issues, I think, this speaks from just a
11 purely measurement perspective. The issue
12 around needing to harmonize and keep things
13 consistent just for the ease and reduction of
14 burden of measurement and not confusing some
15 of the needs of just the technical needs of
16 measurement versus what's appropriate in the
17 actual care of patients. And measurement is
18 tools that reflect it. So you may not capture
19 the young adults that fall into it, I mean, or
20 it may need their own set of targets rather
21 than trying to cover all things with all
22 measures.

1 But I do think that it will be
2 confusing in the audience if we have measures
3 that have a mixture of age endpoints. I'm not
4 sure we will have fostered the standardization
5 that's a priority for us.

6 There may be specific exceptions
7 that you'll want, and if you do, you know, say
8 so, why, and then I think that's reasonable.
9 But, you know, some of them end at 15 and some
10 of them end at 18 and some of them end at 21.

11 DR. ZIMA: It might be okay to
12 simply share with the reader this dilemma, and
13 that, you know, based on different funders,
14 adulthood starts on different ages.

15 DR. WINKLER: right.

16 DR. ZIMA: And that for purpose of
17 this, we specified 21 or 25 or whatever, with
18 the acknowledgment that we're a work in
19 progress.

20 CO-CHAIR WEISS: Well, let me also
21 put another complication on the table, and
22 that is going to the population-wide issues.

1 The data sets that the Census Bureau, for
2 example, uses cut off at 17. When the child
3 turns 18, they're no longer captured in that
4 increment.

5 CO-CHAIR HOMER: Kathy, you had
6 one?

7 DR. JENKINS: Yes, I think this is
8 going to be very important, and I'm just going
9 to personally state my opinion that with all
10 due respect to data harmonization, I think
11 that validity actually trumps everything, and
12 sometimes when there is an explicit call for
13 harmonization across age groups, in
14 particular, there can definitely be a loss of
15 validity.

16 I mean, my example in what I know
17 best, the original adult databases were all
18 children were lumped together and then
19 children by age in years, and then there's the
20 harmonization around less than three months
21 where the data shows that there's a marked
22 increase in mortality in the infants in the

1 first month of life, and anything that doesn't
2 capture that difference between a one month
3 old, sick, critically ill at birth, from a
4 child who goes home for a while and comes
5 back, misses a marked validity problem.

6 And so that's also going to be
7 attention. So when measures come forward, I
8 think that that tension between harmonization
9 around the overall scope of the project or the
10 age brackets, when there are specific validity
11 issues, I'm personally going to feel that you
12 have to make exceptions for that or we'll
13 really throw the baby out with the bath water.

14 And I think that's how people
15 disagree, because they need a harmonization
16 expert.

17 DR. WINKLER: And that's exactly
18 the issue around explaining why if it's not
19 aligned, and if there's a very good reasons
20 for it that should be fine. It's when it
21 seems more arbitrary than not that, you know,
22 this group thinks it's this and this group

1 thinks it's this, you know. There isn't
2 anything that really substantiates one versus
3 the other. It does sort of drive the world
4 out there crazy when there doesn't seem to be
5 a very good and valid reason for what's
6 included.

7 CO-CHAIR HOMER: Do we need to
8 make this decision now?

9 DR. WINKLER: No, no. I think
10 it's one of those be alert sort of. Well, I
11 guess maybe perhaps in the call for measures,
12 do we want to put anything in in terms of
13 their definition of child? And age, I think,
14 is sort of a defining thing of child, or do we
15 leave it open at this point?

16 CO-CHAIR HOMER: I think really
17 the critical question on the table is 18
18 versus 21, you know, on the other end, and
19 your comment on CMS is that Medicaid coverage
20 goes through 18 or through 17 or --

21 MS. PARTRIDGE: Medicaid can go up
22 to 21, state option.

1 CO-CHAIR HOMER: Well, then I
2 would suggest we speak up to 21.

3 CO-CHAIR WEISS: It's mandatory
4 through 18 and then option to 21.

5 CO-CHAIR HOMER: I would suggest
6 age 21 because the AP like 21. It's a
7 Medicaid option up to 21. We won't annoy
8 anybody. I guess the only problem is some of
9 the public health data cuts at 18, but there
10 I think we could put caveats around and do
11 that.

12 DR. WINKLER: So it's less than
13 21, right? Once they turn 21 they turn into
14 something else, otherwise known as an adult.

15 CO-CHAIR HOMER: I mean I think we
16 will --

17 CO-CHAIR WEISS: To age 21.

18 DR. WINKLER: Yes, so it does
19 include 20. So that's fine.

20 CO-CHAIR HOMER: And I think we
21 will probably want to end up making some
22 recommendation down the line that NQF get

1 funded to do measures on the young adult
2 transition related issues both for the
3 biologic reasons that we're talking about of
4 kids with congenital disease, plus the
5 insurance related issues.

6 DR. JENKINS: Could we make sure
7 then that the main group is starting at age
8 21?

9 DR. WINKLER: Now, that gets to be
10 real interesting because most of the measures
11 tend to be specked at 18, and they didn't
12 specifically look at it with an age, but
13 you're right. That gets to be real
14 interesting.

15 DR. JENKINS: We've had this even
16 with the registries, you know. Where does one
17 end and where does the next one begin? And
18 are you asking people to double the report and
19 all this stuff.

20 CO-CHAIR HOMER: How would you
21 resolve it?

22 DR. JENKINS: I don't have a good

1 answer, but I think that what should happen is
2 that wherever one lets off, the next one
3 should generally start, unless, back to my
4 prior point, there's a validity reason which
5 at times there are.

6 The practical reasons are
7 different. If people only have data in
8 certain age ranges, that's where their data
9 source starts for whatever they're putting
10 forward, but with the exception of validity
11 reasons, I think one should end where the next
12 one begins so that the whole population is
13 covered.

14 DR. ZIMA: This discussion, I
15 think, raises something that I anticipate is
16 going to happen for you, and that is sort of
17 bringing in child and then bringing in the
18 mental health group. It's going to take,
19 okay, what lessons were sort of learned that
20 are going to focus the revision of the work
21 that's already happened on the main committee,
22 the issue to age, the issue of goals of

1 caregivers, and I think the concept of
2 transitions.

3 We didn't talk about other
4 transitions in adulthood like employment or
5 decreased divorce. So I think as your work
6 group goes on that there might be another
7 additional feedback to the main committee
8 after you processed what's happening --

9 DR. WINKLER: Sure.

10 DR. ZIMA: -- the next two weeks
11 for you.

12 DR. WINKLER: All right.

13 CO-CHAIR HOMER: I also want to
14 echo, I think, Kathy's earlier point. My
15 guess is from the outcome measures for your
16 grid here, we're going to convince them to --
17 it's just a few, you know, probably something
18 like mortality and morbidity, iatrogenic or
19 hospital acquired, you know, and population
20 health.

21 I think it makes sense for us to
22 put this all out there in detail so people

1 know what to respond to, but when we sort of
2 put it into a grid, I think we'll shrink it
3 down to three or four categories.

4 DR. WINKLER: Work in progress.

5 So all of your thoughts are good. You know,
6 we've got several documents that we generated
7 to share with you, and so we'll kind of
8 package them up and send them to you, and
9 again, feel free to share any of your
10 thoughts.

11 The last thing I wanted to go over
12 was the major evaluation criteria.

13 Do you have your PDF in here, your
14 PDF document? Where is it? Oh, this is it.
15 Okay.

16 This from your PDF packet that was
17 sent to you, and I'm going to go down to page
18 -- I'm not sure where it is. I'll know it
19 when I see it, so that you've got it to follow
20 along -- the major evaluation criteria, and I
21 don't want to belabor this, but I do want to
22 point out to you some of the issues because

1 some of your questions have come up around
2 this, and I do just want to reassure you that
3 the criteria are rather detailed and basically
4 comprehensive.

5 And so we're starting on page --
6 after 17. So, yes, it's its own document.
7 So, Jane, if you're still with us, we're on --
8 it starts following page 17 in your package of
9 materials, the evaluation criteria.

10 We had talked about the conditions
11 of four submissions. So that's kind of
12 administrative.

13 The first major criteria that's
14 sort of discussed -- why am I doing this?
15 Thank you, Charlie. The criteria, four main
16 criteria we mentioned before: importance to
17 measuring report, scientific acceptability to
18 measure properties, usability and feasibility.

19 So I just wanted to point out to
20 you that under each of those criteria we have
21 a definition for what we mean by the main
22 criteria, the importance to measure report,

1 the extent to which the measure is specific.
2 The measure focused important in making
3 significant gains in health care quality as
4 defined by the IOMA, and improving health
5 outcomes for a specific high impact aspect of
6 health care.

7 So it's not just is it important.
8 There are lots of things that are important,
9 but we're trying to focus in on things that
10 are going to have large impacts.

11 This particular criteria has three
12 sub-criteria. One is it addresses a national
13 health goal or priority from NPP, or a
14 demonstrated high impact, large numbers, high
15 severity, high cost. We've actually seen some
16 very, very narrowly focused measures that will
17 be captured, this tiny, tiny, aside from the
18 technical problems, small denominators. The
19 utility of a measure like that in driving
20 significant gains in health care is
21 questionable. So that's the first one.

22 The second one is there is a

1 demonstration of quality problems and
2 opportunity for improvement. We've had
3 measures submitted to us where the current
4 performance is 98 percent with no variation.

5 Good, applause, and move on
6 because it doesn't really help us promote the
7 change we're looking for.

8 CO-CHAIR HOMER: Without
9 belaboring that first one, it's going to be
10 tricky for us.

11 DR. WINKLER: Absolutely.

12 CO-CHAIR HOMER: So for any of the
13 pediatric subspecialty issues, even the
14 relative -- something like sickle cell or
15 something like that, you know. Compared to
16 congestive heart failure, it's going to look
17 like ho-hum. So we're going to have to --

18 DR. WINKLER: Well, --

19 CO-CHAIR HOMER: -- come up with
20 criteria around that.

21 DR. WINKLER: -- but I would say
22 because we've narrowed your focus to children,

1 I think there are high impact areas more so
2 than others within children. We don't have to
3 look at congestive heart failure. We don't
4 need to look at the Medicare population.
5 We're going to look at kids.

6 So I think that's a perfectly
7 reasonable thing. What's high impact within,
8 talking about kids. I don't think we need to
9 -- otherwise, you know, we're going to
10 marginalize children forever.

11 But the demonstration of a true
12 quality problem is an important one, and then
13 the measure focus, either it's an outcome
14 measure -- being an outcome measure gets you
15 a point. I mean, you pass that criteria or
16 there's a relationship that links it with an
17 outcome, and this is true for intermediate
18 outcomes, too. I mean, you know, blood
19 pressure targets should be, you know,
20 associated with long-term reduction in
21 morbidity and mortality, et cetera, et cetera,
22 et cetera.

1 But while this is really a
2 critical aspects, getting the evidence right,
3 going back, what is the quality of the
4 evidence is really an important part of the
5 evaluation for process measures, less so for
6 outcome measures because outcomes are really
7 sort of the end result that people are
8 interested in.

9 Certainly we do want to look at
10 whatever evidence is available, but it will be
11 a little bit of a lesser issue for this
12 project.

13 Realize that that it's a threshold
14 criteria. If you're not important to measure
15 and report, i.e., it's not -- what we're going
16 to get from it isn't worth the investment in
17 data collection and crunching, the burden,
18 then you know, stop. It can be highly valid,
19 but not terribly important.

20 Scientific validity or
21 acceptability of the measure has multiple sub-
22 bullets. One is the measure is well defined

1 and precisely specified. That's the
2 standardization. You can't expect different
3 groups to give you comparable results if they
4 don't start with the same very precise
5 specification. So that's an important thing
6 to look at.

7 Reliability testing, validity
8 testing, as we mentioned before, these are
9 kind of open ended questions. Did you test
10 the validity? How did you do it and what did
11 you find are sort of the sub-questions in the
12 submission form, which I'll show you briefly.

13 And so the same with validity
14 testing. Clinically necessary measure
15 exclusions. One of the significant
16 discussions that's happened over the last few
17 years in major specification is sometimes
18 you'll see measures with lots and lots of
19 exclusions, clinically appropriate, but they
20 contribute very, very little to the actual
21 measure results, and collecting that data for
22 that, you know, tiny exclusion is very costly

1 and burdensome, and it doesn't change the
2 actual measure results very much.

3 So the idea that we're focusing in
4 on the exclusions that actually impact the
5 result as opposed to absolutely everything
6 listed in, you know, a textbook --

7 DR. RAO: So, Reva, just to
8 interrupt you, how would you handle that
9 situation? Would you just take out the
10 exclusions or --

11 DR. WINKLER: Well, I think, you
12 know, the first thing we ask the measure
13 developers is why do you include it. What's
14 it getting for you? What's the mileage out of
15 it? And then perhaps see how amenable they
16 are to like, you know, what happens if you get
17 rid of them. You know, what happens if those
18 are eliminated?

19 I think each one has to be taken
20 individually and have that conversation with
21 the measure developer. I don't think you can
22 make some blanket statements because it

1 depends on how they handle different things,
2 and there may be good reasons for it. But in
3 general, the idea is keeping the measurement
4 burden of data collection reasonable and
5 important as opposed to just making it a
6 laundry list that may improve the face
7 validity for clinicians, but at the same time
8 just doesn't impact the measure.

9 This is the difference between
10 care and measurement, and it has come up more
11 than a few times. It particularly comes up
12 when you have a measure that can otherwise be
13 done by, say, electronic data or
14 administrative data, but you have to go to the
15 chart to pluck out the exclusions. You've
16 taken a measure that's relatively feasible and
17 low burden into something that's almost
18 impossible to do. And if you need to do that,
19 there should be a really good reason for it
20 because it does change the feasibility issues.

21 So that has become just a
22 significant conversation in NQF land.

1 DR. JENKINS: Reva, can I just ask
2 because, you know, preaching to the choir, I
3 completely agree with you there, although the
4 face validity issue is huge for individual
5 docs who don't want to have one patient who is
6 the exception somehow counted against them.

7 Has NQF added in the locus of the
8 appropriate use of the measure in terms of
9 numbers of cases or class or larger group,
10 let's say, a plan, a population, an entire
11 hospital?

12 DR. WINKLER: Not --

13 DR. JENKINS: To try to weather
14 that storm?

15 DR. WINKLER: Not explicitly. I
16 mean, we tend to have so little control that
17 making the recommendations -- and sometimes
18 there are about responsible use of the
19 measures with appropriate statistical validity
20 and significance, usually is a tag to almost
21 any of our reports, but again, you know, yes,
22 it's more in the use kind of element of it.

1 DR. McINERNY: One particular
2 example comes to mind, and when you apply the
3 measure, the pediatricians and others would be
4 concerned for immunizations. Your
5 immunization rates would be affected by the
6 number of parents who were vaccine refusers.

7 And so what do you do with that
8 exclusion?

9 DR. WINKLER: Let me -- not
10 wanting to get into an entirely large
11 conversation about a project that we did on
12 harmonization and immunization measures and
13 the way measures are specified.

14 And actually what they've come
15 down to is stratifying the numerator such that
16 the numerator includes patients who were
17 counseled but refused, patients who got it --
18 somehow I want to say there was a third
19 category, but I can't figure out what it was
20 -- and so you have a way of accounting for
21 everybody, and from that you're able to figure
22 out what the actual immunization rate is, who

1 actually got it as well as factor in the
2 other.

3 And so the measure kind of
4 addresses all of those issues and concerns in
5 the way it is constructed, and that sort of
6 then establishes what we call our standard
7 specification for an immunization measure, and
8 all immunization measures that come in are
9 judged against that standard.

10 So you're right. Those issues
11 have been sort of hammered out along the way.

12 This is what I think David was
13 asking about, the 2E for outcome measures and
14 other measures when indicated. An evidence-
15 based risk adjustment strategy is specified
16 and is based on patient clinical factors,
17 blah, blah, blah, blah, blah.

18 So this is a definite evaluation
19 criteria and then or rationale or data to
20 support no risk adjustment is needed. Well,
21 maybe there is some reason.

22 And then the data analysis

1 demonstrates the methods for scoring. Okay.

2 You crunch the data. What does it look like
3 when it comes out?

4 If there are multiple data sources
5 allowed as we've seen measures, well, there's
6 the HR version, and there is the chart
7 extraction version, and then there is the
8 admin data version. It's like are those
9 comparable so that if someone chose to do it
10 one way versus another, at the end of the day
11 are the results comparable. And so not just
12 saying, oh, yes, any way is fine.

13 And then how are disparities
14 handled? And if not, how do you plan on
15 handling them because it's an important issue?

16 The third one is usability, and
17 the three criteria, this is the extent to
18 which the audiences understand results and can
19 do something with them and are likely to find
20 them useful.

21 So this is one where we don't get
22 lots and lots of information, but when we do,

1 it's golden, and that's if there's any ability
2 to demonstrate meaningful information for the
3 audiences either through public reporting or
4 informing quality improvement.

5 So like I say, we don't get a lot
6 of the really nice testing that everybody
7 would love to say does this work for the
8 intended audiences, but it's certainly one of
9 the criteria.

10 This is where harmonization comes
11 in, the major spec to harmonize with other
12 measures because measures that are very
13 unaligned are hard for implementers to use
14 them as a group. What we've seen is if you
15 have a collection of asthma measures, if they
16 all define the denominator slightly
17 differently or the age range slightly
18 differently, then what they do is they pick
19 and choose to make it as easy to implement as
20 possible, and they won't implement the full
21 group. So the harmonization makes them more
22 usable in the implementation world.

1 And then review of our existing
2 endorsed measures to be sure we're just not
3 adding another one of the same old thing.
4 We're still struggling with trying to figure
5 out how that evaluation against an endorsed
6 measure because, frankly, a new measure may be
7 better, and if it is, that's fine and the
8 feedback goes back on the one that's endorsed
9 in terms of its maintenance review or maybe it
10 needs to be either morph or die or something.

11 So realizing this was sort of a
12 living, breathing kind of thing, and then
13 feasibility, the extent to which the data is
14 readily available to collect, to do the
15 measures without undue burden, and we're
16 trying to hope that pushing toward data
17 collection concurrent with care delivery so
18 it's not an extra step, but it's just part and
19 parcel of it, I mean, that's the vision of the
20 HR. But you may have other clinical systems
21 that may collect data. Case management
22 systems do it, all sorts of things.

1 And the data elements are
2 electronic. You know, that's far easier than
3 any chart abstraction, and if not, you know,
4 do you have a near term path to get there?
5 The idea we don't want to encourage people to
6 keep creating measures based on chart
7 objection. It's not going to be, you know,
8 useful for pretty much anybody.

9 Our experience is those measures
10 don't tend to get used anyway. So they get
11 created and not used. Oh, boy, what have we
12 done?

13 So, again, the feasibility, the
14 exclusions not requiring any additional data
15 source, and ability to audit the data is an
16 important one, and the fact that it can be
17 implemented.

18 Some measures that are already in
19 use have a certain step up here. I mean,
20 they've demonstrated some feasibility, and
21 they've demonstrated something about how the
22 measure performs.

1 So those are the criteria. In
2 terms of how we're going to implement this for
3 you, if you continue on what I'm going to show
4 you is just -- we just gave this to you as an
5 example. This is the pediatric cardiac
6 surgery.

