

SustiNet Health Partnership

Medical Home Advisory Committee

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SustiNet Patient-Centered Medical Home Advisory Committee Regular Meeting

December 16, 2009

Meeting Minutes

Committee Attendees: *Ellen Andrews, Co-chair; Tory Westbrook, Co-chair; Joanna Douglass; Dominique Thornton; Jennifer Jaff; Les Holcomb; Sandi Carbonari; Drew Morton; Jody Terranova; Bruce Gould; Jim Cox-Chapman; Amy Casavina Hall; Tom Woodruff; Rose Stamilio; Kathy LaBella; James Sterling; Margie Giuliano; Judith Meyers; Sylvia Kelly; Maureen Smith; Jim Auger; Rick Duenas; Keith vom Eigen; Ken Lalime; Nancy Wyman, SustiNet Board of Directors Co-chair*

Tory Westbrook opened the meeting by welcoming all members and asking them to introduce themselves. Ellen Andrews presented the attached slide show about the first NCQA accredited medical home in New York.

http://www.ct.0067ov/sustinet/lib/sustinet/referencelibrary/med_home_slide_show_for_briefing.pdf

Ellen said that this medical home provides care that is continuous, comprehensive, coordinated and patient centered, and the employees are very proud of it.

Ellen next described a [medical home builder's website](#), and presented it.

Keith vom Eigen described the Medical Home Builder, which is a program that was initiated by ACP coalitions. It is meant to be a tool to help practices figure out where they are in terms of medical home practice, and how to proceed to reach the standards of a medical home. NCQA sets the criteria for the medical home. There are currently three different levels that are used, and there is a set of targets that must be met in order to qualify for each level. The Medical Home Builder works to help with assessing practices and moving toward becoming a medical home. It acts as a tool to provide educational materials on each of the different areas, providing references and allowing users to access the standards. He said that this is a paid service, but that it is inexpensive. Keith continued by saying that ACP is an internal medicine organization, mostly focused on adult medicine practice, so he said he

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wasn't sure if there would be special features that would be needed by different practices, such as pediatrics. ACP is very interested in using the Medical Home Builder as an educational tool, and is using it to help residents in the medical home transition process to learn about what the standards are, and how to access them. Ken Lalime said that the CT State Medical Society has partnered with the American College of Physicians. They have bought a master license for the Medical Home Builder and are offering it to any primary care practice that works with them and wants to engage in this process. There are a number of practices already using this, and they have found the resources to be tremendous in helping them to move through the various stages of development. Sandi Carbonari said that she feels that it is important to include pediatrics in medical home planning. Joanna Douglass said that she feels that oral health is important to consider, especially in pediatrics, but with adults as well. She continued by saying that dental health should be incorporated into medical home planning.

Jim Cox-Chapman said that he felt that this group would need to come to a common understanding as to exactly what a medical home is. He said that the charge of this Committee is to provide recommendations to a health plan that is trying to be birthed, so that the principles of a medical home can be incorporated into this plan, improving quality of care and lowering costs. Jim also said that the video shown made him realize that there are a lot of elements that could have taken place in his existing practice and other practices here, yet his practice isn't anywhere near to operating with the NCQA requirements for a medical home. He questioned whether the Committee's task is to help define exactly what a medical home is, and what the group wants primary care practitioners to be doing in order to participate in this health plan that has yet to be funded or birthed. An unidentified speaker said that this is a huge undertaking, but that it is the Committee's job to make recommendations about the best way to implement medical homes, the concept and the model, within SustiNet but also more broadly. The recommendations made here could serve as standards across the state, not just for SustiNet members. The goal is for practices to provide medical home services to everybody. The Committee must be sure to include what's important and to have some connection to it, but also not load it up to where practices are overwhelmed. The same speaker said that the Committee must come to an agreement about what's critical, and how to make it as easy as possible on providers, while still improving on quality of care and bringing savings to the state.

Maureen Smith asked if anyone knew what percentage of practices in CT are NCQA accredited. (inaudible). Sandi said that in order for a practice to become a medical home, it requires an enormous amount of work and resources. She said that she felt it would be naïve to think that practices could transform themselves first and then obtain resources. Keith commented that an important element of the medical home concept is to look beyond how the practice works. This really is about population health and looking at populations in communities as targets of health improvement. This can be done within a practice, and a lot of NCQA standards revolve around this, identifying patients with chronic illnesses and addressing their needs. When looking around the country at programs that are successful in terms of improving quality outcomes and saving money, the North Carolina model comes to

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mind. A key element in NC is the population health initiatives; this means not just working as a sole practice where things work smoothly and patients' needs are addressed, but working together as a "medical neighborhood." SustiNet could add and support those kinds of functions in addition to helping practices transform their own systems in the process of care.

