

NATIONAL QUALITY FORUM

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MEDICAID INNOVATION ACCELERATOR PROJECT
TECHNICAL EXPERT PANEL IN-PERSON MEETING

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WEDNESDAY
APRIL 19, 2017

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The Technical Expert Panels met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 1:45 p.m., Andrea Gelzer, Maureen Hennessey, Barbara McCann and Sheryl Ryan, TEP Chairs, presiding.

PRESENT:

ANDREA GELZER, MD, MS, FACP, Senior Vice President and Corporate Chief Medical Officer, AmeriHealth Caritas Family of Companies, BCN Technical Expert Panel Chair

MAUREEN HENNESSEY, PhD, CPCC, Senior Vice President and Director, Quality and Population Health Solutions, Precision Advisors, PMH Technical Expert Panel Chair

BARBARA McCANN, BSW, MA, Chief Industry Officer, Interim HealthCare, Inc., LTSS Technical Expert Panel Chair

SHERYL RYAN, MD, FAAP, Professor of Pediatrics, Section Chief of Adolescent Medicine, Department of Pediatrics, Yale School of Medicine, SUD Technical Expert Panel Chair

CHRISTINA ANDREWS, PhD, Assistant Professor, University of South Carolina

RICHARD BROWN, MD, MPH, Professor, University of Wisconsin School of Medicine and Public Health

JAMES BUSH, MD, FACP, State Medicaid Medical Officer, Wyoming Office of Health Care Financing

DAN CULICA, MD, PhD, Senior Research Specialist, Texas Health and Human Services Commission

CAMILLE DOBSON, MPA, CPHQ, Deputy Executive Director, National Association of States United for Aging and Disabilities (Non-voting)

ANGELA KIMBALL, National Director, Advocacy & Public Policy, National Alliance on Mental Illness

VIRNA LITTLE, PsyD, LCSW-r, MBA, CCM, SAP, Senior Vice President, The Institute for Family Health

DAVID MANCUSO, PhD, Director, Washington State Department of Social and Health Services

DENNIS McCARTY, PhD, Professor of Public Health, Oregon Health & Science University

DIANE McCOMB, MEd, Aging and Disability Lead, Delmarva Foundation

DAVID MOSKOWITZ, MD, MAS, Medical Director, Hope Center, Alameda Health System

JUDIT OLAH, PhD, MS, Quality Improvement Coordinator, UCHealth

ROBERT SCHREIBER, MD, Medical Director, Hebrew SeniorLife

JAMES SCHUSTER, MD, MBA, Chief Medical Officer, Medicaid and Behavioral Services, UPMC Insurance Division

HOWARD SHAPS, MD, MBA, WellCare Health Plans, Inc.

JANICE TUFTE, Engaged Patient

TIFFANY WEDLAKE, MD, MPH, Physician Advisor HealthChoice, Maryland Department of Health and Mental Hygiene

LYNDA ZELLER, MA, Deputy Director, Behavioral Health and Developmental Disabilities Administration, Michigan Department of Community Health (Non-voting)

NQF STAFF:

KATE BUCHANAN, Project Manager
SHACONNA GORHAM, MS, PMP, Senior Project Manager
ANN HAMMERSMITH, JD, General Counsel
MIRANDA KUWAHARA, MPH, Project Analyst
TARA MURPHY, Project Manager

ELISA MUNTHALI, MPH, Vice President, Quality
Measurement

MARGARET (PEG) TERRY, PhD, MS, RN, Senior
Director

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

ALSO PRESENT:

KAREN LLANOS, MBA, Director, Medicaid Innovation
Accelerator Program, Center for Medicaid
and CHIP Services

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

2 1:54 p.m.

3 CHAIR GELTZER: --- social
4 determinants measures, abuse and neglect
5 measures. We did consider the potential for
6 gaming the measures in all of our discussions.
7 We had an animated discussion about the need for
8 a robust engagement patient activation measure
9 for Medicaid.