7 What you will get for each measure
8 for your evaluation is we will embed the
9 responses from the measure developer in this
10 evaluation form and what they answered and
11 then your ability to evaluate it over on the
12 side based on their information.

13 So we're going to lead you through
14 the evaluation criteria step by step. Given
15 the answer to the question, the measure
16 developer has responded to provide us the
17 information for that, for you to be able to do
18 your evaluation. And so you'll just use this.

19 The actual Word documents we give
20 you are a bit interactive, and these bubbles
21 don't come up on the side. They'll actually
22 come up if you point to it, and there will be

1 a bubble that will remind you what the whole
2 criteria is. So you won't have to toggle
3 between documents or it won't be small size.

4 So it's an interactive document.
5 We've got a couple of folks on the staff who
6 love doing all of this technical stuff. So
7 it's grand for the rest of us who haven't a
8 clue. We just watch in amazement.

9 But so all of this gets embedded,
10 and that's why the electronic submission, you
11 know, we've got it electronically. We're able
12 to put it in this and make this a very
13 interactive kind of thing.

14 So this is what you're going to
15 receive once we have measures to evaluate.
16 Again, numbers will determine the exact plan,
17 but we typically separate the committee into
18 like either groups or if it's more like a
19 handful of primary and secondary reviewer who
20 will take the lead for the discussion on each
21 one. It certainly will try and match it up if
22 you have a clinical specialty area of

1 expertise.

2 If we have things that seem to
3 need expertise that we don't have, we'll find
4 an advisor to help out to answer some of the
5 questions. So you know, we'll work with you.

6 Like I say, once we know how many
7 measures we've got, we'll be back with you
8 with a more detailed work plan of exactly how
9 we're going to tackle them. But this is going
10 to be your primary tool for doing the
11 evaluation.

12 Both Lee and Charlie have watched
13 NQF go through evolutions of these. Back in
14 Lee's day, in the first project I did we had
15 evaluation forms. There were tables, and
16 Charlie carried around binders that were five
17 inches deep to do ambulatory care. So this is
18 our way of getting past a lot of the kill the
19 trees and as well as keep things electronic.
20 Because actually once we finalize things for
21 you, when we get the answers on a final one,
22 we can backfill this into the electronic

1 system and we then have the database of not
2 only what they submitted, but your evaluation
3 of it and everything builds from there they
4 tell me.

5 CO-CHAIR HOMER: But it's
6 basically, if I understand it correctly, we're
7 the ones who actually are making the decision
8 about --

9 DR. WINKLER: You bet.

10 CO-CHAIR HOMER: -- for example,
11 is it high impact.

12 DR. WINKLER: Correct.

13 CO-CHAIR HOMER: So we have the
14 criteria and we have the measure. So
15 obviously the developer will say it's high
16 impact and we'll look at the prevalence or the
17 impact and make our own judgment about that.

18 DR. WINKLER: Correct.

19 CO-CHAIR HOMER: So that's
20 basically our work.

21 DR. WINKLER: Exactly.

22 CO-CHAIR HOMER: And then we'll be

1 discussing within this group basically whether
2 the whole groups agrees with, for example, the
3 primary and secondly reviewer.

4 DR. WINKLER: Exactly. That's
5 going to be the primary agenda for your April
6 two-day meeting, is we will be, you know,
7 discussing each of these measures, and for
8 those of you who have done it, these can be
9 very intense meetings. Again, it all depends
10 on how many measures we're talking about.

11 You'll all have the opportunity to
12 lead the discussion around whatever measure
13 you get the lead for, but it will be a group
14 effort. I mean, everyone kind of comes to the
15 conclusion the final evaluation of, you know,
16 is it important; is it scientifically
17 acceptable; is it usable; is it feasible; and
18 then ultimately what is your recommendation
19 for endorsement. Yes or no, should it be
20 recommended for endorsement or not?

21 And that's the decision making
22 that this committee is charged with. So we're

1 trying to give you all the tools and
2 information you need to get there.

3 DR. ZIMA: Question: are there
4 two rounds of ratings, two rounds of expert
5 ratings or just one during the face-to-face?

6 DR. WINKLER: Like I say,
7 depending on the number of measures we may
8 want to have some preliminary phone calls and
9 do some preliminary kinds of things, or if
10 there -- it depends. I've done it any number
11 of ways.

12 We may break you into little
13 groups that you can talk preliminarily among,
14 you know, three or four of you to kind of get
15 some sense of it and bring that to the whole
16 committee. There are a variety of ways of
17 doing it.

18 DR. ZIMA: I'm thinking in terms
19 of the RAND method that was used in Beth
20 McGlynn's study.

21 DR. WINKLER: From Adelphi, from
22 out of Adelphi?

1 DR. ZIMA: Adelphi, you know, that
2 before we can --

3 DR. WINKLER: Not typically.

4 DR. ZIMA: You know, there's a few
5 that everybody agrees and you know ahead of
6 time you are the outlier.

7 DR. WINKLER: Right.

8 DR. ZIMA: Then you start your
9 discussion --

10 DR. WINKLER: Well, one of the
11 requirements is that each one get its day in
12 -- you know, on the agenda so that, one, it's
13 recorded in the transcript. The evaluation is
14 agreed upon by everyone, but you're right.
15 Some of them can go quickly, but some not.

16 But again, if we have a large
17 number of measures, we may want to do some
18 preliminary things to let a few of you, you
19 know, kind of have a chance to talk among
20 yourselves, think about it, because there are
21 often questions. The measure developers are
22 involved in those conversations. So you can

1 ask them, you know. Is this -- what's this?
2 Can you do this? Why didn't you do that?
3 Whatever, so that you have an opportunity to
4 really feel comfortable that your evaluation
5 is based on solid information.

6 Like I say, if we've only got six
7 measures in two days we can do it here. If
8 we've got -- don't faint, Jane -- 60 measures,
9 I'll break them down somehow, you know, and do
10 some preliminary work because there is no way
11 we can do 60 measures de novo in a two-day
12 meeting. Been there, done that. It doesn't
13 work real well.

14 So we've got experience with
15 dealing with various numbers of measures and
16 how to break the work down for the group, and
17 like I said, since right now it's an open
18 ended question on volume, we'll have to wait
19 to see exactly the method we'll choose to do
20 it.

21 MS. PARTRIDGE: Reva, I'm just
22 going to put in a plea that we not do

1 something in which we break down into small
2 groups and discuss a group of measures and
3 then come back to the whole group because when
4 we did that with the perinatal, if you
5 remember, it meant that half of the group had
6 none of the benefit of the discussion.

7 I understand when you've got a big
8 volume it's very, very tricky, but I think for
9 the benefit of the group it's important to be
10 able to hear the richness of the discussion
11 sometimes on measures that weren't assigned to
12 your little group.

13 DR. WINKLER: Okay.

14 MS. PARTRIDGE: Because I think we
15 all felt when we had to vote on the measures
16 we hadn't heard about, that it was not very
17 comfortable.

18 DR. SCHWALENSTOCKER: Just a
19 question really, and it goes to your question,
20 Charlie, earlier about impact of the measure.
21 So I'm just trying to get a sense of what
22 we're going to see from the developer. Does

1 the developer also kind of make a case for why
2 they think the measure should have impact or
3 does have impact?

4 DR. WINKLER: Yes, they are asked
5 to, and you know, some of them are very
6 detailed and some less so. It just kind of
7 depends what they choose to do, but for the
8 most part they're trying to make a case for
9 it.

10 DR. JENKINS: I was just going to
11 make a plea. Maybe you were going to do this
12 anyway, Reva, but you are going to filter out
13 the structure and process measures so that we
14 don't start by debating that first, especially
15 if there's a large volume?

16 DR. WINKLER: Yes. I mean, we
17 should not get them because we're not asking
18 for them. That doesn't mean they won't. I
19 agree with you, but yes, I will probably, you
20 know, do that with the blessing of the co-
21 chairs, you know. Just I think these are
22 process measures. I don't think they qualify.

1 Do you agree?

2 Perhaps, and if there's a
3 controversy we can share with everybody and
4 say, "What do you think? Yes or no? In or
5 out?" kind of thing. The ones that are pretty
6 obvious I think we can do.

7 MS. PARTRIDGE: And similarly,
8 you'll screen out ones that clearly don't meet
9 at least half of the criteria.

10 DR. WINKLER: Well, again, if we
11 end up with large volumes, that certainly
12 would be one way of sorting them out, and
13 again, ultimately that decision is yours, but
14 we can help kind of say, "These don't meet the
15 this criteria. Is it okay if we put them
16 aside and go no further?" and you would have
17 to do that.

18 But, yes, I think that's quite
19 reasonable.

20 DR. LIEBERTHAL: This is a follow-
21 up on what Ellen asked. Are we going to be
22 using objective criteria for impact? And I'll

1 give you an example. Cystic fibrosis has very
2 good outcome measures. If you run a cystic
3 fibrosis center, it has very high impact, but
4 I don't know in general terms if 30,000
5 patients across the country is high impact.

6 DR. WINKLER: Right. I think
7 ultimately that will be your decision. I
8 think the idea that keep it within the child
9 world; don't worry about the high volumes of
10 Medicare patients. Just ignore them.

11 And then I think it will be up to
12 you to decide whether there is value in that,
13 and in the information provided. Again, this
14 is where differences of opinion -- it will be
15 a committee decision how you meet that
16 criteria or not, realizing not everybody is
17 going to agree with you whichever way you go.

18 So there are no absolutes for any
19 of these criteria. Certainly the best
20 measures will score highly on all of the
21 criteria and the not so good measures will not
22 score well on, you know, several criteria.

1 But there is no absolute, you know, threshold.
2 You don't have to have a certain score to pass
3 or anything at this point. It has not been --
4 a grading system like that has not yet been
5 developed.

6 DR. McINERNEY: You know, I do
7 think though that we should keep in mind there
8 are many customers, and some of the customers
9 are very large, such as CMS, and some would
10 be somewhat small, such as the record of CF
11 centers.

12 But all of them would probably be
13 looking for measures, particularly now that
14 we're in the maintenance of certification, and
15 so the specialists are going to want to say,
16 "Oh, my goodness, what can I do for MOC? Ah,
17 here's some outcome measures available for my
18 specialty, and we could do a quality
19 improvement project looking at those outcome
20 measures and see if we can make some changes."

21 And while I have the floor, I just
22 want to say that both usability and

1 feasibility are probably functions somewhat of
2 the eye of the beholder. Fortunately though we
3 have different kinds of beholders here in the
4 room, but we should also think about maybe
5 some other beholders that aren't in the room
6 and try and think about their viewpoint as
7 well.

8 CO-CHAIR HOMER: My experience has
9 been that those are the two fuzziest criteria
10 that become challenging, and it is interesting
11 because we don't have on the steering
12 committee as we typically do, I don't think,
13 you know, major insurers, major
14 representatives of the large integrated
15 delivery systems, things like that.

16 DR. ZIMA: Well, it's interesting.
17 I actually when we did our state study, the
18 people that had the final say on feasibility
19 actually were QA nurses, and so anything that
20 initially passed, if it didn't pass the QA
21 nurse ratings for feasibility, it didn't
22 matter what the expert panel felt.

1 For the medical records, and this
2 was a medical record study, but that--

3 DR. RAO: Reva, how do we deal
4 with missing information, a measure that's
5 pretty good overall, but they have just not
6 completed the forms or there's one or two
7 pieces of missing information there?

8 DR. WINKLER: I mean, like I say,
9 we invite the measure developers to any
10 meetings you have where you've discussing it
11 so that they're available for you to ask
12 questions.

13 At some point I will tell you what
14 we're doing right now is we scan them as soon
15 as they come in. If it looks like they put
16 the information in the wrong spot or they left
17 it blank or something, we circle back with
18 them and say, "Hey, you know, are you sure you
19 want to leave this blank?" because blank,
20 we're assuming there is no information.
21 You've got nothing to contribute. I'm not
22 sure that's going to help your case.

1 We might give -- you know, each
2 project has been a little bit different. For
3 the most part we try and give them an
4 opportunity to spiff them up a bit, but
5 otherwise they just have to fly the way they
6 submit them. If there's no information, I
7 think you have to assume there is no
8 information, and if it's an unknown, it's an
9 unknown for that criteria, and you'll have to
10 see how you want to weigh that in relationship
11 to all of the rest. So that's where you are.

12 DR. JENKINS: Reva, at the end of
13 the day is it the consensus of this group or
14 is it a vote of the group or how does that
15 work?

16 DR. WINKLER: There's actually a
17 vote that forms the basis of the consensus.
18 Consensus is not unanimity. It's allowing
19 everyone to have their say and voting, and
20 then it's sort of the group and majority is
21 generally how we base the recommendations.

22 CO-CHAIR HOMER: But then what

1 happens after this? If we think -- actually,
2 whether we say yes or no, that gets out for
3 public comment; isn't that right?

4 So the general membership can
5 either --

6 DR. WINKLER: Opine.

7 CO-CHAIR HOMER: -- can opine.

8 Can they overrule our negative? So if we
9 don't say something is worthwhile, they can
10 opine. If we do recommend it and the overall
11 membership says --

12 DR. WINKLER: They have got two
13 avenues then. A couple of things. The
14 comment is their sort of assistance to you as
15 their representatives saying, "We don't like
16 this." But again, depending on the number of
17 people, you may have one outlier who says
18 something and everybody else thinks it's
19 grand. I mean, you kind of have to weigh it.

20 But that's why the comments come
21 back from the steering committee, for you to
22 look at and say maybe we should change one of

1 our recommendations based on the comments, or
2 you know, yes, we considered all of these
3 things and we still, you know, have included
4 them in our deliberations and, you know, we
5 stick with our recommendation.

6 So major recommendations have
7 definitely been changed by comment, but it's
8 your decision. I mean, that's why you are the
9 steering committee. It's up to you.

10 But you're getting input from a
11 variety of places, and it's sort of a
12 dialogue, and that's the whole point, and you
13 do want to take the input seriously.

14 In terms of measures recommended,
15 ultimately when they go to vote they could be
16 voted down. Memberships could say, "No, no,
17 no," and that would kill it. That happens
18 extremely rarely, but it has happened.

19 And then ultimately it goes to the
20 CSAC. If they feel that, you know, we were
21 way out in left field somewhere, you know, and
22 the membership didn't pay any attention, they

1 could kind of say, "What are you doing?" you
2 know, and want to have an interaction over
3 what's happening because they're acting on
4 behalf of the board before it goes for final
5 endorsement.

6 So there are a couple of consensus
7 standards, approval committee. It's a
8 subcommittee of the board. The board's
9 function for endorsement, because it is the
10 board of directors who grants the endorsement,
11 they have a subcommittee that they've assigned
12 that task to because, frankly, it's a big
13 task. They meet monthly, and they have a lot
14 of work to do, frankly, and the board just
15 couldn't handle it anymore. So they created
16 a group to take on that function on their
17 behalf.

18 So there are several opportunities
19 for dialogue back and forth to refine this so
20 that at the end of the day this is a product
21 from NQF as an organization of organizations,
22 and everybody having an opportunity to

1 participate. Even if they choose not to, they
2 have the opportunity to participate and weigh
3 in.

4 DR. LIEBERTHAL: Once it goes
5 through the whole NQF process and becomes a
6 standard approved by NQF, organizations can
7 use these and choose to use them or not. What
8 is their incentive to use them?

9 Because I'm like NCQA, that once
10 they approve something and once they make it
11 a HEDIS specification, everybody jumps and
12 uses it.

13 DR. WINKLER: There's a variety of
14 incentives, if you will. The biggest one is
15 when it gets adopted by somebody like CMS, you
16 know. That sort of is pretty much everyone's
17 incentive.

18 And, again, as I mentioned, you
19 know, adoption by the federal government, but
20 adoption by some states, some states are very
21 much more proactive in doing measurement than
22 others.

1 Also, there are a lot of purchaser
2 groups that look to NQF. In fact, for those
3 of you from New York, the New York Attorney
4 General's Office had brokered an agreement
5 with health plans about doctor report cards
6 that they would only be using measures
7 endorsed by NQF or a similar kind of body, and
8 there aren't too many of us. So that kind of
9 thing, and also the consumer purchaser
10 disclosure project, which is a group of
11 consumer and purchaser organizations have also
12 gotten in agreements with the major health
13 plans like United and Aetna and WellPoint, and
14 they are all part of it; that they would use
15 NQF endorsed measures.

16 These are primarily the measures I
17 was working on on the clinically enriched
18 project, the idea being when a doc sees a
19 bunch of patients during the day and some of
20 them are from Aetna and some are from United
21 and some are from WellPoint, and you know, the
22 measures are going to be slightly different

1 depending on which patient you're seeing.
2 That's kind of craziness for the doc. So the
3 idea that they can reach a standard set that
4 they're all going to use, that it just
5 standardizes it and makes it more
6 straightforward for the practitioners out
7 there.

8 So there are a lot of potential
9 incentives going on for use of NQF members,
10 and then a lot of our own members, people on
11 health systems, and I get calls all the time
12 from Baylor, Henry Ford, you know, some of the
13 big systems saying, "Tell me more about the
14 measure you just endorsed. We're going to put
15 it into play. You know, we're doing it," that
16 kind of thing.

17 I was going to say we're going to
18 be doing a survey in inventory to see how
19 widespread all of that use is, but it's a
20 whole variety of users out there actually.

21 DR. LIEBERTHAL: Does NCQA ever
22 use the NQF published measures for their use?

1 DR. WINKLER: It's the other way
2 around. We tend to endorse the QA measures as
3 NQF endorsed measures, and they tend to, you
4 know, just like the Joint Commission does, you
5 know, they tend to put a flag on it. PCPI
6 does the same thing. This measure is endorsed
7 by NQF and within their sites so they know.
8 That carries, you know, importance for various
9 audiences.

10 DR. McINERNEY: Well, yes.
11 Obviously for CMS currently is the PQRI,
12 Physician Quality Reporting Initiative, where
13 they provide a two percent incentive to
14 organizations that use the outcome measures.
15 There's process measures, tool, I guess for
16 that.

17 DR. WINKLER: Definitely.

18 DR. McINERNEY: But that NQF has
19 endorsed. But hopefully with CHIPRA, Medicaid
20 will start to do a similar kind of incentive,
21 I expect if I read between the lines for the
22 CHIPRA, and then I think it will be up to

1 perhaps us to talk to folks who we know to try
2 to get some of the commercial insurers to
3 improve the use of some of these outcome
4 measures in addition to using the HEDIS
5 measures.

6 DR. WINKLER: Right, yes. So
7 there we are. I think we've talked about the
8 next steps, you know, throughout. We're going
9 to be the intent for measures, call for
10 measures in January. If we need to get back
11 to you, you know, we'll do most of it by E-
12 mail, but something may arise. We may need to
13 do a quick conference call. We'll do it. Who
14 knows?

15 Once we have a sense of the number
16 of measures, we'll let you know, and the work
17 plan that will go along with it we'll have to
18 figure out. Like I say, it just depends on
19 the amount of measures, and we may need to do
20 some sorting and staging and who knows what it
21 will be?

22 Donna, did you have a question?

1 DR. PERSAUD: I don't know if we
2 addressed this, but just one item that I
3 didn't want us to lose track of and whether we
4 should have a representative on the mental
5 health group, or is there a child
6 psychiatrist, at least one on the mental
7 health group, or where can we get some
8 coordination ongoing?