Rose Stamilio said that as a member of a physician hospital organization, in going to educate physicians on this model, she found a double edged sword. It wasn't just about getting them to this evaluation, during which her organization used the NCQA questionnaire and guidelines. In the process of identifying what the practices needed to go through, educating them on what the patient-centered medical home actually is, another problem was encountered, and that is getting them the resources needed in order for them to provide care coordination. She said that her group did as much as they could as a PHO to help them understand what needs to be done, but to help them go through the checklist, the bottom line is how are they going to be able to do this, and that is this Committee's challenge. There will need to be additional funding for physicians in order for them to do this.

Judith Meyers asked how many practices nationally have NCQA certification, and which states have the highest number. She said that the Committee will need to look at what policy and systems changes are needed to support the practice change, and what other states have accomplished this, so that the Committee can look at what's already been done. An unidentified speaker said that she has reviewed the House and Senate bills, and that there are a lot of resources for states or regions. She continued by saying that this Committee could have a role in making recommendations to the state for applying for these resources.

An unidentified speaker said that when talking about medical home, there has been much discussion about meeting patients' needs; however, there needs to be discussion about how patients will participate in medical homes. She said that there are two reasons that this discussion is critical; first, patients are a free resource, and by helping to manage their own diseases, healthcare costs will decrease. The other reason is quality of care. It has been proven that patients who participate in their own care are more compliant with doctors' orders and have better health outcomes. For both reasons of cost and quality of care, it will be important to figure out what the patient's role is in a medical home, and to make some modest investment in patient education at the front end, so that patients can be full partners with medical homes.

Rose said that in her experience, physicians were assisted with achieving NCQA diabetes recognition, being given the tools and resources to be able to keep that recognition. There were certain physicians who did not meet the standards, not because of the way they were managing the diabetics, but because their population was not under control. Rose said that this proved to be an eye opener to her organization, because no matter what they do to assist physicians, if there is a large population that is underserved because they don't come in for regular testing or don't follow their diets, those physicians are never going to reach NCQA recognition. Tory said that this was a very good point, and that this Committee would need to keep this in mind, especially when considering how to distribute funding. There will

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always be physicians with challenging patient panels, whose populations require more attention and closer follow-up in order to obtain results. The physician who takes on more challenging patients is penalized. This Committee needs to be aware of the different challenges that physicians face, so that they are not penalized by short funding.

Jim said that for this Commission there clearly needs to be risk adjustment, and there will need to be patient incentives. Jim's medical group aspires to have NCQA accreditation, so they have looked at medical homes. It was clear that electronic health records would help in making the medical home function more smoothly, and would facilitate reaching NCQA requirements. Theoretically, the funding is already in place for electronic health records, by using federal stimulus dollars. Anyone who installs and implements a medical record that can "do meaningful use" by the end of 2010, will be eligible for federal stimulus funding by as much as \$44,000 per provider. Jim continued by saying that he personally doesn't want any more health plans in CT that don't add value, and the value that the Committee is considering will increase quality of care and provide lower costs to the participants. Jim asked if this Commission should be recommending that any provider that wants to be part of SustiNet should be considering using electronic medical records, because medical home is going to be part of this. An unidentified speaker said that there is another committee that is working on the electronic medical record aspect of SustiNet. That committee will be making recommendations, so that while this Committee doesn't have to take that challenge on, it would be useful to refer to it.

Tory said that in initial discussions regarding SustiNet, it was felt that this effort would attempt to create a better quality, lower cost health delivery system for all CT residents. Tory said that his concept is that SustiNet is viewed as leveraging the state's influence, to be able to then roll it out so that the private sector could follow. This Committee could recommend to SustiNet that these are the parameters for a provider to be paid under the SustiNet program, which ultimately is the state employees' health plan and components of the Husky plan and other DSS plans being rolled together. The thought is that then the money would follow in the private sector, as employer groups jump on board, because then there would be this ability to tap in, and this Committee needs to keep this in mind. This Committee will need to present to the SustiNet board the concrete steps that need to be taken, so that the rest of the state can follow. An unidentified speaker said that it sounded like the Committee was creating its own public option here. He also said that the Committee could shape this appropriately.

Joanna Douglass stated that she wanted to emphasize that the medical home involves a team approach to care, and that physicians are a part of this, but that involving other team members will allow more frequent patient contact, and thus better compliance. She further stated that the Committee will need to reframe its thinking by keeping in mind that there will be a team at work here, and not just a physician. She said that the Committee should look at states that have already had a number of practices certified, and also to look at models that have embraced the team approach and seen what the health outcomes and cost savings are as a result.