10 We discussed one measure and decided
11 not to move it forward, but felt that that is an
12 area of special interest and should be revisited.
13 And we felt there was some redundancy in some of
14 the measures.

15 They were, you know, either for an
16 expansive group of a population, or the same
17 measure for a more specific diagnosis. For
18 example, some measures were for all mental
19 health, and some measures might be for
20 schizophrenia.

21 Lots of discussion, great days. Thank
22 you, everybody. Pass the mic.

1 CHAIR RYAN: All right, I'll go next.
2 Hi, my name is Sheryl Ryan, and I was the chair
3 of the Substance Use Disorders TEP. And I want
4 to thank my committee and the support staff, the
5 support staff were great. Committee, we had a
6 very good discussion. I think we brought a
7 variety of perspectives that I think really
8 helped have a good, comprehensive discussion.

9 We started out with 114 by the NQF
10 staff, whittled it down to 44. So we reviewed
11 44, and a total of 25 were recommended finally.
12 And four of those were concept measures; the
13 remainder were measures.

14 We had started out with just three
15 areas being evaluated, three domains: clinical
16 care, care coordination, and caregiver
17 experience. And there were none in the other
18 areas of access safety and population that were
19 available for us to discuss.

20 By the time we'd finished, we'd
21 reallocated some to access, a couple to safety.
22 So by the time we finished, we had maybe four of

1 our six domains covered. We still didn't have
2 anything in caregiver experience, and we still
3 don't have, no measures from population,
4 population level.

5 A number of themes. We had a lot of,
6 in our clinical care, there were a lot of
7 measures looking at screening, screening for
8 composite alcohol and other drugs, screening for
9 separate alcohol or just tobacco. And we felt
10 that what we were really -- and there were some
11 that were separate for treatment after somebody
12 had been screened.

13 So one of the things we felt, it was
14 a theme, is that we would have liked to have seen
15 was more of a coordinated group of measures that
16 went from someone who was being screened,
17 assessed, treatment, and then ultimately looking
18 at outcomes of that treatment.

19 And we just don't have those measures.
20 So we felt that it would have been nice to have
21 some of these sort of cascading measures that
22 captured the whole, you know, range of what we

1 might want to be doing in the clinical setting.

2 There were a number of gaps that we
3 identified that I'll list. One was that we felt
4 with our opioid use and the opioid problem, we
5 really needed a number of more specific measures
6 that were related to measurement.

7 We had problems with our denominators;
8 we had problems with our numerators. Many items
9 were not well-validated. And it kind of limited
10 the validity of the measurements that we were
11 being asked to review. And I think we were all
12 feeling like, well, if we could have rewritten
13 some of these, it would have been better.

14 So, since that wasn't our task --

15 (Laughter.)

16 CHAIR RYAN: That's, right, that's
17 right. But, you know, but looking back on it, we
18 realize that there's just, you know, that the
19 domain of measures in that area is just really
20 limited. And I think people are sort of, at each
21 state, are sort of doing what they can coming up
22 with their own measures.

1 And we felt that a lot of our
2 denominators were just not well-defined. We
3 tried to clarify what they were, but again, those
4 limited what we could conclude about the measure.

5 Other gaps, I think, 18 year olds and
6 up were by and large very well represented. We
7 had very few measures for under 18 year olds.
8 You know, there were a couple for 12-18, but by
9 and large, most of that population is really sort
10 of not getting a whole lot of attention in terms
11 of measures that are being used.

12 And I'm coming from the perspective as
13 a pediatrician, this is where a lot of our
14 substance use starts. So interventions aimed at
15 prevention and early intervention, we're not
16 capturing that, which is important. Maybe it's
17 not big drivers of our cost right now, but they
18 are the ones that are going to be driving costs
19 down the line.

20 Another big gap that we felt was there
21 was virtually nothing about pregnant women or any
22 kind of recommendations for obstetrical care

1 related to substance use disorders. Absolutely
2 nothing, not even in the 114. I don't think I
3 saw anything when we viewed the -- and we really
4 feel that this is a huge gap, especially with our
5 neonatal abstinence syndrome.