9 DR. WINKLER: Yes, what's nice is
10 -- Ian, stand up and wave to the folks -- Ian
11 Corbridge is our project manager. Ian happens
12 to be a mental health nurse, and he's going to
13 run the -- do we have a child person on the
14 mental health? I can't remember.

15 Okay, all right. Yes, okay.

16 CO-CHAIR HOMER: That wasn't
17 recorded. I don't know if you could step up
18 to the microphone and say that again.

19 MR. CORBRIDGE: I apologize. We
20 have had the discussion. I guess as far as I
21 know there's not an individual who
22 specifically deals with children psychiatric

1 issues on the mental health steering
2 committee. So Bonnie and I have had
3 discussion of looking into how can we
4 collaborate to either look to see if we can
5 get someone or if there might be some
6 facilitation or, I guess, working with this
7 steering committee specifically on child
8 health relating to mental health issues.

9 CO-CHAIR HOMER: So I think maybe
10 to communicate a strong sense to the NQF
11 leadership of this committee that we would
12 like to see child expertise brought onto that
13 other committee.

14 DR. ZIMA: And I think that's sort
15 of informative. It would be better to have
16 another person, and that I'd be happy to do a
17 little bit of leg work with the president of
18 the American Academy of Child Psychiatry to,
19 you know, let him know that we're interested,
20 and then see if the academy can maybe come
21 with another nomination if the mental health
22 committee feels that they need a child

1 psychiatrist.

2 DR. WINKLER: Definitely I hear
3 the message. We need to kind of sort through
4 because I want to say you aren't the only
5 child psychiatrist. I saw a list of names.
6 So I need to kind of, you know -- exactly.
7 Something is triggering very minimally in my
8 brain. I just can't remember the details of
9 it. So we'll definitely talk about it.

10 And they're meeting next week, and
11 we can check in with them as well, but your
12 point is very well taken and we'll follow up,
13 right?

14 MR. CORBRIDGE: Thank you. Yes.
15 Thank you.

16 DR. WINKLER: Okay.

17 CO-CHAIR HOMER: Any other
18 business, Reva?

19 DR. WINKLER: I don't think so. I
20 mean, you've all been absolutely wonderful
21 hanging in there with us. This meeting was
22 meant to kind of bring everybody to the same

1 page of information, what NQF is doing, what
2 this project is all about, getting your
3 feedback on how we should go forward. I think
4 you've done a remarkable job. Your enthusiasm
5 is very much appreciated.

6 And so please, we do have lunch,
7 but otherwise I don't have anything more on
8 the agenda. So, Charlie, it will be up to you
9 if you--

10 CO-CHAIR HOMER: I think we stand
11 adjourned, but thank you. You've been
12 terrific.

13 (Whereupon, at 12:15 p.m., the
14 steering committee meeting was concluded.)

15

16

17

18

19

20

21

22

A				
AAP 88:6 110:13	acting 154:3	adopted 155:15	agreed 44:4 142:14	announcement
ability 133:1	active 92:8 94:5	adoption 155:19,20	agreement 156:4	78:17 79:4
135:15 136:11	actively 33:18	adult 31:6 113:17	agreements 156:12	announcing 78:4
able 12:22 18:6	activities 4:3	116:14 117:1	agrees 140:2 142:5	annoy 116:7
80:12 90:6 130:21	activity 99:3	adulthood 38:20	Ah 148:16	annual 9:12
136:17 137:11	actual 28:2 78:19	39:1 110:4 112:14	ahead 4:14 51:9	anonymously 81:6
144:10	111:17 126:20	119:4	55:6 142:5	answer 10:8 13:12
above-entitled 77:6	127:2 130:22	adults 27:19 108:9	AHRQ 6:19 9:7	71:6 79:18 99:18
ABP 83:15 84:2	136:19	111:19	10:17 14:16 15:13	118:1 136:15
absence 40:22	acute 9:15,18 64:22	advance 78:17	36:15 94:11	138:4
61:19,20	65:6 70:18 102:4	adverse 66:10 67:1	aims 101:7 102:4	answered 136:10
absolute 148:1	102:17	68:2,12,14,20	105:8	answering 10:5
absolutely 103:4	AC/PC 1:14	70:4,6 71:8,11,19	alcohol 74:10,21	answers 79:17
123:11 127:5	add 38:12 40:6	72:17,22	75:1	138:21
162:20	53:13 66:6 68:4	advisor 138:4	alert 115:10	Anthony 91:17
absolutes 147:18	added 21:6 129:7	advisory 84:21	aligned 114:19	anticipate 85:22
abstraction 135:3	adding 67:22 69:22	advocacy 74:4	Allan 1:15 21:19	118:15
abuse 38:16 60:22	134:3	advocate 73:5	57:16 58:2	anybody 12:7
61:8,10,13 62:4	addition 71:1 159:4	advocates 96:17	allergists 97:5	37:21 64:7 76:16
62:10,19 63:7,7	additional 119:7	advocating 91:11	allergy 97:18	80:9 116:8 135:8
63:13 74:11	135:14	96:20	Alliance 91:8	anymore 154:15
academy 43:16	additionally 42:4	Aetna 156:13,20	allocated 20:18	anytime 92:22
88:12 91:18	additions 77:15	affective 11:16	allowed 132:5	anyway 14:1 83:17
161:18,20	address 81:12	age 7:15 8:13,14	allowing 151:18	106:3 135:10
acceptability	addressed 160:2	10:11 11:3,11	alluding 33:15	145:12
121:17 125:21	addresses 122:12	71:15 100:14	68:16	AP 116:6
acceptable 29:18	131:4	101:4 103:1,18,20	alternative 59:5	apologize 91:10
140:17	Adelphi 141:21,22	104:1 108:12	altogether 47:5	160:19
accepted 71:22	142:1	110:1 112:3	amazement 137:8	appearance 24:20
accepting 30:13	ADHD 22:10	113:13,19 114:10	amazing 9:9 87:15	appendicitis 11:12
access 83:15 84:7	adhere 33:7	115:13 116:6,17	Ambassador 1:9	11:15
accountability 44:9	adherence 24:10	117:7,12 118:8,22	ambulatory 10:2	applause 123:5
49:6,15 50:21	24:11,13,15 25:3	133:17	12:2 13:3 17:3	applicable 30:22
53:3 57:10 60:9	25:8,15,19 26:17	agency 32:12	55:16 66:18 71:1	102:7
63:20	27:7,8,9 28:10	agenda 4:16 99:20	138:17	apply 27:22 31:14
accountable 49:7	29:3,4	140:5 142:12	amenable 127:15	130:2
accounting 130:20	adjourned 163:11	163:8	American 83:12	applying 91:4
accurate 16:3	adjusted 29:13	agents 74:1	89:2 91:15 95:7	appreciated 163:5
achieving 93:19	adjustment 73:11	ages 101:12 102:6,7	96:1 161:18	appropriate 65:7
Acknowledging	87:5,7 131:15,20	102:16,20 103:21	amount 17:9 79:15	97:13 98:9 107:17
75:15	admin 17:11 132:8	112:14	82:11 99:9 159:19	111:4,16 126:19
acknowledgment	administrative	aggregate 19:2	AMSPDC 89:1	129:8,19
112:18	121:12 128:14	ago 72:12	analysis 13:14	appropriately 5:6
acquired 65:21	adolescent 11:15	agree 26:10 59:8	17:16 53:12 106:4	approval 154:7
68:2,13 69:8 72:3	91:19	70:11 75:9 129:3	106:15 109:9	approve 86:2
119:19	adolescents 11:19	145:19 146:1	131:22	155:10
	104:8	147:17	anesthesia 87:17	approved 155:6

April 140:5	52:8 53:22 55:9	based 4:16 5:3	big 9:20 10:15	brackets 114:10
arbitrary 114:21	86:1 133:15	24:15 54:9,14,16	11:20 41:10 64:6	brain 162:8
area 21:12 55:7	attaining 20:22	54:21 55:8,17	91:7 110:22 144:7	brains 108:4
70:22 71:1 72:12	attempt 80:9	60:15 62:12 67:9	154:12 157:13	brainstorming
137:22	attention 73:15	85:3,15 86:14	biggest 101:2	89:1 91:1
areas 70:12,18	81:12 114:7	112:13 131:15,16	155:14	breadth 30:10
85:10,11,22 101:1	153:22	135:6 136:12	binders 138:16	break 14:18 36:9
109:14 124:1	Attorney 156:3	143:5 153:1	biologic 117:3	76:13 77:16
arena 21:21	attribution 14:9	basically 44:7	Bipolar 91:9	141:12 143:9,16
arenas 96:2	audience 112:2	104:20 121:3	birth 84:9 114:3	144:1
arm 11:12	audiences 132:18	139:6,20 140:1	bit 7:20 15:12 51:5	breast 16:12
array 101:3	133:3,8 158:9	basis 9:21 94:8	57:14 70:21 72:14	breathing 38:11
arrayed 101:12	audit 135:15	151:17	79:21 81:11 99:6	134:12
arrived 6:5	autism 84:16 91:9	bath 114:13	99:16 101:8	Brief 4:12
art 73:12	93:20	Baylor 157:12	125:11 136:20	briefly 126:12
article 9:7	autistic 111:3	Bear 20:2	151:2,4 161:17	bring 6:14 8:18
ASHLEY 1:23	automatically 94:5	beginning 53:15	blah 131:17,17,17	141:15 162:22
aside 122:17	94:12	begins 118:12	131:17,17	bringing 30:19
146:16	available 61:11	behalf 154:4,17	blank 50:16 150:17	118:17,17
asked 145:4 146:21	125:10 134:14	behavior 38:18	150:19,19	brings 109:9
asking 4:20 18:5	148:17 150:11	behavioral 24:8	blanket 127:22	broaden 68:5
100:4 117:18	Avenue 1:10	27:5 28:11,17,21	blanks 108:20	broadly 89:20
131:13 145:17	avenues 152:13	38:13	blasts 94:7	broke 21:14
aspect 122:5	avoid 78:21	behaviors 38:14	blessing 145:20	broken 11:3 15:11
aspects 125:2	avoided 72:2	63:14	blocker 28:5	104:19
assess 22:16 42:5	aware 8:19 15:20	beholder 149:2	blocking 37:5	brokered 156:4
52:14	awareness 75:18	holders 149:3,5	blood 124:18	bronchitis 9:16
assessment 22:5	awful 79:11	belabor 120:21	blurring 108:7	11:8
65:15 71:14	a.m 1:10 3:2 77:8,9	belaboring 123:9	board 27:22 83:12	bronchopulmona...
assigned 6:21		believe 9:12	154:4,8,10,14	71:3
52:19 144:11	B	belonging 52:20	board's 154:8	brought 4:19 78:4
154:11	baby 114:13	belts 62:14	body 85:16 156:7	93:13 103:10
assignment 7:5	back 6:14 8:5 17:2	benefit 81:16 144:6	boilerplate 20:5	161:12
assistance 152:14	25:14 28:1,8	144:9	39:8	bubble 137:1
associated 67:7	51:13 52:12 77:2	benefits 98:2	bone 69:16	bubbles 136:20
95:1 124:20	77:20 103:14	best 86:4,12 113:17	Bonnie 1:20,25	budget 87:14
association 84:13	114:5 118:3 125:3	147:19	18:6 49:4 51:2	bugs 80:9
91:2,15 92:5	134:8 138:7,13	bet 108:20 139:9	60:2 61:18 63:11	building 101:17
97:10	144:3 150:17	beta 28:5	90:17 161:2	102:11
assume 7:13 56:19	152:21 154:19	Beth 141:19	Books 4:4	builds 139:3
92:4 94:9 151:7	159:10	better 23:5 32:2	boss 39:2	built 38:3
assuming 32:21	backfill 138:22	35:22 57:19 73:20	bottom 50:18 64:11	bullet 20:18 21:4,6
75:1 150:20	background 20:5	74:5,5,5,6 102:20	bowel 83:1	21:13 23:16,18,22
asterisks 105:21	bad 41:1	134:7 161:15	box 100:20	24:5 41:20 42:4
asthma 7:14,15 8:1	bands 11:4	beyond 22:13	boxes 101:20	42:14 45:11,15
8:8,9,11 9:15 11:8	bars 45:2	67:22	boy 135:11	46:12 47:20 50:1
36:19 37:14 45:19	base 13:15 151:21	bicycle 24:22 62:14	BPD 71:3	50:10,15,18 52:18

60:7 62:9 66:7 68:5 100:12 105:21 bullets 19:21 29:15 30:4,16 46:11 52:2 57:16 63:18 64:3,11 101:11 102:16 125:22 bunch 25:14 156:19 burden 111:14 125:17 128:4,17 134:15 burdensome 127:1 Bureau 113:1 bury 42:3 business 162:18	33:6 34:21 35:12 42:4,20 43:2,9,10 44:8 49:6 50:21 51:6,20 55:16 57:20,21 58:5,19 60:8,12,16 63:20 64:13,22 65:21 66:2,18,21 68:2 68:13 69:8 70:18 92:18 93:21 96:13 97:18 104:21 105:13 111:17 122:3,6,20 128:10 134:17 138:17 caregiver 39:12,14 39:18 56:4 caregivers 119:1 caring 52:15 Carl 37:8 carried 138:16 carries 158:8 carry 12:5 81:11 case 73:20 134:21 145:1,8 150:22 cases 71:19 129:9 casual 22:1 categories 100:11 120:3 category 41:15 130:19 cause 9:12 caveats 116:10 CDC 84:11 CDC's 84:8 cell 123:14 Census 113:1 center 16:10 84:8 147:3 centers 148:11 certain 19:6 67:5 90:9 92:12 99:9 118:8 135:19 148:2 certainly 7:2 41:15 85:6 96:5 99:15 99:19 100:13 101:1 104:10	125:9 133:8 137:21 146:11 147:19 certification 148:14 cessation 29:8 30:20 31:3 37:11 cetera 48:12 74:6 124:21,21,22 CF 16:10 84:5 148:10 CHADD 91:7 chair 93:3 chairs 89:3,5 91:20 145:21 challenged 51:17 challenging 149:10 chance 10:3 76:8 77:17 142:19 change 20:15 24:8 26:20 27:5 28:12 28:19,21 38:13 42:7 56:3 58:15 59:4,10,12,13,14 60:7 86:18 123:7 127:1 128:20 152:22 changed 153:7 changes 77:15 148:20 changing 58:9,11 chapter 44:1 chapters 43:17 character 70:5 characteristics 57:1 103:6 charged 140:22 Charles 1:10,13 Charlie 10:22 25:5 28:9 38:19 51:1 52:3 81:21 91:9 94:17,17 100:4,15 121:15 138:12,16 144:20 163:8 chart 128:15 132:6 135:3,6 CHC 94:14	CHCA 12:16 check 16:21 76:17 76:19 91:1 162:11 checking 16:15 checklist 22:7 child 61:8 child 1:3,8 2:17 13:14,19 20:20 32:19 43:5,7,8 44:12 50:21 60:10 60:16,20 61:10,13 62:4,10,19 63:7 72:12 90:15,18 91:19 107:8,17 109:3 113:2 114:4 115:13,14 118:17 147:8 160:5,13 161:7,12,18,22 162:5 childbirth 11:21 childhood 18:9 children 9:5,10,12 10:22 15:2 31:4,7 39:15 51:16,16,17 51:19,22 52:5,8,9 52:9 56:10,20 63:21 71:12 74:6 82:7,9,11 93:9 96:14,20 109:4,6 110:15 111:3 113:18,19 123:22 124:2,10 160:22 children's 82:21 89:13,15 108:10 child's 101:19 child-serving 43:2 44:9 60:8 CHIP 110:14 CHIPRA 6:17 158:19,22 choice 73:22 choir 129:2 choose 105:20 133:19 143:19 145:7 155:1,7 choosing 86:14 chose 132:9	chronic 33:16 35:11 52:22 102:4 102:17 circle 41:21 150:17 city 56:11 claims 17:10,11 46:7 clarifies 58:5 clarifying 53:14 CLARKE 1:14 64:10,16,20 66:5 66:10,16 67:10,14 70:6 94:21 95:10 95:12 108:5,14 class 86:12 129:9 clear 29:19 109:9 109:10 clearly 99:10 106:8 146:8 clinic 111:4 clinical 26:13,14,15 34:2 45:16,19 52:19 54:22 64:14 65:18 67:22 68:5 69:4,7 71:7 72:15 89:22 131:16 134:20 137:22 clinically 126:14,19 156:17 clinician 54:15 84:20 clinicians 33:18 128:7 closure 110:9 clue 42:15 137:8 cluster 109:13 CMS 16:16 17:8 110:16 115:19 148:9 155:15 158:11 codes 19:6 coding 15:21 16:1,7 coffee 76:15 cognitive 21:8 22:21 collaborate 161:4 collaborative 83:2
C				
C 2:10 20:8 CAHPS 35:18,21 call 3:14 5:2,5 8:11 19:14,19 20:13 31:21 35:17 78:2 78:5,6,19,20 80:20 81:21 89:19 92:20 113:12 115:11 131:6 159:9,13 calls 141:8 157:11 cancer 72:13,15 capacity 32:21 35:14 56:20 capture 8:4 35:15 36:13 38:15 62:2 111:18 114:2 captured 69:6 75:8 113:3 122:17 captures 29:5 capturing 52:10 93:18 cardiac 70:15 71:9 87:17 95:11,16 136:5 cards 156:5 care 10:3 12:2 13:3 23:8 32:6,9,22				

95:21	commercial 18:14 159:2	concept 32:15 35:15 38:15 42:16 49:5,16 57:11,22 59:17 61:17 101:17 119:1	contact 15:13 51:6 60:16 81:5 91:18 93:5,14 97:9	counted 71:19 129:6
colleague 17:17	Commission 158:4	concerned 52:13 130:4	content 60:8	counters 46:6
colleagues 76:10	committee 1:3,9 50:12 90:22 91:16	concerns 74:8 131:4	continue 20:17 136:3	country 97:4 147:5
collect 18:1,3 92:12 134:14,21	91:20 118:21	concluded 163:14	contribute 38:10 72:14 126:20 150:21	counts 13:20
collecting 126:21	119:7 137:17	conclusion 140:15	control 36:19,19 129:16	couple 6:12 16:11 20:14 57:15 64:11 90:20 137:5 152:13 154:6
collection 125:17 128:4 133:15 134:17	140:22 141:16	concurrent 134:17	controversy 70:13 146:3	course 12:15 32:20 93:4,10 97:1
collective 109:6	147:15 149:12	condition 16:17 32:19 58:10,11,15 59:4,10	convened 83:13	cover 95:15 109:14 111:21
collects 18:8 40:14	152:21 153:9	conditions 8:12 9:11 40:17 43:22 44:18 50:20 82:22 102:7 121:10	conversation 5:3 42:8 77:11 89:11 100:5 127:20 128:22 130:11	coverage 115:19
College 95:8 96:1	154:7 161:2,7,11 161:13,22 163:14	conference 159:13	conversations 14:3 18:21 100:18 142:22	covered 118:13
column 100:12	common 11:1 27:15 73:3 85:19 86:16	conflicting 85:13	convince 119:16	covers 95:3
columns 15:3	Commonwealth 17:5	confusing 111:14 112:2	Cooley 37:8	Co-Chair 1:13,13 3:3,7,10 4:2 15:5 16:14 18:22 21:18 23:21 25:6,22 26:5,18 27:4 28:20 29:2 31:16 34:18 35:13,20 36:5,11 40:18 41:14 43:12 44:4 44:12 45:13 46:1 46:8 47:19 48:10 49:10 50:9,14 53:16,21 54:17 55:5,18,21 58:9 58:14,21 59:1,8 59:14 61:12,22 63:1,6,9 64:1,18 65:17 66:4,14,22 67:20 69:21 71:2 72:21 73:17 74:19 75:21 76:3,16,21 77:3,10 80:17 83:4,6,11 87:12 88:9 89:4 90:17 94:18 96:22 97:3 98:13 102:21 103:5,13 104:16 110:7,12 111:8 112:20 113:5 115:7,16 116:1,3 116:5,15,17,20
combinations 106:10	communicate 60:14 92:4 161:10	congenital 68:17 69:3 71:11 75:12 75:19 95:1 108:10 108:17 117:4	convince 119:16	
combined 14:15	companies 94:3	congestive 57:8 123:16 124:3	Cooley 37:8	
come 19:10 20:10 31:18 56:15 57:18 65:13 67:21 68:13 81:6,7 82:19 86:5 90:21 98:8 101:10 106:14,17 107:20 108:3 110:9 114:7 121:1 123:19 128:10 130:14 131:8 136:21,22 144:3 150:15 152:20 161:20	comparable 104:17 126:3 132:9,11	connected 91:14 93:21	cooperative 19:5	
comes 10:16 37:21 87:11 90:14 114:4 128:11 130:2 132:3 133:10 140:14	compare 103:17,19	conquer 100:1	coordinated 91:6	
comfortable 24:1 25:5 143:4 144:17	compared 41:17,18 123:15	consensus 86:6 151:13,17,18 154:6	coordination 105:14 160:8	
coming 13:20 17:11 78:6 81:10 87:19	completed 150:6	consider 18:17 25:16 99:20 110:15	Corbridge 1:22 160:11,19 162:14	
comma 28:11 35:1 35:2 60:20,20	completely 129:3	considered 26:16 153:2	core 6:17 107:8	
comment 7:21 39:10 63:14 110:2 115:19 152:3,14 153:7	compliance 23:22 24:7,12 27:13	construct 102:18 105:22	correct 48:17 139:12,18	
comments 77:14 152:20 153:1	complication 65:22 68:20 112:21	constructed 131:5	correctly 72:8 139:6	
	complications 11:21 58:13 68:2	consumer 84:18 91:7 92:22 93:1 156:9,11	Corry 93:4	
	component 95:22 98:20		cost 9:13,21 10:19 12:11,19 14:9,11 14:14 122:15	
	comprehensive 121:4		costly 9:11 126:22	
	computer 12:5 20:2		council 89:12 92:22 93:1,7,11	
	conceivable 53:13		counsel 27:8 40:9 41:5	
	concentrated 70:10		counseled 130:17	
			counseling 26:20 28:14,18 30:20	
			count 97:1	

117:20 119:13 123:8,12,19 139:5 139:10,13,19,22 149:8 151:22 152:7 160:16 161:9 162:17 163:10 Co-Chairs 1:11 co-counts 27:13 CPNP 1:14 craziness 157:2 crazy 115:4 create 22:18 106:17 created 42:2 135:11 154:15 creating 135:6 credit 86:21 criteria 5:11,16 8:8 13:17 79:21 85:6 86:15 120:12,20 121:3,9,13,15,16 121:20,22 122:11 123:20 124:15 125:14 131:19 132:17 133:9 136:1,14 137:2 139:14 146:9,15 146:22 147:16,19 147:21,22 149:9 151:9 critical 115:17 125:2 critically 114:3 cross-cutting 31:10 Crotched 37:6 crunch 9:8 132:2 crunching 125:17 crystal 109:10 CSAC 153:20 current 123:3 currently 48:16 158:11 customer 88:12 customers 148:8,8 cut 10:18 113:2 cutoff 108:7	cuts 116:9 cystic 16:8 37:13 82:15 147:1,2 <hr/> D <hr/> dah 42:20,20,21 data 9:8,13 10:7,7 10:13,20 12:1,8 12:22 13:8,21 14:4,15,17,21 15:11,18,20 16:3 17:3,6,10 18:1 40:13 41:3 79:9 79:12 92:5,12 113:1,10,21 116:9 118:7,8 125:17 126:21 128:4,13 128:14 131:19,22 132:2,4,8 134:13 134:16,21 135:1 135:14,15 database 16:5 17:13 19:3 96:11 103:3 139:1 databases 113:17 daunting 99:14 David 1:14 62:17 66:4 79:22 131:12 David's 103:14 day 2:14 4:7,12,13 4:16,17 33:20 132:10 138:14 142:11 151:13 154:20 156:19 days 79:1,3 143:7 da-da-da-da 76:6 DDs 111:7 de 143:11 deaf 51:16 deal 150:3 dealing 75:3 110:15 143:15 deals 160:22 debating 145:14 December 78:10 decide 32:18 75:7 147:12	decision 27:2 32:14 34:11,13 35:1 115:8 139:7 140:21 146:13 147:7,15 153:8 decreased 36:20,21 119:5 deem 55:11 deep 138:17 Defects 84:9 defer 23:10 91:22 define 38:4 53:19 63:18 133:16 defined 46:17 75:8 122:4 125:22 defining 54:2 58:15 70:4 115:14 definite 26:14 131:18 definitely 49:3 83:8 92:10 107:19 113:14 153:7 158:17 162:2,9 definition 27:17 110:18 115:13 121:21 degree 31:9 79:17 97:9 Dehydration 11:10 delayed 38:15 delays 96:14 deliberations 153:4 Delighted 3:8 delivery 134:17 149:15 delve 14:17 demonstrate 133:2 demonstrated 122:14 135:20,21 demonstrates 132:1 demonstration 123:1 124:11 Denise 92:6 Denise's 92:10 denominator 46:2 51:21 52:4 53:2,3	53:19 54:5,5 133:16 denominators 49:2 122:18 department 89:2,5 93:22 104:21 departments 89:8 89:22 depending 141:7 152:16 157:1 depends 22:12 26:9 86:9 87:2,6 128:1 140:9 141:10 145:7 159:18 depicting 105:18 depression 9:15 14:10 41:5 91:12 depressive 37:4 describe 30:5 describing 70:22 desirable 21:2 30:10 63:19 106:15 109:17 desirably 101:1 detail 119:22 detailed 79:16 121:3 138:8 145:6 details 6:16 13:16 162:8 deterioration 58:13 determine 6:10 137:16 developed 106:18 148:5 developer 127:21 136:9,16 139:15 144:22 145:1 developers 33:3 86:17 127:13 142:21 150:9 developing 14:22 32:20 33:8,9 87:8 90:10 development 21:7 23:6 33:9 39:1 90:15 93:19 developmental	21:10 84:9 88:15 93:15 96:14 devices 74:5 devil's 73:4 diabetes 52:9 57:8 diagnose 75:2 diagnosed 16:7 56:21 diagnoses 10:12 11:6 12:17 18:9 diagnosis 9:9 dialogue 153:12 154:19 dice 12:21 42:13 dicing 12:10 die 134:10 difference 67:4 71:7 114:2 128:9 differences 147:14 different 8:12 14:22 16:21 23:22 30:6,7 31:13 34:3 67:1,8 73:20 90:10 91:3 94:19 101:18 105:3,4 109:11 112:13,14 118:7 126:2 128:1 149:3 151:2 156:22 differentiate 26:19 differently 61:3 133:17,18 difficult 8:10 dig 15:11 dilemma 112:12 dimensional 101:14 dimensions 32:7 34:22 107:12 dinner 4:5 direction 53:11 directions 53:5 directors 91:2 154:10 disabilities 84:10 93:15 disabled 51:16
---	---	--	---	---

disagree 114:15	docs 129:5	41:19,22 42:19,22	106:22 107:5,6,10	144:20
disagreeing 67:21	doctor 156:5	43:1,3,4,7,8,10,14	108:5,13,14,16,19	early 74:12
discharges 10:18	doctors 16:2	44:11,20 45:5,9	108:22 109:22	ease 111:13
disclosure 156:10	document 29:14	46:10,14,15,21	110:22 111:9	easier 135:2
discovered 15:8	77:22 105:20	47:1,3,6,8,11,14	112:11,15,16	easiest 14:20 86:19
discuss 144:2	120:14 121:6	47:16,22 48:3,4,7	113:7 114:17	86:22
discussed 15:16	137:4	48:11,14,16,18,22	115:9 116:12,18	easily 89:17
121:14	documents 79:10	49:3,8,11,12,14	117:6,9,15,22	easy 9:6 20:8 65:10
discussing 140:1,7	120:6 136:19	49:17,22 50:4,7	118:14 119:9,10	133:19
150:10	137:3	50:13 51:1,4,10	119:12 120:4	echo 119:14
discussion 2:14,19	doing 10:9 24:8	51:13,19 52:6,12	123:11,18,21	echoing 74:8
7:4 19:12 51:8	79:8,19 82:6	52:17,21 53:4,7,9	127:7,11 129:1,12	ed 7:15 8:1 59:6
62:8 85:10 89:14	100:20 109:8	53:10,20 54:11	129:13,15 130:1,9	96:17,19
118:14 137:20	110:17 121:14	55:3,14,20 56:1,8	139:9,12,18,21	education 43:5
140:12 142:9	137:6 138:10	56:22 57:4,6,12	140:4 141:3,6,18	96:15
144:6,10 160:20	141:17 150:14	58:4,7,12,17,22	141:21 142:1,3,4	effective 105:7
161:3	154:1 155:21	59:3,13,16,21	142:7,8,10 144:13	effects 72:22
discussions 56:18	157:15,18 163:1	60:2,5 61:6,14,16	144:18 145:4,10	efficacy 35:9,10,10
126:16	dollar 14:14	62:5,7,13,15,16	145:16 146:10,20	effort 140:14
disease 8:12 9:19	Donna 1:18 29:11	63:4,8,10,12,15	147:6 148:6	efforts 37:12,15
16:12 33:16 36:3	159:22	64:5,10,12,16,20	149:16 150:3,8	either 10:18 29:14
40:8 41:9 46:19	door 29:22 42:10	65:20 66:5,8,10	151:12,16 152:6	36:20 54:7 84:19
50:6 51:14 52:22	double 91:1 117:18	66:12,16 67:2,10	152:12 155:4,13	98:22 105:12
64:15 65:19 66:1	DR 3:12,16,20 4:15	67:13,14,19 68:4	157:21 158:1,10	106:16 124:13
68:1,6,8 82:14	7:22 8:3,7,16 10:1	68:9,12,15,21,22	158:17,18 159:6	133:3 134:10
83:1 84:4 108:11	10:5 12:14,18	69:14 70:3,6 71:6	160:1,9 161:14	137:18 152:5
117:4	13:3,5,6,7,13,18	71:21 72:19 73:2	162:2,16,19	161:4
diseases 41:12	14:8,12 15:1,4,7	73:4,9 74:4,7,15	draft 5:7 19:19	elaborate 59:11
44:15 50:2 84:13	15:17,19 16:18,20	75:11,15,20 76:2	106:20	electronic 79:6
disorder 11:16	17:5,20,22 18:2	76:5,18 77:1,4,21	drafted 5:1 19:17	81:8 98:2 128:13
disparities 42:12	18:11,18,19,20	80:19 81:2 82:14	20:1	135:2 137:10
49:2,15 132:13	19:8 22:2,6,8,9,11	82:18,19 83:5,10	dramatically 75:13	138:19,22
disparity 46:17	23:1,3,4,8,9,11,17	85:1,5,21 86:7	drive 115:3	electronically 15:6
50:7	23:19 24:3,10,11	87:13 88:5,10,16	driving 38:16	137:11
dissected 70:9	24:13,21 25:2,4	88:18,19,21 89:9	122:19	element 85:7
disseminate 97:1	25:18 26:2,7,10	90:5,7,20 92:7,13	drop 65:2 76:3	129:22
disseminated 89:20	27:2,6,7,9,11,14	92:21 93:6,12,14	104:13,14	elements 21:1
97:4	27:19,21 28:7,15	94:1,4,9,13,15,16	drug 72:22	22:17 36:8 100:9
dissemination	29:1,6,9,12,21	94:21 95:7,10,11	drugs 73:19 74:6,6	101:21 135:1
92:14	32:1 33:12,13	95:12,19 96:5,9	due 113:10	eliminate 99:11
distribute 5:6	34:6,16,17 35:3,5	97:2,5,7 98:15,16	duplicates 81:8,16	eliminated 127:18
divide 100:1	35:8,19 36:2,5,7	99:5,21 100:3	dysplasia 71:4	Ellen 1:19 78:3
divorce 119:5	36:12,14 37:5	102:2,8,9,11	D.C 1:10	88:9 146:21
doc 156:18 157:2	38:1,6,8,9,12,17	103:4,8,16,19	<hr/>	Embassy 1:9
DOCHERTY 1:14	38:19,22 39:2,6,8	104:2,4,6,7,9,12	E	embed 136:8
68:4 69:14 73:2	39:13,16,22 40:2	105:1,2,4,6,7,16	E 2:10 159:11	embedded 137:9
90:7	40:4,7,12,21 41:6	105:17,19 106:2	earlier 51:7 119:14	embrace 97:12

emergency 97:18 104:20	essentially 12:19 30:1 49:18,20 63:17 77:22	example 16:6 26:19 26:22 29:4,7 36:19 38:13 44:14 45:14,18,21 47:2 53:22 56:8 58:20 60:19 62:3 63:2,3 68:10 70:1,19,20 71:3,9 72:16 73:1 73:7,18 74:20 113:2,16 130:2 136:5 139:10 140:2 147:1	49:4 109:16 113:12	140:17
EMMA 1:23	establishes 131:6	explicitly 68:19 129:15	expressed 109:3	febrile 73:7
emotion 22:22	estimates 60:15	extent 32:16 122:1 132:17 134:13	extracted 109:3	federal 155:19
emphasis 65:8 70:8	et 48:12 74:6 124:21,21,22	extra 134:18	extrapolate 18:15	feed 99:17
employment 119:4	ethnicity 46:18	extraction 132:7	extremely 4:8 77:11 153:18	feedback 78:2 119:7 134:8 163:3
empty 106:8	evaluate 136:11 137:15	extrapolate 18:15	eye 149:2	feel 64:9 91:3 97:12 108:2 110:3 114:11 120:9 143:4 153:20
encompass 62:10	evaluated 96:8	extremely 4:8 77:11 153:18	E-mail 81:12 90:16 98:3	feeling 78:22
encompasses 43:5	evaluating 5:12 80:3	examples 24:22 58:8 70:1		feels 161:22
encounter 46:3	evaluation 2:19 5:11 79:19,21 86:15 120:12,20 121:9 125:5 131:18 134:5 136:8,10,14,18 138:11,15 139:2 140:15 142:13 143:4	exception 118:10 129:6	F	felt 144:15 149:22
encourage 135:5	evening 4:3	exceptions 112:6 114:12	FAAP 1:15	fetal 74:10,20 75:1
encouraged 78:13 78:13	event 65:21 66:11 67:1 68:20 71:11 71:19	exclusion 13:16 126:22 130:8	face 9:21 128:6 129:4	fibrocystic 16:12
ended 126:9 143:18	events 68:2,13,14 70:4,7 71:8 72:17	exclusions 126:15 126:19 127:4,10 128:15 135:14	face-to-face 141:5	fibrosis 16:8 37:13 82:15 147:1,3
endorse 158:2	everybody 3:19 6:7 30:22 130:21 133:6 142:5 146:3 147:16 152:18 154:22 155:11 162:22	existing 134:1	facilitation 161:6	field 71:16 84:5 86:3 153:21
endorsed 6:21 7:2 7:8 8:21 25:19 31:5 35:18 98:21 106:5,16 134:2,5 134:8 156:7,15 157:14 158:3,6,19	everyone's 155:16	expansive 70:21 109:14 110:18	facilities 61:1	figure 12:9 42:1 55:3 57:12 106:20 130:19,21 134:4 159:18
endorsement 140:19,20 154:5,9 154:10	evidence 85:3,15 125:2,4,10 131:14	expect 71:4 126:2 158:21	fact 135:16 156:2	file 19:16
endpoints 112:3	evolution 11:18	expenditures 16:16	factor 131:1	files 98:3
endorse 158:2	evolutions 138:13	experience 32:6,8,9 34:21 54:11 55:15 64:22 79:13 86:16 92:17 135:9 143:14 149:8	factors 87:9 131:16	filled 108:21
endorsed 6:21 7:2 7:8 8:21 25:19 31:5 35:18 98:21 106:5,16 134:2,5 134:8 156:7,15 157:14 158:3,6,19	exact 22:18 137:16	expert 114:16 141:4 149:22	failure 24:20 27:20 57:8 123:16 124:3	filling 79:13
endorsement 140:19,20 154:5,9 154:10	exactly 11:2 12:4 18:5 40:4,6 42:15 99:8 102:12 103:8 103:8 107:5 114:17 138:8 139:21 140:4 143:19 162:6	experimenting 91:4	faint 143:8	filter 107:1,7 145:12
endpoints 112:3		expertise 138:1,3 161:12	fair 25:19	final 138:21 140:15 149:18 154:4
engagement 105:11		experts 61:4	fairly 25:20 57:22 79:5 99:14	finalize 138:20
enjoyable 4:3		explainable 71:18 71:20	fall 111:19	finally 19:20
enriched 156:17		explaining 114:18	fallen 75:13	find 8:5 9:6,6,10,11 18:10 35:17 39:16 44:13 78:15 86:12 88:1 90:2 126:11 132:19 138:3
enthusiasm 163:4		explanation 56:4	families 33:22 35:7	file 19:16
entire 42:9 46:2 51:11 54:21 56:6 129:10		explicit 21:3 34:4 46:16 47:10 49:1	family 20:20 32:5 32:17,20 34:20 35:10 92:14	files 98:3
entirely 130:10			far 8:19 37:15 55:15 82:12 135:2 160:20	filled 108:21
environment 38:2 38:4			favorites 11:13	filling 79:13
environmental 38:2			feasibility 121:18 128:20 134:13 135:13,20 149:1 149:18,21	filter 107:1,7 145:12
envision 107:18			feasible 128:16	final 138:21 140:15 149:18 154:4
EP 88:1				finalize 138:20
epidemiological 44:22				finally 19:20
Epilepsy 96:12				find 8:5 9:6,6,10,11 18:10 35:17 39:16 44:13 78:15 86:12 88:1 90:2 126:11 132:19 138:3
ER 7:13				fine 48:3 50:13 57:11 114:20 116:19 132:12 134:7
error 67:9				finished 51:10
especially 14:4 38:3 57:16 90:3 145:14				first 20:18 23:6,16 23:18 38:21 45:10 45:14,15 46:12 50:10 52:18 72:11