6 You know, just use, what we know about
7 use of substances, all substances throughout
8 pregnancy. So we felt that that was another real
9 gap that was there.

10 Let's see, and I think, you know, we
11 also felt that a lot of our measures were very
12 much process-oriented, and that we really didn't
13 have a whole lot of outcome measures.

14 So maybe, you know, it's like we're
15 providing treatment. So, taking the step beyond
16 that, is that treatment? Really, do we have any
17 evidence about whether the treatment is resulting
18 in any kind of positive outcomes, either
19 decreased use of emergency services or re-
20 hospitalizations, or decrease in the behaviors
21 that we're trying to intervene about?

22 We really don't have real good outcome

1 measures, those were lacking. You know, how well
2 our patients are doing in some of the
3 interventions that were being measured as part of
4 the process. So we felt that there were a number
5 of criteria that you could use to assess success,
6 but these really were not represented at all in
7 the universes of measures that we were asked to
8 evaluate.

9 So I think that pretty much covered
10 it.

11 CHAIR McCANN: Thank you. This is
12 Barbara McCann, and I had the privilege to chair
13 the Community-based Long-term Services and
14 Support, and I'll do my best to represent the
15 incredible brilliance of our group.

16 We had 28 measures. And it may sound
17 like the easy thing to do, but boy, it was a
18 stretch. It was a stretch. There are at least
19 five major populations in this, in HCBS, in Home
20 and Community-Based Services. We didn't come
21 close, as I'm hearing with the rest of the
22 chairs, to even any measures for those

1 populations.

2 We found ourselves often looking at
3 medical measures, health care measures, and
4 trying to adapt them to their benefit in home and
5 community-based services. So you're happy that
6 they're going to get a once a year visit, and we
7 are hopeful that in that visit, needs will be
8 identified.

9 So the stretch was significant in many
10 areas. In others, we are looking for structure
11 because there is no standard of practice. We're
12 just looking for how you begin. So if you want
13 to go to an outcome, you have to make sure that
14 the issues were ever assessed to begin with, to
15 do that.

16 We also have proxies, but we also
17 found an interesting thing that could be
18 positive. And that is, we needed definitions to
19 speak to each other.

20 So as an individualized plan of care
21 evolves in medicine to be patient-centered and
22 goal-oriented, folks who were not in medicine

1 thought, 'No, well, that's not a patient-centered
2 plan.'

3 So we had to get to the point where
4 going forward, we need a definition of what each
5 of us is talking about, because it's not
6 understood the same within the populations that
7 we serve. So that was, I mean, we had to bridge
8 just to be able to explain it in the process.

9 As we also, I think, have highlighted,
10 many of the measures were Medicare. However,
11 such as, screening for falls at home is a big
12 deal, and that's for all ages, not just Medicare.
13 So we have the same issue there on an ongoing
14 basis.

15 We have several measures that need
16 additional validation. So we came down to six
17 measures we would go forward with, five promising
18 concepts, and two concepts that we would go
19 forward. This is clearly an element of Medicaid
20 that's going faster than we can possibly imagine,
21 but we have almost nothing, almost nothing to
22 look at.

1 And we started rewriting all of our
2 measures, I don't know what your problem was. So
3 it was a challenge, but I think at the end of the
4 day, we were able to bridge a great deal, but we
5 have a long way to go, long way to go.

6 DR. TERRY: So I'm going to just take
7 us through the next steps of what's going to
8 happen after this. And before I begin, I just
9 want to say, this may change slightly because of
10 this meeting. So whatever I say, don't hold me
11 totally accountable for what I say.

12 But as we designed it, there were five
13 steps. The first is to review the measures that
14 come forward.

15 The second is to vote en bloc of all
16 measures recommended by each TEP, and that does
17 not include those that the Coordinating Committee
18 pulled out as something they wanted to look at
19 from the main list that were recommended, and
20 those not recommended, where the Coordinating
21 Committee actually could identify some they
22 wanted to still look at.