78:21 107:11 114:1 121:13 122:21 123:9 127:12 138:14 145:14 fit 63:13,21 64:1 68:18 69:10 99:3 106:6 107:4 fitness 21:10 23:5 23:12,18 fits 105:22 five 8:9,10,13,13,22 9:11 71:14 72:11 138:16 fix 23:20 flag 158:5 flirting 32:16 floor 148:21 fly 151:5 focus 60:12 73:15 74:18 86:10 93:8 118:20 122:9 123:22 124:13 focused 82:6 97:14 122:2,16 focusing 109:5,6 127:3 folks 37:6 43:18,19 44:2 78:12 93:2,7 109:2 137:5 159:1 160:10 follow 9:3 14:2 15:15 19:11 120:19 146:20 162:12 followed 11:16 following 121:8 follow-up 7:20 Ford 157:12 forever 124:10 form 80:5 126:12 136:10 formal 79:5 formally 93:21 format 49:19 79:6 former 17:17 forming 82:22	forms 79:14 138:15 150:6 151:17 forth 70:10,20 154:19 Fortunately 149:2 FORUM 1:1 forward 4:10 86:20 114:7 118:10 163:3 foster 39:21 fostered 112:4 Foundation 82:16 91:10 96:12 four 11:7 120:3 121:11,15 141:14 fracture 11:13 frame 44:22 104:22 framework 2:16 5:8 100:6,11 107:7 frankly 134:6 154:12,14 free 64:9 108:2 120:9 freely 98:3 frequently 62:21 FRIDAY 1:5 friend 91:16 front 48:15 55:22 56:4 57:14 76:6 80:16 99:10 frustration 109:2 full 133:20 function 154:9,16 functioning 20:19 20:20,22 functions 149:1 fund 85:14 funded 117:1 funder 110:16 funders 112:13 further 146:16 future 4:6 fuzziest 149:9 <hr/> G <hr/> gains 122:3,20	gaps 100:21 106:8 gather 14:5 general 7:13 12:8 61:16 86:9 95:15 128:3 147:4 152:4 generally 118:3 151:21 General's 156:4 generate 10:14 generated 12:16 120:6 generic 31:10 geographic 46:18 47:1 55:2 getting 27:12 31:21 35:11 46:11 50:10 61:8 69:19 86:17 96:18 109:16 125:2 127:14 138:18 153:10 163:2 Ginger 91:17 92:1 give 13:8 16:6 22:14 45:13 77:20 126:3 136:19 141:1 147:1 151:1 151:3 Given 16:15 136:14 gives 41:12 giving 54:2 70:1 glad 17:17 go 3:9 4:14,20 5:10 5:22 8:5 19:19 23:5 28:1 52:11 61:14 77:22 78:9 79:2 80:13 89:7 96:20 100:6 102:19 109:20 110:13,13,21 115:21 120:11,17 128:14 138:13 142:15 146:16 147:17 153:15 159:17 163:3 goal 39:4 86:12 122:13 goals 101:7 102:17	104:11 118:22 goes 28:13 40:5 49:17 63:16 90:12 105:12,14 114:4 115:20 119:6 134:8 144:19 153:19 154:4 155:4 going 5:4 6:11 9:17 20:9 31:18 32:18 36:2,16 37:1 39:9 46:9 47:7 52:2 54:1,3,6 56:11,11 73:8,10,11,13 75:22 77:18,22 78:9,18 79:2,7,20 80:2 86:20 87:20 88:1 92:7 98:17 99:3 103:2,14 106:7 108:20 110:12,13,16 112:22 113:8,8 114:6,11 118:16 118:18,20 119:16 120:17 122:10 123:9,16,17 124:5 124:9 125:3,15 135:7 136:2,3,13 137:14 138:9,9 140:5 143:22 144:22 145:10,11 145:12 146:21 147:17 148:15 150:22 156:22 157:4,9,14,17,17 159:8 160:12 golden 133:1 good 3:4,6,7,19 4:4 4:7 16:2 19:8 38:11 69:22 70:19 70:20 73:21 76:18 76:20 80:9 84:10 85:6,16 96:4 99:18 114:19 115:5 117:22 120:5 123:5 128:2 128:19 147:2,21	150:5 goodness 16:14 148:16 goofy 78:8 Googling 91:13 gotten 156:12 GOUTHAM 1:19 government 155:19 grab 14:20 grading 148:4 graduating 62:20 graduation 63:5 grafters 69:16 grafts 70:2 grand 137:7 152:19 Grandma 39:20 grants 154:10 graphers 69:18 great 12:12 17:21 43:18 108:3 greater 7:14 8:1 110:4 Greenhill 92:1 grid 119:16 120:2 group 60:7 82:2,16 83:1,14,14,20 84:5,11,22 90:13 90:18 91:11 93:20 95:3 96:7 97:14 101:6 108:8 110:9 114:22,22 117:7 118:18 119:6 129:9 133:14,21 140:1,13 143:16 144:2,3,5,9,12 151:13,14,20 154:16 156:10 160:5,7 groups 43:16 52:7 83:17,19 84:4,16 84:18,21 85:13 86:5 94:11,20 104:1 110:2 113:13 126:3 137:18 140:2 141:13 144:2 156:2
---	---	---	--	---

growth 21:7 23:6
38:22
guarantee 68:14
guess 11:14 25:6
28:15 35:16,17
45:9 53:17 70:7
103:2 115:11
116:8 119:15
158:15 160:20
161:6
guide 6:10
guideline 85:3,9,18
guidelines 85:11,13
guys 100:9

H

hairs 26:6 60:22
half 16:11 33:14
144:5 146:9
hammered 131:11
hand 69:1 79:11
handful 137:19
handle 32:18 127:8
128:1 154:15
handled 132:14
handling 132:15
hanging 162:21
happen 40:14
54:10 55:9 65:5
73:8 78:18 118:1
118:16
happened 67:8
81:9 118:21
126:16 153:18
happening 89:21
119:8 154:3
happens 4:15,17
10:19 70:17 79:7
127:16,17 152:1
153:17 160:11
happy 15:9 29:9
77:12 107:15
108:2 161:16
hard 50:11 133:13
harmonization
113:10,13,20
114:8,15 130:12

133:10,21
harmonize 111:12
133:11
harmonized 31:2
head 8:4
header 45:2
heading 28:21
health 1:3,8 2:17
11:17 21:16,16
22:4,5 28:3 32:10
32:11 36:16,18,22
37:2 38:2 40:20
41:20 42:20 44:6
44:7,8,19 45:4,6
46:4 47:13,21
48:6 49:6,9 50:16
50:20 51:20 54:13
57:20,21 58:5,10
58:18 59:22 60:12
61:2,7 62:1 63:3
63:20 64:13 65:21
66:2,20 68:1,13
69:8 74:22 75:5
75:17 88:12,16
90:18,22 91:2
93:21,22 96:14
105:12 107:8,17
109:3 111:1 116:9
118:18 119:20
122:3,4,6,13,20
156:5,12 157:11
160:5,7,12,14
161:1,8,8,21
Healthcare 18:13
19:1
hear 111:1 144:10
162:2
heard 144:16
heart 27:20 46:19
57:8 68:17 69:3
71:11 108:11
123:16 124:3
HEDIS 155:11
159:4
Hello 3:19
helmet 24:22 62:14
help 5:5 6:9 18:6

20:17 61:4 68:3
106:4,20 107:21
123:6 138:4
146:14 150:22
helpful 5:18 14:6
helping 19:5
Henry 157:12
heresy 94:2
hesitate 97:22
Hey 150:18
Hi 3:20
hierarchy 102:3
high 38:14,17
62:20 63:4,13
70:14 122:5,14,14
122:15 124:1,7
139:11,15 147:3,5
147:9
higher 46:11
highlighted 6:20
highly 21:2 63:19
106:13 125:18
147:20
Hilton 1:9
hits 11:15
HIV 74:11,13 75:9
75:11,12,15,19
hold 41:22,22
59:19
holes 106:7
holidays 79:1
home 32:11 37:7
38:2 56:18 57:1
62:17 114:4
Homer 1:10,13 3:3
3:10 4:2 16:14
23:21 25:6,22
26:5,18 27:4
28:20 29:2 31:16
34:18 35:13,20
36:5,11 40:18
43:12 44:4,12
45:13 46:1,8
47:19 49:10 50:9
50:14 53:16,21
54:17 55:5,18,21
58:9,14,21 59:1,8

59:14 61:12,22
63:1,6,9 64:1,18
65:17 66:4,14,22
67:20 69:21 71:2
73:17 74:19 75:21
76:3,16,21 77:3
77:10 80:17 83:4
83:6,11 87:12
88:9 89:4 90:17
94:18 98:13
102:21 103:5
104:16 113:5
115:7,16 116:1,5
116:15,20 117:20
119:13 123:8,12
123:19 139:5,10
139:13,19,22
149:8 151:22
152:7 160:16
161:9 162:17
163:10
hooked 82:12
hope 74:20 98:6
134:16
hopefully 6:3 106:6
158:19
hoping 6:7
hospital 10:17 17:4
64:22 65:15,16
70:18 89:16 108:9
108:10 119:19
129:11
hospitalization
11:6 12:1 14:11
45:22 53:22
hospitalized 65:6
hospitals 32:11
66:20 89:7,13
hosts 69:18 70:2
hours 65:21
house 57:2,5
ho-hum 123:17
HQ 94:15
HR 132:6 134:20
huge 18:13 93:20
96:19 129:4
hundred 16:11

98:21
hyperactivity
36:21 37:3
hyphen 43:8

I

Ian 1:22 160:10,10
160:11
iatrogenic 119:18
idea 51:6 58:13
95:20 127:3 128:3
135:5 147:8
156:18 157:3
ideas 82:1 107:15
108:4
identical 31:7
identified 109:15
identify 89:15
idiosyncratic 93:17
ignore 147:10
ignoring 65:3
ill 91:8 114:3
illness 35:11 40:11
imagine 96:19
imbedded 85:8
immediately 82:20
immunization 41:8
41:11 43:21 56:10
130:5,12,22 131:7
131:8
immunizations
130:4
impact 122:5,14
124:1,7 127:4
128:8 139:11,16
139:17 144:20
145:2,3 146:22
147:3,5
impacts 122:10
impairment 70:2
implement 133:19
133:20 136:2
implementation
133:22
implemented
135:17
implementers

133:13	67:15	institutions 90:9	invite 150:9	73:9 74:4 87:13
importance 121:16	increase 113:22	insurance 94:2	involved 32:17	94:9,15 95:7,11
121:22 158:8	increment 113:4	117:5	33:8 111:5 142:22	95:19 98:16 99:21
important 37:17	indexed 45:8	insurers 149:13	involvement 33:5	102:2,9 103:19
46:20 55:7,12	Indiana 17:18	159:2	92:18	104:4,7 106:22
69:1 98:20 99:22	indicated 131:14	integrated 149:14	in-patient 14:10	107:6 113:7 117:6
103:17 106:13	indicator 45:4 49:9	intended 23:17	IOM 101:7 102:17	117:15,22 129:1
107:9 110:9 113:8	54:4 69:1 75:5,17	51:15 133:8	104:11,12 105:2,8	129:13 145:10
122:2,7,8 124:12	91:16	intense 140:9	105:22	151:12
125:4,14,19 126:5	indicators 40:20	intent 78:6,16	IOMA 122:4	Jim 17:17
128:5 132:15	44:8,19 45:6	81:20 159:9	ironing 80:8	job 163:4
135:16 140:16	47:13,21 48:6	interaction 154:2	issue 13:22 38:1	Johnson 17:3
144:9	50:16 61:7 62:2	interactive 136:20	41:8 60:22 78:6	joining 3:21
importantly 99:1	63:3	137:4,13	110:22 111:11	joint 44:8 49:15
impossible 128:18	individual 129:4	interest 30:9	114:18 118:22,22	50:21 158:4
improve 73:6 128:6	160:21	interested 31:21	125:11 129:4	judged 5:16 131:9
159:3	individually 127:20	45:20 54:19,20	132:15	judgment 139:17
improved 6:2 25:9	individuals 49:7	56:5 65:13 82:4,8	issues 64:20 65:1	jump 55:6
37:3 43:21 56:9	infant 44:22 48:7	125:8 161:19	69:8 87:5 89:14	jumps 155:11
improvement	48:11 104:7	interesting 16:4,19	96:9 103:10	justice 43:6 60:10
20:21 21:5 36:18	infants 11:5 104:5	37:20 40:13 85:12	111:10 112:22	60:20
43:15 91:11 95:21	113:22	89:11 106:14	114:11 117:2,5	juvenile 43:5 60:10
123:2 133:4	infection 75:12	109:22 117:10,14	120:22 123:13	60:20
148:19	infections 48:21	149:10,16	128:20 131:4,10	
improving 122:4	68:11 72:3	intermediate 24:17	161:1,8	K
inaccurate 15:22	infectious 9:19	25:1,7 26:11,11	item 160:2	Kaiser 15:17 45:20
incentive 155:8,17	inflammatory 83:1	26:13 29:18 30:3	iteration 107:18	Kathy 1:15 12:13
158:13,20	information 4:20	30:15 34:7,10,14	iterative 107:19,19	29:12 51:14 79:13
incentives 155:14	6:14 16:5 19:10	124:17	i.e 125:15	87:12 98:13,13
157:9	79:15 132:22	internally 99:7		113:5
inches 138:17	133:2 136:12,17	interpret 22:15	J	Kathy's 59:9
incidence 12:11	141:2 143:5	interrupt 127:8	J 1:15	119:14
40:16 41:11	147:13 150:4,7,16	intersect 13:2	Jane 1:18 3:18,20	keep 15:17 111:12
include 21:7 22:6	150:20 151:6,8	intersected 8:19	121:7 143:8	135:6 138:19
50:19 53:2 54:18	163:1	intervention 24:16	January 159:10	147:8 148:7
56:4 116:19	informative 161:15	28:11,17 67:12	JD 1:18	keeping 128:3
127:13	informed 84:19	68:7 69:22	JENKINS 1:15	kids 12:8 17:4 28:1
included 40:19	informing 133:4	interventions 66:21	12:14 24:10 26:10	37:13,17 62:20
94:12 97:6 115:6	inhaled 55:11	73:1	27:7 33:13 35:5	82:12 109:21
153:3	initially 149:20	introduction 5:13	38:19 39:2 41:19	117:4 124:5,8
includes 50:19 79:1	initiation 31:19	Introductions 2:13	44:20 47:11,16	kill 138:18 153:17
130:16	Initiative 158:12	4:12	48:7 49:3,11,22	kind 5:17 6:9 7:9
including 20:20	inner 56:10	introductory 29:15	50:7 51:19 52:21	8:22 9:3 10:10
30:8 31:4 35:20	input 5:4 6:8 81:18	39:17	53:10 57:6 59:3	12:8 14:1,2,4,18
42:6 45:7 54:22	153:10,13	inventory 157:18	59:13,21 61:16	18:4,9 19:10,22
61:19,20 87:16,22	insignificant 79:15	invested 17:8	62:5 65:20 68:15	21:10,11,14 23:12
inconvenience	Institute 102:3	investment 125:16	68:22 71:6 72:19	24:7 27:11 34:15

74:2 75:18 76:8 78:17 79:7 91:3,4 96:18 100:21 102:13 105:14 106:14 109:8 120:7 121:11 126:9 129:22 131:3 134:12 137:13 140:14 141:14 142:19 145:1,6 146:5,14 152:19 154:1 156:7,8 157:2,16 158:20 162:3,6,22	93:8,12,16,18 94:7,14,22 96:16 97:12,14,19 98:1 98:3 99:11 100:13 100:15,16,19 101:1,3,4,7,15 102:13,16 104:20 105:10,12,17 107:11,16 108:3,9 109:5,16,18 111:6 112:7,9,13 113:16 114:21 115:1,18 117:16 119:17,19 120:1,5,18 123:15 124:9,18,19 125:18 126:22 127:6,12,16,17 129:2,21 135:2,3 135:7 137:11 138:5,6 140:6,15 141:14 142:1,4,5 142:12,19 143:1,9 145:5,20,21 147:4 147:22 148:1,6 149:13 150:18 151:1 153:2,3,4 153:20,21 154:2 155:16,19 156:21 157:12,15 158:4,5 158:7,8 159:1,8 159:11,16 160:1 160:17,21 161:19 161:19 162:6	land 5:17 128:22 landed 27:16 language 5:2 45:3 large 78:5 91:11 122:10,14 130:10 142:16 145:15 146:11 148:9 149:14 largely 45:16 larger 129:9 Larry 92:1 Laughter 39:5 57:3 laundry 128:6 lay 5:17 13:11 lead 28:22 136:13 137:20 140:12,13 leadership 161:11 leading 84:5 leads 89:8 learned 118:19 leave 51:3 115:15 150:19 led 43:19 Lee 1:17 32:3 33:13 34:8 92:22 138:12 Lee's 138:14 left 150:16 153:21 left-hand 100:12 leg 161:17 legislation 26:20 lends 107:2 lengthy 19:12 lesser 125:11 lesson 11:4 lessons 40:9 118:19 let's 51:22 74:20 129:10 level 67:5 88:3 levels 54:13,15 library 36:9 LIEBERTHAL 1:15 7:22 8:7 15:19 17:22 24:13 25:4 34:16 58:4 85:1,21 94:1 97:5 146:20 155:4 157:21	life 21:17 22:5 101:19 114:1 limits 30:11 line 3:17 64:9 68:10 77:19 86:18 97:22 105:7,9 116:22 lines 3:13,15,16 12:14 88:5 95:5,6 95:18 158:21 line-related 72:2 link 80:13 linkage 29:19 links 26:14 124:16 list 8:18 10:11 12:16 19:18 30:4 34:21 51:11 84:10 84:15 87:18 90:16 94:7 97:6 99:11 99:13,14 100:12 106:17 128:6 162:5 listed 127:6 lists 13:1 82:10 listserves 90:12 literature 85:16 little 15:12 31:1,12 36:10 41:21 51:4 51:5 52:13 53:17 57:14 70:21 79:21 81:11 93:17 99:6 99:16 101:8 125:11 126:20 129:16 141:12 144:12 151:2 161:17 lives 19:3 57:4 living 134:12 location 46:18 locus 53:12 129:7 logical 68:17 long 29:19 longer 113:3 long-term 124:20 look 5:3,8 10:1,3 13:4,11,16 28:1 45:21 46:5 56:12 65:2 74:2 75:12	85:5 98:20 100:10 103:6 117:12 123:16 124:3,4,5 125:9 126:6 132:2 139:16 152:22 156:2 161:4 looked 10:17 99:12 looking 3:8 4:10 5:18 6:8 9:4 10:9 11:22 16:8 31:2 36:7 45:18 52:3 69:12 76:19 123:7 148:13,19 161:3 looks 150:15 lose 160:3 loss 113:14 lot 4:9 15:2 20:19 34:13 65:5 79:12 84:6 85:10,11 87:4 88:19 92:17 95:8 96:16 105:5 106:10 108:13,16 109:2,4,10,11,14 133:5 138:18 154:13 156:1 157:8,10 lots 30:19 122:8 126:18,18 132:22 132:22 loud 60:6 lousy 47:3 love 92:6 133:7 137:6 low 128:17 luckily 6:1 lumped 61:1 113:18 lunch 163:6 lunchtime 6:1
kinds 49:21 67:9 90:14 106:3 109:11 141:9 149:3 knew 47:17 110:1 know 8:3,10 9:5,8 9:14 10:11 11:8 11:15 12:1,7,9,15 14:8,21 16:3,20 17:1 18:2,8,13,16 20:14,17 24:8 25:10 28:2,5,5,16 29:12,13 30:13 31:2,11 34:8 35:1 36:8 37:10,19 38:11 39:16,18,20 40:9,17 41:8,11 42:8,12,18 43:14 45:1 49:1 50:18 50:19 54:19 55:8 55:10 56:20 57:2 59:18,20 61:1 62:9,11,16 64:21 65:12,15 67:6,16 68:18 69:2 70:7,8 70:17,18 72:6 77:2 78:22 79:11 79:22 80:7,11,20 81:8,21 82:7,9,18 83:2,7 84:21 85:16 86:13,19 87:8 88:8,12,14 88:22 92:12,19	knowing 5:17 knowledge 24:5 32:15 85:17 known 68:21 116:14 knows 92:1 159:14 159:20 Kramer's 4:4	L	laid 107:11	M
	L 1:10,13,14 lack 31:19 40:22 99:1			mail 159:12 main 96:7 117:7 118:21 119:7 121:15,21 maintenance 20:21 134:9 148:14

major 11:6 57:1 77:15 120:12,20 121:13 126:17 133:11 149:13,13 153:6 156:12	McGlynn's 141:20 McINERNY 1:16 15:17 16:20 18:11 18:19 22:6,9 24:21 29:6 37:5 40:7 43:14 48:16 52:12 53:4,9 56:8 61:6 62:16 68:9 71:21 75:11 80:19 82:14,19 83:5,10 88:5 104:9 108:19 130:1 148:6 158:10,18	124:14 125:14,21 125:22 126:14,21 127:2,12,21 128:8 128:12,16 129:8 130:3 131:3,7 134:6,6 135:22 136:7,9,15 139:14 140:12 142:21 144:20 145:2 150:4,9 157:14 158:6	135:18 137:15 138:7 140:7,10 141:7 142:17 143:7,8,11,15 144:2,11,15 145:13,22 147:2 147:20,21 148:13 148:17,20 153:14 156:6,15,16,22 157:22 158:2,3,14 158:15 159:4,5,9 159:10,16,19	membership 54:14 94:6 152:4,11 153:22 Memberships 153:16 mental 11:17 28:3 36:17,22 37:2 61:2 90:18,22 91:2 93:22 96:13 111:1 118:18 160:4,6,12,14 161:1,8,21 mentally 51:17 91:8 mentioned 11:1 34:22 63:11 91:9 108:6 121:16 126:8 155:18 mentioning 52:7 merged 17:12 merging 17:9 31:8 message 97:11 98:6 162:3 messy 21:14 met 1:9 method 141:19 143:19 methods 132:1 microphone 3:4 60:3 64:19 160:18 mileage 127:14 Miles 84:1 milestones 21:11 93:19 MILLER 1:17 million 19:3 Mimi 84:1 mind 44:22 82:19 90:21 130:2 148:7 mine 12:3 minimal 99:8 minimally 162:7 mining 108:4 minor 36:14 minutes 4:21 76:22 miscellaneous 77:14
majority 60:13 151:20 making 32:14 34:12,13 35:2,10 80:9 109:15 116:21 122:2 128:5 129:17 139:7 140:21 manage 55:10 79:12 management 24:6 25:21 32:21 33:17 34:3 53:1 57:7 134:21 manager 160:11 managing 33:18 mandatory 116:3 manipulate 79:9 marginalize 124:10 Marina 1:10,13 Marina's 20:3 MARINELARE... 1:22 marked 113:21 114:5 MARLENE 1:17 marrow 69:16 Massachusetts 1:10 52:1 match 137:21 materials 5:12 110:21 121:9 maternal 11:20 maternity 93:5 Mathematica 17:15 matter 77:7 86:14 149:22 Maureen 93:4 maze 46:4 MBA 1:19 McAllister 37:8	MD 1:13,14,15,15 1:16,17,18,19,20 mean 25:8 26:18 27:8 30:5,6 31:16 35:18,22 38:6 39:13,15 40:15 41:4 49:18 54:8 55:5 58:6 61:11 73:5,17 74:17,19 77:21 79:15 94:14 96:15,17 111:19 113:16 116:15 121:21 124:15,18 129:16 134:19 135:19 140:14 145:16,18 150:8 152:19 153:8 162:20 meaningful 133:2 meant 19:13 29:3 62:1 144:5 162:22 measure 2:19 7:16 7:22 8:8,15 9:1 22:19 24:15 25:17 29:20 30:21,22 31:14,17 33:10,11 35:18 37:21,22 53:18 61:10 69:9 69:10,17 71:10,13 72:8 85:7 86:17 87:6 88:8 92:15 92:20 96:7 103:20 121:18,22 122:1,2 122:19 124:13,14	21:22 33:5 65:8 103:22 109:21 111:11,14,16,17 128:3,10 155:21 measures 5:2,13,14 5:19 6:17,21,22 7:2,3,7,8,11,12 8:20,21 19:14 25:14,20 27:12 29:17 30:1,14,20 31:3,6,13 36:1 38:5 41:16 42:5 44:6,7 45:5,7 50:8 54:12,12,14,20,21 55:15 63:19 69:17 72:12 74:16,22 78:2,5,7,19 80:20 82:5 83:3,3,7,8 84:20 85:3 86:3 86:11,18 87:3,20 88:19 90:10 91:5 98:7,22 99:13 100:16,22 101:5 101:18 106:6,15 109:4,12 111:22 112:2 114:7 115:11 117:1,10 119:15 122:16 123:3 125:5,6 126:18 129:19 130:12,13 131:8 131:13,14 132:5 133:12,12,15 134:2,15 135:6,9	measured 24:16 measurement 21:22 33:5 65:8 103:22 109:21 111:11,14,16,17 128:3,10 155:21 measures 5:2,13,14 5:19 6:17,21,22 7:2,3,7,8,11,12 8:20,21 19:14 25:14,20 27:12 29:17 30:1,14,20 31:3,6,13 36:1 38:5 41:16 42:5 44:6,7 45:5,7 50:8 54:12,12,14,20,21 55:15 63:19 69:17 72:12 74:16,22 78:2,5,7,19 80:20 82:5 83:3,3,7,8 84:20 85:3 86:3 86:11,18 87:3,20 88:19 90:10 91:5 98:7,22 99:13 100:16,22 101:5 101:18 106:6,15 109:4,12 111:22 112:2 114:7 115:11 117:1,10 119:15 122:16 123:3 125:5,6 126:18 129:19 130:12,13 131:8 131:13,14 132:5 133:12,12,15 134:2,15 135:6,9	measuring 2:16 90:13 121:17 meat 20:13 Medicaid 16:21,22 17:18 43:17 44:2 44:2 110:14 115:19,21 116:7 158:19 medical 10:2 37:7 56:18 57:1 83:16 83:18,22 84:21 89:4 90:14 150:1 150:2 Medicare 124:4 147:10 medication 25:2,19 25:20 27:12,14,17 27:18 29:4 medications 28:4 Medicine 102:3 meds 28:3 meet 146:8,14 147:15 154:13 meeting 1:3 86:11 89:12 92:22 140:6 143:12 162:10,21 163:14 meetings 4:6 140:9 150:10 meld 59:17 Melissa 1:22 30:19 member 72:10 89:6 89:7 92:8 94:14 members 46:5 94:6 97:8 157:9,10

missed 64:11	mutually 86:17	134:10	122:13	offered 100:15
misses 114:5		negative 40:15	NQF 1:21 5:10	offering 81:22
missing 45:14	<hr/> N <hr/>	152:8	6:21 7:2,10 8:21	Office 156:4
63:22 66:3 150:4	N 2:10,10	Network 82:17	30:2 81:6 82:10	offline 64:4
150:7	NACHRI 89:5	neurologic 70:2	85:4 94:5 98:21	oh 16:14 23:19
misspelled 9:16	94:10,14	neurological 71:13	104:18 116:22	47:22 103:4 106:2
mixed 92:9	NAMCS 13:4	71:14,17 73:15	128:22 129:7	120:14 132:12
mixture 112:3	name 81:7,10 92:10	neurology 96:10,12	138:13 154:21	135:11 148:16
MOC 148:16	names 37:6 162:5	neuropathy 73:1	155:5,6 156:2,7	okay 9:17 12:18
model 33:17 34:3	NAMI 91:8	neurosurgery	156:15 157:9,22	19:8 20:12 22:2
modified 57:19	narrow 109:18	70:19 95:16	158:3,7,18 161:10	22:20 23:19 24:11
100:13	narrowed 123:22	neutropenia 73:2,7	163:1	27:9 29:1 34:17
modify 100:14	narrower 36:1	neutrophil 73:19	NQF's 7:19 86:2	38:18 43:3 44:11
moment 40:5 99:19	narrowly 122:16	new 15:8 35:7	NSQIP 95:20 96:6	46:14 48:2,6,14
money 17:9	national 1:1 10:2	62:14 80:7 83:1	96:7	49:6,17 50:4
monitor 40:16	17:13 84:8,11,13	87:16,17 95:20	number 15:2 25:19	52:10 56:1 58:7
month 114:1,2	91:8 92:5 95:20	106:5 134:6 156:3	99:13 110:5,8,10	64:7 75:20 76:7
monthly 154:13	122:12	156:3	130:6 141:7,10	76:19 97:21 98:11
months 113:20	NCARE's 93:1	newborn 11:1	142:17 152:16	102:1,15 103:16
mood 11:16	NCQA 8:7,22	NHANES 17:22	159:15	104:13 105:1,16
morbidity 64:14	155:9 157:21	18:8	numbers 18:13	106:2 112:11
65:8,16,18 66:1,2	near 135:4	nice 12:21 46:16	61:11 122:14	118:19 120:15
66:6,15,17,19	necessarily 28:12	105:19 107:6	129:9 137:16	132:1 144:13
67:6,11,18 68:1,5	51:21 52:4 85:8	133:6 160:9	143:15	146:15 160:15,15
68:6 69:7,19 72:7	93:20	nicely 96:20	numerator 53:19	162:16
72:15 119:18	necessary 126:14	NICHQ 94:11	54:4 130:15,16	old 79:10 111:6
124:21	need 5:4 16:21 33:1	NIDA 61:2	nurse 149:21	114:3 134:3
morning 3:4,6,7,19	37:10,19 46:12	night 10:9,14 13:11	160:12	Olds 62:17
4:17 6:7	49:14 51:21 52:4	NIH 90:8,9	nurses 62:17	once 92:9 116:13
morning's 77:11	57:13 58:18 64:2	NOCHOMOVITZ	149:19	137:15 138:6,20
morph 134:10	65:7 73:10 76:15	1:23	N.W 1:10	155:4,9,10 159:15
MORSELL 1:23	76:16 78:1 80:4	nomenclature		Oncology 82:16
mortality 12:17	80:11 81:19 97:4	48:17	<hr/> O <hr/>	ones 9:20 10:15
44:22 48:8,12	98:5 101:12	nomination 161:21	O 2:10	31:1 49:5 53:11
65:2,3,6 67:17	102:22 103:2	non-conversion	obesity 38:3	57:10 64:6 101:3
104:7 113:22	107:22 110:19	62:6	objection 135:7	139:7 146:5,8
119:18 124:21	111:20 114:15	normal 38:11	objective 21:22	ongoing 69:4 86:22
Mountain 37:7	115:7 124:4,8	normally 72:18	146:22	160:8
move 96:2 123:5	128:18 138:3	89:22	objectivity 65:14	oops 19:13
moving 23:21 34:2	141:2 159:10,12	note 4:5	obvious 146:6	open 3:13,15,16
MPH 1:15,18,20	159:19 161:22	notes 56:3	obviously 49:19	29:22 37:1 58:1
MSc 1:17	162:3,6	notified 98:10	75:13 87:21 95:13	81:13 115:15
multi 101:13	needed 21:21 59:11	nouns 28:12	102:10 139:15	126:9 143:17
multiple 13:20,21	131:20	NOVEMBER 1:6	158:11	openness 60:14
31:1,12 86:1,2,10	needing 111:12	novo 143:11	occurred 108:6	opens 62:13
102:22 103:7	needs 51:20 53:18	NPP 32:6 101:7	occurring 72:18	operation 69:3
125:21 132:4	106:18 111:15,15	102:16 105:2,9	occurs 69:19	operator 3:13,15

opine 5:9 152:6,7 152:10	26:14,15,15 29:17 30:3,5,9,10,15 34:2,7,11 37:2 38:5 58:16 59:18 60:13 62:17 65:4 67:6 68:17 71:13 71:17 72:1 73:16 74:18 90:18 96:21 107:2,4,8 109:18 122:5 124:18 125:6	parentheses 75:17 parenthesis 34:20 parents 37:12,14 37:18 39:21 111:5 130:6 parent-family 34:12 part 25:10 26:17 29:3 32:14 33:22 34:4 54:18 55:7 69:18 83:19 86:8 97:8 125:4 134:18 145:8 151:3 156:14 partially 71:17 PARTICIPANT 48:13,20 110:11 PARTICIPANTS 3:6 participate 155:1,2 participating 82:8 particular 80:6 87:6 113:14 122:11 130:1 particularly 13:1 54:19,20 55:15 56:5 57:17 81:4 82:4 128:11 148:13 partly 61:22 partner 41:4 Partnership 84:11 partnerships 43:15 PARTRIDGE 1:17 17:7 32:4 41:2 56:17 72:10 74:13 92:3,11,16 93:3 93:10 115:21 143:21 144:14 146:7 pass 107:11 124:15 148:2 149:20 passed 149:20 passive 33:6 path 135:4 patient 21:15,20 32:5,21 33:5	34:20 35:9 52:15 58:15 59:4 62:11 67:9 69:4 70:10 92:17 103:15 104:14,19 107:4 129:5 131:16 157:1 patiently 32:3 patients 7:14 16:7 18:14 33:18,19 35:6 45:18 54:8,9 55:9 56:13 57:9 65:4,6 104:10,10 108:10 111:2,17 130:16,17 147:5 147:10 156:19 patient-family 105:10 patient/out 103:15 104:14 Paul 84:1 pay 153:22 paying 39:7 PC 24:14 PCPI 85:2 158:5 PDF 120:13,14,16 pediatric 31:17 35:21 72:13 82:16 83:14,16,22 87:14 87:16 88:1,4 89:2 89:5 94:10 95:1,5 95:13,13,22 96:11 99:1,2 123:13 136:5 pediatrically 97:13 pediatricians 43:16 44:1 130:3 Pediatrics 83:13 people 30:7 48:9 65:13 76:19 78:22 80:4 89:13 96:13 97:17 98:10 114:14 117:18 118:7 119:22 125:7 135:5 149:18 152:17 157:10	pepper 36:20 percent 56:16,16 65:3 67:18 123:4 158:13 percentage 48:8 perception 34:12 perfect 13:17 67:6 perfectly 30:16 107:4 124:6 performance 96:16 123:4 performing 14:6 performs 135:22 perinatal 74:14 144:4 periods 101:19 Perkins 1:18 3:18 3:18,22 17:1 PERSAUD 1:18 29:12 45:5 46:10 47:6 48:3 49:14 105:2,6,16,19 160:1 person 27:1 89:15 91:18 97:9 160:13 161:16 personal 78:8 81:5 personally 69:7 113:9 114:11 perspective 35:6 111:11 pertinent 103:21 103:22 104:5,8 Peter 56:9 PhD 1:13,14,19 phone 141:8 phrase 58:11,16 physical 21:7,9 23:4,12,17 physician 32:11 56:19 158:12 physicians 23:10 52:14 pick 86:4 133:18 picture 41:10,12 pieces 150:7 pipes 109:13
	P			
opine 5:9 152:6,7 152:10 opinion 78:8 113:9 147:14 opportunities 154:18 opportunity 123:2 140:11 143:3 151:4 154:22 155:2 opposed 31:1 46:5 50:2 127:5 128:5 oppressive 36:21 optimal 20:22 option 115:22 116:4,7 options 19:9 organization 80:22 154:21 organizations 80:21 81:4 92:6,9 94:10 154:21 155:6 156:11 158:14 oriented 84:18 original 113:17 orthopedics 95:17 ought 66:6 70:21 108:8 outcome 6:22 7:3,5 7:7,12,16 12:15 22:3 24:2,14,17 24:18 25:1,7,16 26:1,3,19,22 28:17 29:20 33:11 34:14 37:17,22 38:10 40:22 63:18 69:3 71:8 83:3,7 87:3 92:20 96:7 100:16 101:5 119:15 124:13,14 124:17 125:6 131:13 147:2 148:17,19 158:14 159:3 outcomes 2:17 7:11 20:4 21:15 25:10	outlier 142:6 152:17 outreach 56:12,14 overall 9:21 10:22 50:3 114:9 150:5 152:10 overlap 101:8 105:5,6 overlay 105:21 overrule 152:8 overuse 105:11 107:3 owning 86:21 owns 86:20 Oxford 82:17	package 15:9 120:8 121:8 packet 120:16 page 20:4 51:9 100:16 120:17 121:5,8 163:1 pages 79:16 paid 17:11 pain 36:19 paired 41:10 PAN 22:7 panel 149:22 panels 84:22 paradigm 35:7 paragraph 39:17 parcel 134:19 parent 21:15,20 33:5 39:11,14,19 84:18		

place 4:4	55:17 56:6 59:22	161:17	71:22 122:18	provide 45:16
placement 59:19	60:15 61:7 62:1	presiding 1:11	123:1	106:8 136:16
places 73:20	62:12 63:3 69:15	pressure 124:19	procedure 67:5	158:13
153:11	70:11 71:12 74:22	presumably 54:5	process 8:20 25:9	provided 147:13
plan 6:6 32:10 33:7	75:3,5,17 87:8	pretty 62:18 64:17	25:12 26:3 30:1	provider 49:1
33:8,10 54:13	99:1,2 105:11	83:21 84:10 95:17	30:13 33:10 34:14	52:20
55:1 56:6 76:11	118:12 119:19	135:8 146:5 150:5	38:7,8 74:16	providersp 42:9
80:15 96:2 129:10	124:4 129:10	155:16	75:10 78:3 80:5	providers 110:17
132:14 137:16	populations 31:13	prevalence 12:11	80:12 125:5	proxy 41:9
138:8 159:17	42:5,9,11 44:3	44:15,16,17	145:13,22 155:5	psychiatric 91:15
plannish 46:4	50:2,5 54:22	139:16	158:15	160:22
plans 156:5,13	population-wide	prevent 72:7	processed 29:17	psychiatrist 160:6
play 73:4 157:15	41:16 112:22	preventable 41:12	119:8	162:1,5
playing 11:9	portfolio 7:19 30:2	73:5	processes 38:10	psychiatry 91:19
plays 7:10 11:10	33:17 57:9 109:21	prevented 72:5	55:19	161:18
38:4	possession 27:15	prevention 32:1	produce 70:13	psychotic 111:3
plea 143:22 145:11	27:18	41:9 61:19 74:9	produced 17:6	public 116:9 133:3
please 29:11 64:19	possibility 19:7	102:5	product 154:20	152:3
163:6	possible 21:3 72:12	preventive 102:18	productive 4:9	published 10:6,10
plethora 87:15	133:20	previous 14:13	39:7 77:12	13:10 17:3 157:22
Plovnick 91:16	possibly 5:22 22:8	previously 21:4	professional 45:17	pull 12:21 13:9
pluck 128:15	post 65:16	primarily 29:16	program 12:5	pulled 4:18 6:18
plug 101:16 106:7	potential 5:8 91:21	156:16	62:18 95:20	14:1 19:15
plus 117:4	157:8	primary 39:12,18	programs 16:22	purchaser 156:1,9
pneumonia 11:7	potentially 36:13	104:21 137:19	44:13 110:14	156:11
72:3	PQRI 158:11	138:10 140:3,5	progress 112:19	purely 111:11
pockets 89:21	practical 118:6	principally 95:14	120:4	purpose 112:16
point 20:3,7 21:19	practice 45:17	prior 52:2 118:4	progression 64:15	pursue 19:9
26:9 28:13 30:18	52:15 55:1 56:6	priorities 105:3	65:19 68:1,6	pushed 78:22
33:21 36:14 59:9	56:19 59:10	priority 112:5	project 5:20 25:21	pushing 134:16
70:7 72:1 73:10	practices 56:13	122:13	30:9 98:8 99:17	put 9:7 23:13,15
76:18 99:6 103:14	practicing 73:12	private 19:4	104:19 106:17	25:13 26:16 29:7
107:14 115:15	practitioners 157:6	proactive 155:21	114:9 125:12	34:20 37:10 40:7
118:4 119:14	pragmatic 39:7	probably 7:4 10:8	130:11 138:14	42:6 46:22 47:12
120:22 121:19	pre 11:14	10:13 12:17 13:9	148:19 151:2	48:15 51:1,3 53:6
124:15 136:22	preaching 129:2	14:21 15:1,12	156:10,18 160:11	55:10 59:18 60:4
148:3 150:13	precise 15:21 126:4	18:15 29:5 46:11	163:2	61:8 65:7,14
153:12 162:12	precisely 126:1	66:6 84:10,12,15	promote 123:6	68:10 69:11 74:9
points 44:5	pregnant 74:11	89:17 90:16	prompt 81:13	76:5 99:20 100:19
policy 61:4 86:2	preliminarily	101:20 116:21	properties 121:18	104:14 112:21
popped 100:15	141:13	119:17 145:19	prophylactically	115:12 116:10
population 31:11	preliminary 141:8	148:12 149:1	73:21	119:22 120:2
41:20 44:6,16,19	141:9 142:18	problem 8:14	propose 74:21 75:6	137:12 143:22
45:4,6,7,16,17,19	143:10	15:21 81:17 85:12	proprietary 18:17	146:15 150:15
46:2,17 47:12,21	prescribe 25:12	114:5 116:8	prospective 33:3	157:14 158:5
48:5 49:2,9 50:3	PRESENT 1:12,21	124:12	protection 62:11	puts 79:8
50:15 52:19 54:21	president 92:2	problems 13:22	proven 24:19	putting 39:9 58:4