1 We have a lot of what we call save
2 measures throughout this process, just because
3 we're, you know, the data is not always perfect
4 in this world, and we want to make sure that it
5 reflects, you know, what's going on in each of
6 these TEPs.

7 The next part would be that the
8 Coordinating Committee will vote en bloc and
9 everything that just go through without any
10 discussion. Then for those that are pulled out
11 for discussion, they will vote on each measure.
12 There are some guidance that we have for them to
13 use, a little bit like the guidance we had for
14 the decision logic, just a little bit shorter.

15 And when they're completed that, they
16 will look at all the measure sets, and they will
17 vote on each measure set as a whole. When I say
18 they look at it, they'll be looking at issues
19 such as, you know, how many domains are
20 represented. It's a little bit of what came out
21 of the discussion today, actually.

22 And then they will vote on each

1 measure set to recommend to HHS or CMS. So just
2 to tease that out just a little bit, next
3 measure, next slide I mean. Great.

4 I think I sort of said this, but the
5 objectives really are to review any new
6 information that we receive that can go to the
7 CC, there may be some new information.

8 I know there were some, in the group
9 I was in, BCN, we're going to look to see if
10 there's anything additional here, there may be
11 other groups with that, to evaluate measures
12 submitted from the TEPs, you know, through an
13 additional process of what we call
14 reconsideration, and then to finalize it.

15 We do not want this Coordinating
16 Committee to be really duplicative of what we did
17 in the TEPs, that's not the goal. But to really
18 look from a broader view or broader lens. I
19 mean, some of the work has already been done for
20 them.

21 So they'll have a smaller set to look
22 at, and you know, and they'll have comments from

1 what is going to be passed on to them from the
2 work here. So it won't be the level of depth,
3 although maybe for some areas and some measures.

4 These measures we want to be a
5 resource for all states, and we want to make sure
6 they're available for quality improvement and
7 maybe someday payment activities.

8 So onward to the next one. Just to,
9 again, a little bit more delineation the way this
10 is going to work. So, and I've alluded to this.
11 The CC will be provided with two lists. Those
12 that, measures that measure concepts that were
13 recommended and those that weren't.

14 And for those that, and they'll have
15 a process, as the TEPs did, to do pre-work. So
16 they'll be provided with these lists, and they'll
17 look at them to see if there's any they want to
18 pull out for further discussion of those that
19 were recommended.

20 And for those not recommended that
21 they want, they get two choices per person to
22 recommend others for further discussion. So,

1 again, that's how we're going to do that.

2 They will, from the list, from both
3 activities, they will actually reconsider the
4 measures that were already looked at. And I also
5 mentioned they'll vote en bloc. So the next part
6 is they'll vote en bloc for everything that just
7 moved forward. Next slide.

8 So three, four and five gets into the
9 details. Three involves the review of the -- I'm
10 sorry, three involves the voting individually on
11 the measures and measure concepts.

12 Four involves the review of the entire
13 measure set for each program area for balance as
14 I said, type domains, measures that are
15 immediately ready. And then five is the final
16 vote.

17 And with that, I'm going to turn it
18 back over to -- any questions on the next steps?
19 Yes?

20 MEMBER BUSH: So on that last slide,
21 it looked like point three means they're going to
22 vote on everything we just voted on, because they

1 vote for the ones we approved and vote on the
2 ones we didn't approve?

3 DR. TERRY: So they're going to vote
4 on those that move forward without discussion,
5 just to look at them and vote on those. They can
6 pull out individually any that they want to
7 discuss that have been approved or recommended.

8 And then they can pull out up to two
9 of those that weren't recommend. And they'll
10 discuss those -- the purpose for that is for them
11 to take a deeper dive into those.