104:18 118:9
P-R-O-C-E-E-D-...
 3:1
p.m 163:13

Q

QA 89:8 149:19,20
 158:2
QI 89:7
qualify 22:5 145:22
quality 1:1 21:16
 22:16 73:6 89:14
 89:16 91:15 95:21
 122:3 123:1
 124:12 125:3
 133:4 148:18
 158:12
query 16:19
question 7:21 10:6
 10:8 12:13 13:12
 18:5 23:2 25:15
 35:16 59:16 71:7
 74:7 80:16,18
 97:15 101:2
 102:15,19 108:18
 115:17 136:15
 141:3 143:18
 144:19,19 159:22
questionable
 122:21
questions 79:22
 85:2 102:12 121:1
 126:9 138:5
 142:21 150:12
queue 7:8
quick 12:4 159:13
quickly 142:15
quiet 51:4
quite 5:22 13:12
 42:18 72:13
 146:18
quote 25:16

R

R 1:14,17
race 46:18
raise 75:18,19
 98:17

raises 118:15
ran 10:7
RAND 141:19
randomly 73:8
range 133:17
ranges 100:14
 118:8
RAO 1:19 10:1
 14:8 15:1 23:17
 27:11,19 36:5
 38:1,8 46:15 47:1
 51:13 62:13 70:3
 73:4 127:7 150:3
Rare 84:13
rarely 153:18
rate 54:1 56:10
 63:5 75:1 130:22
rated 101:10
rates 41:9 43:21
 45:21 48:8 61:10
 62:3,4 63:6,7 65:2
 71:3,10 72:19
 75:12,22 76:1,6
 130:5
ratings 35:1 141:4
 141:5 149:21
ratio 27:18
rationale 131:19
ratios 27:15
raw 10:13 13:8
reach 33:2 90:1
 94:19 157:3
reaching 89:12
react 6:8 102:14
read 9:17 158:21
reader 112:12
readily 94:7 98:3
 134:14
readmission 58:8
readmissions 59:6
ready 3:8
real 12:4 16:19
 99:10,18 117:10
 117:13 143:13
Realize 125:13
realizing 5:15
 134:11 147:16

really 11:18 13:10
 20:6 24:1 25:16
 26:2 29:22 30:14
 31:11 36:18 38:7
 53:1 60:21 65:10
 65:11 70:9 72:4
 74:17 86:20 87:2
 87:5 89:11 90:4
 98:8 107:21
 109:19 114:13
 115:2,16 123:6
 125:1,4,6 128:19
 133:6 143:4
 144:19
realm 14:4 57:7
reason 53:17 115:5
 118:4 128:19
 131:21
reasonable 30:17
 74:2 75:5 104:22
 110:10 112:8
 124:7 128:4
 146:19
reasons 99:14
 114:19 117:3
 118:6,11 128:2
reassure 121:2
Rebecca 94:7
recall 56:11
receive 32:9 137:15
received 5:11
recidivism 59:20
 61:20
recommend 27:10
 152:10
recommendation
 81:7 116:22
 140:18 153:5
recommendations
 129:17 151:21
 153:1,6
recommended 6:19
 140:20 153:14
reconvene 76:22
record 77:7 148:10
 150:2
recorded 142:13

160:17
records 150:1
red 64:9
redo 57:14
redrafted 19:18
reduce 62:19
reduced 38:13,17
reducing 59:19,19
 74:10 91:12
reduction 37:3
 40:8 111:13
 124:20
refer 39:10
referred 16:10
 39:19
referring 39:11
 49:4
refers 58:15
refill 76:15
refine 154:19
reflect 29:14 54:6
 111:18
reflected 110:20
reflections 77:15
reflective 109:1
refused 130:17
refusers 130:6
regardless 67:7
registries 87:14
 117:16
regular 94:8
regularly 92:4
relapse 72:20
related 21:16 22:5
 61:17 66:20 68:10
 89:19 103:12
 117:2,5
relates 51:7
relating 161:8
relationship 86:19
 124:16 151:10
relative 123:14
relatively 80:7
 128:16
release 18:16
relevance 98:22
 99:2

relevant 31:17
 71:15 84:22
Reliability 126:7
reliably 75:2
relief 21:5
remarkable 163:4
remember 17:10
 22:12 144:5
 160:14 162:8
remembered 12:6
remind 137:1
remove 47:4
renal 87:17
report 14:16 22:2
 117:18 121:17,22
 125:15 156:5
reported 21:15,21
 63:7
reporting 133:3
 158:12
reports 10:10
 14:19 61:12
 129:21
representative
 160:4
representatives
 149:14 152:15
represented 96:10
represents 59:4
 67:17
requests 70:22
required 80:1
requirement 85:20
requirements
 142:11
requires 85:2
requiring 135:14
Research 90:15
researcher 88:17
resolve 117:21
respect 17:8 38:3
 73:6 81:15 113:10
respiratory 11:8
respond 82:4 120:1
responded 136:16
responding 36:15
response 20:15

73:8	87:14 88:18 89:13	saying 30:13 48:1,5	sector 19:4 55:16	120:17
responses 136:9	100:3,19 101:12	50:5 57:20 61:15	sectors 43:2,9,10	sentence 53:14
responsibility	102:8 104:2,6	62:6,8 132:12	50:22 51:7 60:8	sentences 53:11
60:18	107:5 110:8	152:15 157:13	60:17	separate 62:8
responsible 89:16	112:15 116:13	says 4:11 39:2	see 3:8,13 7:1,6,9	137:17
129:18	117:13 119:12	47:20 50:1,15	11:17 12:3 13:1	separated 21:3
rest 30:2 58:20	125:2 131:10	53:22 61:5 65:17	14:5 15:10,13,20	seriously 153:13
60:6 137:7 151:11	142:7,14 143:17	66:15 152:11,17	16:8 19:9 21:17	service 51:7 57:18
result 28:18 69:5	147:6 150:14	SAZ 12:5	25:13 31:2 32:7	58:6 62:22
125:7 127:5	152:3 159:6	scan 150:14	37:20 47:3,22	services 57:20 58:5
results 22:15,16	160:15 162:13	Schaeffer 84:1	55:9 69:14 77:17	58:19 64:14 88:16
126:3,21 127:2	risk 38:14,17 63:13	scheduled 76:13	82:1 87:4 100:20	93:15
132:11,18	68:21 70:14 73:11	schizophrenia	100:21,22,22	servicing 43:8 44:13
resumed 77:8	74:10 87:4,9	111:4	101:9 103:12,14	50:22 60:16
retain 86:21	131:15,20	schizophrenic 28:4	107:19 120:19	session 47:17
Reva 1:24 3:11 4:7	road 87:1	school 11:11 60:9	126:18 127:15	set 6:18,19 31:5
15:5 27:11 46:15	Rob 91:16	62:21 63:5 89:4	143:19 144:22	92:2 111:20 157:3
72:10 77:18 90:8	Robert 17:2	96:16	148:20 151:10	sets 113:1
92:3 96:22 127:7	Rochester 56:9,11	schools 60:19	157:18 161:4,12	setting 96:3
129:1 143:21	role 7:10 11:9,11	SCHWALENST...	161:20	severity 12:15,20
145:12 150:3	38:4	1:19 23:1,4,9 35:8	seeing 11:7 54:12	122:15
151:12 162:18	roll 52:12	88:10,18,21 89:9	65:13 109:19	sex 40:9
review 2:14 4:12,13	rolled 21:11	92:13 144:18	157:1	sexually 40:10
4:21 75:6 77:20	room 1:9 23:10	scientific 121:17	seen 30:19 54:10	44:15 48:20
134:1,9	149:4,5	125:20	70:15 122:15	share 4:9 12:12
reviewer 137:19	rounds 141:4,4	scientifically	132:5 133:14	15:10 17:19 19:22
140:3	route 85:19	140:16	sees 156:18	60:9 97:22 107:13
reviewing 4:14	Row 1:9	scope 114:9	self 24:5	107:15 108:2
55:7	rudimentary	score 147:20,22	self-management	112:12 120:7,9
revision 118:20	103:11	148:2	35:14	146:3
RFP 70:8	run 17:18 64:21	scoring 132:1	send 15:6,9 64:8	shared 32:13 34:11
rich 109:20	65:1 99:14 104:11	screen 41:5 146:8	76:11 77:18 78:11	35:1 60:18
richness 144:10	147:2 160:13	se 85:18	78:12,14 79:4	SHARRON 1:14
rid 49:13 58:20	runs 12:7	search 16:4,7	80:12,14,19 89:18	shift 33:15
127:17	rural 47:1	searching 29:16	90:8,11,16 97:10	show 8:18 29:19
right 8:3,16 9:22		seat 62:14	97:12 120:8	79:7 80:2 100:17
13:18 15:4 17:5	S	seatbelt 24:22	sender 81:12	126:12 136:3
20:1 22:2,9 27:4,6	S 1:15 2:10	26:21	senders 33:3	shows 113:21
30:5,18 31:6	safe 40:9 105:8	second 20:2 33:14	sending 80:21	shrink 120:2
33:12 35:4 37:8,9	safety 62:9,13 67:9	42:3 46:12 47:15	81:20	shuffled 4:16
39:13 40:5,6,21	105:10	47:17 48:1 50:1	sense 45:11 106:10	sick 13:19 114:3
42:22 46:1 47:14	SAMSA 94:11	66:7 122:22	119:21 141:15	sickle 123:14
47:15 48:18 49:20	satisfaction 35:4	secondary 137:19	144:21 159:15	side 19:4 72:22
50:4 51:2 53:20	satisfied 32:8	secondly 140:3	161:10	108:20 136:12,21
58:7 65:22 67:13	save 76:11 77:18	section 46:13 47:12	sensitive 17:3	significance 129:20
67:19 72:5 74:15	saves 39:19	48:1	42:12 46:17 50:8	significant 7:10
76:2,5 78:20 79:2	saw 162:5	sections 88:6	sent 56:14 81:1	11:9,11 72:7

122:3,20 126:15 128:22 significantly 6:9 43:20 similar 156:7 158:20 similarly 69:2 146:7 simply 112:12 sin 52:15 single 89:15 site 94:18 sites 158:7 sitting 17:15 32:5 69:14 situation 34:15 127:9 six 104:11 143:6 size 137:3 slash 60:17 slice 12:20 42:13 slicing 12:10 Slides 56:9 slightly 133:16,17 156:22 small 15:1 82:10 122:18 137:3 144:1 148:10 smokers 62:6 smoking 26:21 27:1 29:7 30:20 31:3,19 37:11,15 37:18 44:16 sneaks 11:12 social 21:8 40:2 societies 87:22 88:2 88:4 94:22 97:8 society 89:2 90:14 95:14 soliciting 42:5 45:5 solid 62:18 143:5 somebody 15:13 18:12 53:21 74:21 155:15 somewhat 107:18 148:10 149:1 soon 93:1 150:14	sorry 3:10 23:20 32:4 50:10 58:10 58:14 98:15 sort 4:21 7:11,13 9:6 15:15 18:1 19:17 20:5 21:21 24:3 26:4,8 27:15 27:16 31:10 32:14 38:5 39:11 41:10 42:2 46:3 55:11 65:12 70:8,9 72:1 78:2,4,16 81:10 84:17 97:14 99:22 101:17 106:19 107:11 108:7 109:7,9 115:3,10 115:14 118:16,19 120:1 121:14 125:7 126:11 131:5,11 134:11 151:20 152:14 153:11 155:16 161:14 162:3 sorting 146:12 159:20 sorts 10:12 108:3 134:22 sound 9:22 sounds 4:2,4 102:15 source 118:9 135:15 sources 132:4 space 82:6 101:14 spaces 106:8 108:21 speak 116:2 speaks 91:9 111:10 spec 133:11 special 51:20 96:17 96:19 111:6 specialists 148:15 specialties 95:4 specialty 88:6 94:22 95:5,18 104:20 137:22 148:18	specific 29:20 31:12 36:3 49:5 50:2,6 51:18 53:5 61:9 63:2 69:13 82:15 84:4 97:16 97:19 103:22 112:6 114:10 122:1,5 specifically 81:19 117:12 160:22 161:7 specification 54:3 126:5,17 131:7 155:11 specifications 22:13 53:5 specified 112:17 126:1 130:13 131:15 specify 29:16 37:19 55:22 specked 117:11 specs 28:2 spectrum 103:21 spelling 69:8 spiff 151:4 split 95:4,17 splitter 104:17 splitting 26:6 60:21 sponsor 16:15 spot 150:16 spreadsheet 79:8 staff 1:21,24,25 4:8 79:12 99:9 137:5 staging 159:20 stand 160:10 163:10 standard 5:11 27:17 131:6,9 155:6 157:3 standardization 86:10 112:4 126:2 Standardized 22:4 standardizes 157:5 standards 154:7 start 81:20,22 88:20 100:8 101:9	111:2 118:3 126:4 142:8 145:14 158:20 started 8:22 starting 11:17 42:17 107:14 117:7 121:5 starts 8:9 112:14 118:9 121:8 state 43:17 51:22 73:12 91:2 92:5 93:17 109:1 113:9 115:22 149:17 statements 127:22 states 43:20 50:6 51:14 91:3,5 92:12 155:20,20 statins 28:2 statistical 129:19 status 21:16 22:4 46:19 59:13,15 69:4 71:8 stays 17:4 STDs 48:10,11 62:3 104:4 STEEP 103:1 steering 1:3,8 149:11 152:21 153:9 161:1,7 163:14 step 25:9 134:18 135:19 136:14,14 160:17 steps 159:8 steroids 55:11 stewardship 86:22 stick 153:5 stimulate 73:19 stimulating 15:2 STIs 48:17 stop 37:14,14,18 125:18 stops 27:1 storm 129:14 story 33:22 straightforward 157:6	strategy 100:1 131:15 stratifying 130:15 stroke 71:10 strong 161:10 structure 38:9 96:3 145:13 structured 21:22 79:6 struggled 42:1 struggling 19:15 28:9 32:5 51:5 61:17 134:4 studies 85:16 study 87:8 141:20 149:17 150:2 studying 56:14 stuff 18:4 28:6 79:16 88:12 106:18 108:17 117:19 137:6 sub 125:21 subcommittee 154:8,11 subgroup 95:1 subheading 50:17 subjective 65:11 submission 29:19 79:5 80:5 126:12 137:10 submissions 86:1 121:11 submit 5:15 78:7 80:13 151:6 submitted 5:19 123:3 139:2 submitter 79:17 subsidiaries 70:14 83:22 88:7 108:15 subsidiary 57:7 83:14,16,17 87:22 88:2,4 96:2 123:13 substance 38:15 60:22 63:12 74:11 substantial 17:9
--	--	---	--	---

substantiates 115:2	suspect 17:13 72:17	140:10	textbook 127:6	14:14,15,17 17:4
sub-criteria 122:12	symptom 21:5 22:7 36:18 37:2	tap 96:4	thank 3:22 19:20 97:2 121:15	17:15 18:3 21:1,9 21:19 22:12 24:14
sub-questions 126:11	symptoms 36:22 37:4	target 5:5	162:14,15 163:11	24:21 25:8,8,14 25:15 26:7 28:8
successful 24:19 37:16	syndrome 11:10 74:10 75:1	targeting 5:18 97:20	thankfully 75:14	28:13,20 29:4,21 30:3 32:15 33:14
Suddenly 73:15	system 139:1 148:4	targets 111:20 124:19	Thanks 3:20	34:16,18 35:13 36:15 37:15,16
sufficient 58:22	systems 134:20,22 149:15 157:11,13	task 154:12,13	than/equal 110:4	38:14,20 40:18 42:16 44:5,18,21
suggest 81:3 116:2 116:5	T	tax 39:7	therapeutic 73:22	46:10,15,19 47:6 47:8 51:17 55:6
suggested 83:12 84:3	T 2:10,10	taxpayer 39:3	therapy 27:10	55:18,21 56:2 57:13,22 58:5,12
suggesting 47:20	table 104:17 110:3 112:21 115:17	team 98:5	thereof 31:19	59:2,9,11 60:11 60:21 61:3,5 62:7
suggestion 47:11	tables 13:10 138:15	technical 55:13 69:2 80:7,8	thing 5:10 9:2 10:16 11:9,11	63:11 64:1,2,16 65:7 66:5 67:2
suggestions 58:2 81:22	tackle 138:9	111:15 122:18 137:6	13:7 14:19 19:11 21:10 23:12 38:5	68:15 69:15,21,22 70:20 71:2 73:9
suicide 41:3 44:17 48:13,14 91:12	tag 129:20	teen 91:11	45:10 47:9 59:5 66:18 67:11,14	74:8 75:7,9 76:7,9 76:9 78:3,15
suicides 48:8	take 5:8 17:10 60:17 65:18 71:12	telephone 1:18	72:5 80:1,7 81:5,9	80:22 82:3 83:8 83:15,17,18,20
summary 9:7 14:16 14:19	85:19 87:1,10 99:9 118:18 127:9	tell 105:22 139:4 150:13 157:13	86:11 99:22 100:4 100:21 105:13	84:6,7,17 87:10 87:13 90:3,20,21
support 85:4 131:20	137:20 153:13 154:16	tells 4:8	106:14,22 108:5 108:15 109:7	91:18,22 92:2 94:13,21 99:6,8
supporting 85:7	taken 127:19 128:16 162:12	ten 19:3	115:14 120:11 124:7 126:5	99:15,15,21 101:22 102:21,22
supposed 69:17	talk 5:21 21:5 35:9 42:17 66:19 67:12	tend 18:18 25:7 40:16 54:13,13,14	127:12 134:3,12 137:13 146:5	103:1,9 104:9,21 106:11,13 107:12
sure 15:7 23:3 30:21 34:1 40:4	67:17 70:12 79:20 93:18 94:17 99:6	54:15 82:10 87:5 109:13 117:11	156:9 157:16 158:6	108:22 110:2,8,8 110:10,19 111:10
47:9 50:9 51:14 61:18,21 64:5	119:3 141:13 142:19 159:1	129:16 135:10 158:2,3,5	158:6	112:1,8 113:7,10 114:8,14 115:9,13
66:3 81:16 96:11 99:5 103:5 110:5	talked 4:19 6:15 19:18 20:19 23:13	tension 114:8	things 4:18 6:12,20 7:11 14:2,5 15:8	115:16 116:10,15 116:20 118:1,11
112:4 117:6 119:9 120:18 134:2	33:16 64:12,13 96:15 100:9	57:17 75:22 135:4	16:12 21:8 24:19 27:20 28:16 30:7	118:15 119:1,5,14 119:21 120:2
150:18,22	121:10 159:7	terms 12:2 14:9 19:11,21 65:4	31:10 36:10 37:13 41:1,7,13 48:9	124:1,6,8 127:11 127:19,21 131:12
Surgeons 95:8 96:1	talking 6:13,17 8:17 9:3 12:10	82:3 98:11 99:16 100:10 107:1	49:16,21 59:20 61:20 62:10 65:5	142:20 144:8,14 145:2,21,22 146:4
surgery 68:18 70:15 71:9,11	20:6,16 24:4 42:11 45:11,15	100:10 107:1 115:12 129:8	67:9 71:22 72:8 74:1,9 79:18	146:6,18 147:6,8 147:11 148:7
73:16 95:13,14,15 136:6	49:20 66:18 67:3 67:4 72:11 87:3	134:9 136:2 141:18 147:4	81:18 87:9 88:1 90:21 95:15 99:10	
surgical 83:19 94:18,19 95:3,21	100:8 109:17 117:3 124:8	153:14	103:10 106:4,21 109:17 111:12,21	
surprise 11:2		terribly 37:16 125:19	122:8,9 128:1 134:22 138:2,19	
surprised 35:21		terrific 163:12	138:20 141:9 142:18 149:15	
surrogate 65:12		test 126:9	152:13 153:3	
survey 10:3 35:21 36:3 37:7 157:18		tested 88:14 92:19	think 5:9 10:21	
survival 66:8		testing 74:11,13 75:10 126:7,8,14		
		133:6		
		text 39:19		

149:4,6,12 151:7 152:1 158:22 159:7 161:9,14 162:19 163:3,10 thinking 5:14 14:7 28:9,16 33:13 34:5,7 41:7 42:7 50:14 51:15 60:6 69:9 82:2 89:10 89:20 93:16 96:12 97:17 107:3 110:1 111:2 141:18 thinks 114:22 115:1 152:18 third 32:20 42:14 60:7 130:18 132:16 THOMAS 1:16 Thompson 19:1 thought 6:22 8:17 59:22 63:12 64:6 69:6 77:10 84:8 92:21 95:22 98:19 101:11 102:2 thoughts 97:21 120:5,10 three 32:7 34:21 91:21 97:11 113:20 120:3 122:11 132:17 141:14 threshold 125:13 148:1 threw 42:15 throw 114:13 time 11:18 13:11 60:14 76:20 77:19 81:17 90:3 98:1 128:7 142:6 157:11 timely 105:8 times 13:21 118:5 128:11 tiny 122:17,17 126:22 title 78:8 today 4:7,10	toggle 137:2 token 81:3 Tom 80:17 108:18 tool 21:22 22:18 71:14 106:20 107:1,21 138:10 158:15 tools 22:3 36:4 111:18 141:1 top 8:4 9:5,9,11 10:11 11:16 12:16 14:14 20:4 47:7 47:12 52:13 54:18 topic 85:10 98:12 98:18 tossed 24:7 total 46:5 track 160:3 traditional 46:7 transcript 142:13 transition 38:20 39:1 117:2 transitions 119:2,4 transmitted 40:10 44:15 48:20 transplant 69:16 trauma 9:15 70:19 traveling 6:3 treat 65:4 treated 34:10 108:11 treatment 24:1,8 25:11 28:10 32:19 33:7,8,10 68:7,7,8 69:20 treatments 24:18 74:5 treats 61:2 trees 138:19 tricky 13:13 123:10 144:8 tried 9:17 20:15 trigger 37:1 44:21 45:3 60:1 triggering 162:7 triggers 36:17 trouble 21:14	53:18 105:18 true 41:3 56:18 57:6 94:12 124:11 124:17 truly 71:18 trumps 113:11 try 37:12 52:14 86:4 129:13 137:21 149:6 151:3 159:1 trying 12:9 20:10 30:4,15,21 32:17 42:1 44:5,13,21 52:18,22 59:17 60:11 67:21 73:14 74:18 84:7 86:12 101:13 102:13 103:9 106:19 111:21 122:9 134:4,16 141:1 144:21 145:8 turn 116:13,13 turns 31:5 72:4 113:3 Twenty-one 110:11 two 6:20 7:11 16:1 28:12 31:6,8 32:13 37:6 49:16 56:3 66:1 69:11 85:1 86:17 91:20 96:9 97:11 107:12 119:10 141:4,4 143:7 149:9 150:6 152:12 158:13 two-day 140:6 143:11 two-dimensional 101:14 two-step 78:3 type 34:3 36:3 39:9 60:14 63:20 types 48:9 63:18 101:5 typically 63:16 137:17 142:3 149:12 typist 47:4	U	136:18 155:7,7,8 156:14 157:4,9,19 157:22,22 158:14 159:3 useful 10:16 78:15 101:16 102:22 103:2 132:20 135:8 users 157:20 uses 113:2 155:12 usual 28:6 78:11 88:11 89:18 109:13 usually 66:20 95:2 108:11 129:20 utility 122:19 utilization 51:8 57:18,21 58:19 60:12 64:14
			V	vaccine 130:6 vagueness 26:8 valid 115:5 125:18 validity 9:21 113:11,15 114:5 114:10 118:4,10 125:20 126:7,10 126:13 128:7 129:4,19 valuable 102:1 value 35:6,6 147:12 Vanderbilt 22:10 variability 74:3 variation 69:5 71:16 123:4 variety 73:19 141:16 153:11 155:13 157:20 various 12:20 40:17 85:13 93:2 143:15 158:8 vehicle 92:15 ventilator 72:3 venue 70:8 Verdier 17:17 Vermont 43:19

82:17	130:18 135:5	welcomed 78:13	we've 4:18 5:1 8:19	67:19 68:12,21
version 132:6,7,8	141:8 142:17	welfare 43:5 60:10	14:1 15:8,22	74:15 75:20 76:2
versus 39:14 47:1	148:15,22 150:19	60:20	16:10 30:19 64:11	76:5,18 77:1,4,21
70:2 104:12	151:10 153:13	WellPoint 156:13	70:14 75:8 77:13	81:2 82:18 85:5
111:16 115:2,18	154:2 160:3 162:4	156:21	80:8 85:12 86:16	86:7 88:16,19
132:10	wanted 6:14 34:19	went 19:21 42:4	87:1 89:10 106:5	90:5 92:7,21 93:6
view 25:22 26:9	120:11 121:19	77:7 101:6	117:15 120:6	93:12 94:4,13,16
67:18	wanting 130:10	weren't 144:11	122:15 123:2,22	96:5 97:2,7 98:15
viewed 73:14	wants 51:1	we'll 4:5,20 5:21,22	132:5 133:14	99:5 100:3 102:8
viewpoint 33:19	Washington 1:9,10	12:3 15:8 19:9	137:5,11 138:7	102:11 103:4,8,16
149:6	84:14	25:14 35:17 48:15	143:6,8,14 159:7	104:2,6,12 105:1
viral 11:10	wasn't 10:8,11 47:9	57:12 64:8 76:11	whichever 147:17	105:4,7,17 106:2
virtually 8:8	160:16	76:12,21 77:2,3,4	whoa 106:12	107:5,10 108:13
vision 134:19	watch 137:8	77:17 78:1,12	widely 88:13	108:16,22 111:9
visit 7:15 8:2 13:15	watched 138:12	80:12 85:5 87:4	widespread 157:19	112:15 114:17
54:9,15 55:8	water 114:13	94:16 114:12	winds 70:11	115:9 116:12,18
visiting 62:17	waters 96:18	120:2,7 138:3,5,7	WINKLER 1:24	117:9 119:9,12
visits 7:13 13:19,20	wave 160:10	139:16,22 143:18	3:12,16,20 4:15	120:4 123:11,18
Voices 92:14	way 11:12,22 13:12	143:19 159:11,13	8:3,16 10:5 12:18	123:21 127:11
volume 10:19,20	18:5 26:13 34:19	159:16,17 162:9	13:5,7,18 14:12	129:12,15 130:9
12:11,19 143:18	50:17 83:21 85:18	162:12	15:4,7 16:18 17:5	139:9,12,18,21
144:8 145:15	86:16 90:2 104:22	we're 4:10 5:4 6:8	17:20 18:2,18,20	140:4 141:6,21
volumes 146:11	107:13 130:13,20	6:11 11:7,17	19:8 22:2,8,11	142:3,7,10 144:13
147:9	131:5,11 132:10	15:22 18:5 20:6	23:3,8,11,19 24:3	145:4,16 146:10
vote 144:15 151:14	132:12 138:18	26:5 29:16 30:13	24:11 25:2,18	147:6 150:8
151:17 153:15	143:10 146:12	30:14,21 37:1	26:2,7 27:2,6,9,14	151:16 152:6,12
voted 153:16	147:17 151:5	44:5,13,21 46:9	27:21 28:15 29:1	155:13 158:1,17
voting 151:19	153:21 158:1	46:10 47:7 54:20	29:9,21 32:1	159:6 160:9 162:2
	ways 10:12 12:20	60:11 69:22 73:14	33:12 34:6,17	162:16,19
	141:11,16	74:17 75:19 76:13	35:3,19 36:2,7,12	women 74:11
wait 77:3,4 143:18	weather 6:2 129:13	79:6,20 80:2	38:6,9,17,22 39:6	wonder 18:12
walk 42:10	Webinar 43:18	86:12 87:3 93:11	39:13,22 40:4,12	72:14
want 3:12 4:13	website 6:19 8:5	93:18 96:17	40:21 41:6,22	wondered 90:10
13:4 19:22 20:10	43:18 80:13	108:20 109:5,19	42:22 43:3,7,10	wonderful 162:20
22:21,22 29:22	week 90:21 162:10	110:15 112:18	44:11 45:9 46:14	wondering 26:12
31:12 36:9 42:13	weeks 119:10	117:3 119:16	46:21 47:3,8,14	88:11 90:7 108:8
46:22 47:4 48:22	weigh 151:10	121:5,7 122:9	47:22 48:4,11,14	Wood 17:2
49:12 51:3,11	152:19 155:2	123:7,17 124:5,9	48:18,22 49:8,12	word 22:3,4 44:10
52:11 60:4 61:7	weight 27:3 38:11	125:15 127:3	49:17 50:4,13	79:10 98:9 109:16
61:14,18 64:4	104:4	134:2,4,15 136:2	51:1,10 52:6,17	136:19
67:16 68:9 76:14	Weiss 1:11,13 3:7	136:13 137:11	53:7,20 54:11	words 24:6 43:2
78:21 86:20	15:5 18:22 21:18	138:9 139:6	55:3,14,20 56:1	67:22
101:19 104:11	41:14 48:10 72:21	140:10,22 144:22	56:22 57:4,12	wordsmith 55:4
109:20 112:7	96:22 97:3 103:13	145:17 148:14	58:7,12,17,22	wordsmithing 28:8
115:12 116:21	110:7,12 111:8	150:14,20 157:14	60:2 61:14 63:4,8	49:19 64:2
119:13 120:21,21	112:20 116:3,17	157:15,17 159:8	63:10,15 64:5,12	work 6:11 7:10
121:2 125:9 129:5	Welcome 2:13 4:11	161:19	66:8,12 67:2,13	9:18 29:10 32:6

43:17 47:18 49:22 57:13 69:15 76:8 79:12 80:6,10 82:6 86:8 89:21 90:4,9,13 92:17 98:5,20 99:9 100:17 109:10 112:18 118:20 119:5 120:4 133:7 138:5,8 139:20 143:10,13,16 151:15 154:14 159:16 161:17	years 8:9,10,13,13 8:22 16:1 17:2 62:19 71:14 72:11 83:13 111:6 113:19 126:17	18 110:4 112:10 113:3 115:17,20 116:4,9 117:11		
worked 19:1 96:6 workers 40:2 56:14 working 20:7,17 43:22 44:1 84:20 110:3,20 156:17 161:6 works 22:22 100:1 Work-arounds 80:5 world 62:14 70:16 72:16 78:4,14 81:8 82:11 97:18 97:18 98:2,4 100:6 109:3 115:3 133:22 147:9 worry 147:9 worst 81:9 worth 16:15 125:16 worthwhile 152:9 wouldn't 41:2 89:22 107:12 wrapped 34:1 write 50:11 writing 25:11 wrong 19:16 150:16	yesterday 4:22 5:3 6:13 19:19 20:7 20:16 21:19 23:13 32:16 33:16 65:9 100:10 108:6 York 156:3,3 young 108:8 110:4 111:19 117:1	18-year 108:7	<hr/> 2 <hr/>	
worked 19:1 96:6 workers 40:2 56:14 working 20:7,17 43:22 44:1 84:20 110:3,20 156:17 161:6 works 22:22 100:1 Work-arounds 80:5 world 62:14 70:16 72:16 78:4,14 81:8 82:11 97:18 97:18 98:2,4 100:6 109:3 115:3 133:22 147:9 worry 147:9 worst 81:9 worth 16:15 125:16 worthwhile 152:9 wouldn't 41:2 89:22 107:12 wrapped 34:1 write 50:11 writing 25:11 wrong 19:16 150:16	<hr/> Z <hr/>	2E 131:13 2's 4:16 20 9:5,9 62:19 116:19 2006 9:13 10:20 17:14 2009 1:6 2015 1:9 21 110:13 112:10 112:17 115:18,22 116:2,4,6,6,7,13 116:13,17 117:8 22 111:5 25 6:18 112:17	<hr/> 3 <hr/>	
worked 19:1 96:6 workers 40:2 56:14 working 20:7,17 43:22 44:1 84:20 110:3,20 156:17 161:6 works 22:22 100:1 Work-arounds 80:5 world 62:14 70:16 72:16 78:4,14 81:8 82:11 97:18 97:18 98:2,4 100:6 109:3 115:3 133:22 147:9 worry 147:9 worst 81:9 worth 16:15 125:16 worthwhile 152:9 wouldn't 41:2 89:22 107:12 wrapped 34:1 write 50:11 writing 25:11 wrong 19:16 150:16	<hr/> Z <hr/>	3 105:7 30 78:22 79:3 108:12 30,000 147:4 30-day 78:20	<hr/> 5 <hr/>	
worked 19:1 96:6 workers 40:2 56:14 working 20:7,17 43:22 44:1 84:20 110:3,20 156:17 161:6 works 22:22 100:1 Work-arounds 80:5 world 62:14 70:16 72:16 78:4,14 81:8 82:11 97:18 97:18 98:2,4 100:6 109:3 115:3 133:22 147:9 worry 147:9 worst 81:9 worth 16:15 125:16 worthwhile 152:9 wouldn't 41:2 89:22 107:12 wrapped 34:1 write 50:11 writing 25:11 wrong 19:16 150:16	<hr/> 1 <hr/>	5 2:13 50 16:21 500-plus 99:13	<hr/> 6 <hr/>	
worked 19:1 96:6 workers 40:2 56:14 working 20:7,17 43:22 44:1 84:20 110:3,20 156:17 161:6 works 22:22 100:1 Work-arounds 80:5 world 62:14 70:16 72:16 78:4,14 81:8 82:11 97:18 97:18 98:2,4 100:6 109:3 115:3 133:22 147:9 worry 147:9 worst 81:9 worth 16:15 125:16 worthwhile 152:9 wouldn't 41:2 89:22 107:12 wrapped 34:1 write 50:11 writing 25:11 wrong 19:16 150:16	1 2:14 4:12,13,17 10 100:16 10:00 1:10 10:26 77:8 10:30 76:14 10:54 77:8 100 67:17 12:15 163:13 121 2:19 13 1:6 14 87:13 15 76:22 112:9 150 20:11 17 113:2 115:20 121:6,8	60 143:8,11	<hr/> 7 <hr/>	
worked 19:1 96:6 workers 40:2 56:14 working 20:7,17 43:22 44:1 84:20 110:3,20 156:17 161:6 works 22:22 100:1 Work-arounds 80:5 world 62:14 70:16 72:16 78:4,14 81:8 82:11 97:18 97:18 98:2,4 100:6 109:3 115:3 133:22 147:9 worry 147:9 worst 81:9 worth 16:15 125:16 worthwhile 152:9 wouldn't 41:2 89:22 107:12 wrapped 34:1 write 50:11 writing 25:11 wrong 19:16 150:16	<hr/> 1 <hr/>	9 56:16	<hr/> 9 <hr/>	
worked 19:1 96:6 workers 40:2 56:14 working 20:7,17 43:22 44:1 84:20 110:3,20 156:17 161:6 works 22:22 100:1 Work-arounds 80:5 world 62:14 70:16 72:16 78:4,14 81:8 82:11 97:18 97:18 98:2,4 100:6 109:3 115:3 133:22 147:9 worry 147:9 worst 81:9 worth 16:15 125:16 worthwhile 152:9 wouldn't 41:2 89:22 107:12 wrapped 34:1 write 50:11 writing 25:11 wrong 19:16 150:16	<hr/> X <hr/>	9:08 3:2 90 56:16 96 65:3 98 123:4		
worked 19:1 96:6 workers 40:2 56:14 working 20:7,17 43:22 44:1 84:20 110:3,20 156:17 161:6 works 22:22 100:1 Work-arounds 80:5 world 62:14 70:16 72:16 78:4,14 81:8 82:11 97:18 97:18 98:2,4 100:6 109:3 115:3 133:22 147:9 worry 147:9 worst 81:9 worth 16:15 125:16 worthwhile 152:9 wouldn't 41:2 89:22 107:12 wrapped 34:1 write 50:11 writing 25:11 wrong 19:16 150:16	<hr/> Y <hr/>			
yaddy-yadda-dah 24:6 year 7:14 8:1 55:10 78:21				