12 MEMBER BUSH: So not all of the ones
13 that we didn't approve, just up to two each?

14 DR. TERRY: Up to two per person.

15 MEMBER BUSH: Okay, thank you.

16 DR. TERRY: It's called the save, as
17 we keep calling it. Yeah, thank you, yeah. All
18 right, there are no other questions. So I'm
19 going to pass it on to I think Maureen, no?

20 CHAIR HENNESSEY: Oh, yeah.

21 MS. KUWAHARA: Hi there. We will now
22 take this time to hear from any members of the

1 public that would like to offer comments. If you
2 are not connected via phone, you can use the chat
3 function at the bottom of your screen to submit a
4 comment. Operator, can you please given
5 instructions to the participants.

6 OPERATOR: Yes, ma'am. At this time,
7 if you would like to make a public comment,
8 please press star then the number one. And there
9 are no public comments from the phone line.

10 MS. KUWAHARA: Thank you.

11 CHAIR HENNESSEY: So we may have
12 juxtaposed the agenda a little bit, just want to
13 check and verify. Are there any other questions,
14 discussion that anyone else would like to have
15 with regard to the discussions we've had today?
16 Yes, James?

17 MEMBER BUSH: Just, yeah, so a couple
18 of quick comments. One of the things that we
19 brought up at the end of meeting is ever since
20 CMS expanded our 1915(c) subassurances, we've
21 become aware of there's a large gap around
22 quality, around the 1915(c) DD and the home and

1 community-based services waivers.

2 And I didn't really, and of course, it
3 may not have been in our group, but I don't know
4 if you saw any in your group, but that is an area
5 with a lot of need for further measurement. So
6 that was one comment that I would like to see
7 addressed, because that was an area we had not
8 been looking at until very recently, and there's
9 way too much problems there.

10 The second problem that I just had
11 with some of my discussion was apparently in the
12 long LTSS group, there's some question about the
13 role of med reconciliation. And apparently there
14 were several med reconciliation measures in that
15 group that were voted out.

16 And my understanding from speaking to
17 some of the members was they thought that might
18 have been addressed in other areas. But we only
19 addressed those of inpatient and emergency room.

20 And so is there anything about med
21 reconciliation in the purely outpatient setting?
22 Because that's an area where we see a lot of

1 problems as well. So those are my only two
2 comments.

3 CHAIR McCANN: We did address med
4 reconciliation. We went through the measures.
5 Our challenge was that the measures that we
6 looked at didn't take it back to the home. That
7 med reconciliation was upon discharge from the
8 hospital, that's great, and then when they got to
9 the physician's practice.

10 But actually we brought up med
11 reconciliation from our perspective needs to
12 occur in the home. And our rejection, if you
13 will, or our lack of wanting to push those
14 measures forward, based on the scope of the
15 measure, is that it didn't address reconciliation
16 in the home and community, which we thought was
17 the most important.

18 We also rejected a measure regarding
19 adherence that was limited to the pharmaceutical
20 claims for a refill, which we thought did not
21 address adherence, which is a huge issue in the
22 community. So it was not because of an issue of

1 a lack of understanding the importance of
2 medication reconciliation. We couldn't get
3 anything that moved it to the home at that point.

4 MEMBER BUSH: Great, I appreciate
5 that. And then, and again, we had several things
6 that we thought we wanted to bring to the
7 Coordinating Committee as well about some gaps.
8 So I appreciate those comments, and I'm sure
9 those will be carried forward as well.

10 CHAIR HENNESSEY: Any other comments?
11 Thank you for those? Any other comments,
12 questions from the group today? I think I would
13 like to echo what's already been said in terms of
14 thanking not only this total group, but the TEP
15 that I worked with today, and then also the team
16 Kate and everyone from the NQF staff. It's just
17 a great job of organizing and preparing, so thank
18 you.

19 DR. TERRY: And I will say the final
20 thank-yous. So I first want to thank our chairs
21 for their work they've done, for all the calls we
22 had in advance, for leading these groups, and for

1 their expertise. So I really wanted to thank
2 each person for what they brought to the table.

3 And I also want to thank the TEP
4 members. People were really very engaged and
5 very knowledgeable, very, very knowledgeable, on
6 these topics. And we asked you to do pre-work
7 and you all did pre-work, and I think that's
8 great.

9 So thank you very much to everybody
10 for the hard work over two days, and for the
11 results of what we have now. And you'll
12 certainly hear the end result as we move forward.
13 And please don't hesitate to email staff if you
14 have any questions in between.

15 And I also want to thank the team, I'm
16 sorry, I want to thank our team, the NQF team.
17 They really worked hard to put this together. I
18 want to thank the CMS for coming here, for
19 supporting us to clarify all those things they
20 did over the last two days. Really, it's been
21 very, very helpful.

22 This is our partnership on this that,

1 you know, we talk to them every week, so you know
2 that. And they give us guidance, and we ask them
3 questions, and we move forward, and we try to
4 come to an understanding. So it's been great.

5 So, again, thank you to everybody for
6 this work, and hopefully you'll make all your
7 trains and airplane connections, and --

8 MS. GORHAM: Before we run out the
9 door, we just want to go over next steps to give
10 you all some kind of direction of where the
11 project is going.

12 DR. TERRY: Oh, I'm sorry, I jumped in
13 too soon.

14 MS. KUWAHARA: So I have spoken with
15 my colleagues, and it's our understanding that
16 all measure deliberations were finalized today.
17 So we propose cancelling the May 3rd meeting. We
18 are seeking an affirmative hand-raise from you
19 all if you are in agreement.

20 (Show of hands.)

21 MS. KUWAHARA: Seeing many
22 enthusiastic hands, we will cancel that meeting.

1 Up next, we will be publishing our draft report
2 for public comment. That'll include all the TEP
3 and Coordinating Committee measure recommendation
4 results. And that'll be posted no later than
5 August 21st.

6 Then on September 14th, we will be
7 submitting our final report to HHS. All right,
8 thank you very much.

9 DR. TERRY: And I think that does
10 conclude the meeting, so thank you again.

11 (Whereupon, the above-entitled matter
12 went off the record at 2:17 p.m.)
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<p>able 12:8 13:4 above-entitled 25:11 Absolutely 9:1 abstinence 9:5 abuse 4:4 Accelerator 1:3 3:16 access 5:18,21 accountable 13:11 activation 4:8 activities 16:7 17:3 adapt 11:4 additional 12:16 15:10 15:13 address 21:3,15,21 addressed 20:7,18,19 adherence 21:19,21 Administration 2:20 Adolescent 1:18 advance 22:22 Advisor 2:17 Advisors 1:16 Advocacy 2:5 affirmative 24:18 agenda 19:12 ages 12:12 Aging 2:4,10 agreement 24:19 aimed 8:14 airplane 24:7 Alameda 2:12 alcohol 6:8,9 Alliance 2:6 alluded 16:10 AmeriHealth 1:13 Analyst 3:3 Andrea 1:9,12 ANDREWS 1:20 ANGELA 2:5 animated 4:7 ANN 3:3 apparently 20:11,13 appreciate 22:4,8 approve 18:2,13 approved 18:1,7 APRIL 1:6 area 4:12 7:19 17:13 20:4,7,22 areas 5:15,18 11:10 16:3 20:18 asked 7:11 10:7 23:6 assess 10:5 assessed 6:17 11:14 Assistant 1:20 Association 2:4 attention 8:10 August 25:5 available 5:19 16:6</p>	<p>aware 19:21</p> <p>back 7:17 17:18 21:6 balance 17:13 Barbara 1:10,16 10:12 based 21:14 basis 12:14 BCN 1:13 15:9 Behavioral 2:15,19 behaviors 9:20 benefit 11:4 best 10:14 better 7:13 beyond 9:15 big 8:17,20 12:11 bit 14:13,14,20 15:2 16:9 19:12 bloc 13:15 14:8 17:5,6 bottom 19:3 boy 10:17 bridge 12:7 13:4 brilliance 10:15 bring 22:6 broader 15:18,18 brought 5:6 19:19 21:10 23:2 BROWN 1:21 BSW 1:16 BUCHANAN 3:2 BUSH 2:1 17:20 18:12 18:15 19:17 22:4</p> <p>call 14:1 15:13 called 18:16 calling 18:17 calls 22:21 CAMILLE 2:3 cancel 24:22 cancelling 24:17 captured 6:22 capturing 8:16 care 2:1 5:16,16 6:6 8:22 11:3,20 caregiver 5:16 6:2 Caritas 1:13 Carolina 1:20 carried 22:9 cascading 6:21 CC 15:7 16:11 CCM 2:7 Center 2:12 3:16 certainly 23:12 chair 1:14,16,17,19 4:3 5:1,2 7:16 10:11,12 18:20 19:11 21:3 22:10</p>	<p>chairs 1:10 10:22 22:20 challenge 13:3 21:5 change 13:9 chat 19:2 check 19:13 Chief 1:12,16,18 2:14 CHIP 3:17 choices 16:21 CHRISTINA 1:20 claims 21:20 clarify 8:3 23:19 clearly 12:19 clinical 5:15 6:6 7:1 close 10:21 CMS 15:1 19:20 23:18 colleagues 24:15 come 10:20 13:14 24:4 coming 7:21 8:12 23:18 comment 19:4,7 20:6 25:2 comments 15:22 19:1,9 19:18 21:2 22:8,10,11 Commission 2:3 committee 5:4,5 13:17 13:21 14:8 15:16 22:7 25:3 community 2:20 21:16 21:22 community-based 10:13,20 11:5 20:1 Companies 1:13 completed 14:15 composite 6:8 comprehensive 5:8 concept 5:12 concepts 12:18,18 16:12 17:11 conclude 8:4 25:10 Conference 1:8 connected 19:2 connections 24:7 consider 4:5 coordinated 6:15 Coordinating 13:17,20 14:8 15:15 22:7 25:3 coordination 5:16 Coordinator 2:13 Corporate 1:12 cost 8:17 costs 8:18 Counsel 3:3 couple 5:21 8:8 19:17 course 20:2 covered 6:1 10:9 CPCC 1:14 CPHQ 2:3 criteria 10:5 CULICA 2:2</p>	<p>D.C 1:9 DAN 2:2 data 14:3 DAVID 2:8,11 day 13:4 days 4:21 23:10,20 DD 19:22 deal 12:12 13:4 decided 4:10 decision 14:14 decrease 9:20 decreased 9:19 deeper 18:11 definition 12:4 definitions 11:18 deliberations 24:16 delineation 16:9 Delmarva 2:11 DENNIS 2:9 denominators 7:7 8:2 Department 1:19 2:9,18 2:20 depth 16:2 Deputy 2:3,19 designed 13:12 details 17:9 determinants 4:4 Developmental 2:19 diagnosis 4:17 DIANE 2:10 direction 24:10 Director 1:15 2:4,5,8,11 2:13,19 3:8,15 Disabilities 2:4,19 Disability 2:10 discharge 21:7 discuss 5:19 18:7,10 discussed 4:10 discussion 4:7,21 5:6,8 14:10,11,21 16:18,22 18:4 19:14 20:11 discussions 4:6 19:15 disorders 5:3 9:1 dive 18:11 Division 2:15 DOBSON 2:3 doing 7:1,21 10:2 domain 7:19 domains 5:15 6:1 14:19 17:14 door 24:9 DR 13:6 18:3,14,16 22:19 24:12 25:9 draft 25:1 drivers 8:17 driving 8:18 drugs 6:8</p>

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C E R T I F I C A T E

This is to certify that the foregoing transcript


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Project TEP In-Person Meeting

Before: NQF

Date: 04-19-17

Place: Washington, DC

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