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Sandi said that when a practice becomes a medical home, there is no separation of patients; all the patients are treated in the same way, and the Committee needs to keep this in mind. She continued by commenting on electronic medical records, saying that her practice doesn't currently have this technology. She said that there is federal stimulus money, but practices have to invest huge amounts before getting any stimulus funding. It's more of a reimbursement, so this will be a huge barrier, especially to all Medicaid practices. Sandi also said that the medical home is patient-centered, so the number one person is the patient, with everything revolving around that patient. These practices are termed physician led; that's because there has to be someone who is overseeing the process, but it is definitely a team effort.

An unidentified speaker said that in the Senate bill, medical homes are described as physician led. In the House bill, medical homes are described as being led by physicians, nurse practitioners and physician assistants. An unidentified speaker said that UConn has an urban service track that is used in the schools of medicine, dental medicine, pharmacy and nursing. Students are taught about situational leadership. Basically this means that different members of the team take leadership, depending on the issue and the desired outcome. This will be a good way to approach this effort. Another unidentified speaker said that her only concern is that the majority of physicians are in very small practices, led by one or two physicians. Often the only other members of the practice are a nurse and an aide. It is hard to incorporate the team concept when challenged with so few members. This proves to be challenging to large groups, to develop the process and identify all the resources, but with small practices it is a different type of problem. Ken said that statistically, 88% of practices in CT have four physicians or less. There will need to be some organized care management function delivery models to make this effort work, at least until there is an all payor solution. In models around the country that his organization has seen that have worked, it is an all payor solution that has worked. Without the reimbursement models to support this type of practice, it won't flourish. Ellen said that the Flushing medical home that was discussed earlier has three or four physicians, proving that it can be done in a small practice. They found that it did cost money to set it up, but then they made money down the road, because of the scheduling issues and the efficiencies that they came up with. Tory said that there are some models that the Committee may choose to emulate, that promote and reimburse, having the infrastructure to improve quality of care as well as receiving reimbursement that reflects either the population that is being served or the centralization of services that are being provided. This Committee is forming something different, but with the same concept towards some of these startup dollars and even delayed benefits, there may be models the Committee can point to as incentives for where physicians should be transitioning, to either an electronic medical record or something more collaborative, and becoming more like a neighborhood, where there is a dentist, for example, who would participate. The Committee will need to work to define this concept and introduce to physicians the larger picture of making this work.

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Nancy Wyman spoke briefly, thanking everyone for all their efforts in working on this Committee.

Tory said that he and Ellen would like to bring others to the meetings beginning in January, either in person with presentations or sending papers or electronic presentations to help with further defining the health home/medical home. This Committee will need to put parameters around this so that it can be introduced to the larger body. Tory added that he feels that this Committee needs to come up with an impact statement, by defining medical home, looking at the parameters of NCQA accreditation as well as looking at models that are nearby that work. He asked if Committee members had suggestions for anyone who could share their knowledge with the group. Keith suggested that it would be helpful to hear from someone with an integrated view of what's going on around the country, to learn what the state of the art is. He suggested Bruce Landon, who could perhaps give an overview of some of the pilot programs in Boston, and lessons that have been learned during the process. Kathy LaBella said that it would be valuable to invite someone from the American Dietetic Association or the CT Dietetic Association. Registered dietitians are part of the medical home model for prevention, so they should be considered for this effort. She said that she is the State Policy Representative, so she would be willing to be the contact, or it could be Theresa Dotson, who is the Public Policy Coordinator. Drew Morton said that he is a member of the American Academy of Physicians' Assistants, who has been working on this concept and looking at models in other states. He said that group would probably be willing to make a presentation to the Committee.

Maureen Smith said that she found it interesting that the Committee has representation from a private insurer in supporting medical homes. She said that it would be interesting to hear from Anthem regarding the payor aspects of this, and how it impacts the delivery system. Ellen pointed out that the Committee also has representatives from Aetna and CHN who could speak. Jim Augur said that Anthem is engaged in about a half dozen pilot projects across the country that are in various stages, most of them all payor models. Anthem has also worked with independent organizations that have done some level of review of those pilots, and Jim said he'd be happy to bring these resources to the table. Rick Duenas said that the University of Bridgeport, which is the local chiropractic school, would be happy to provide some input. They also have a College of Naturopathic Medicine, and if there's interest from the Committee, he could arrange for a representative to make a presentation. Another idea Rick presented was inviting someone from the Veterans Administration Hospitals, where chiropractic providers have been successfully integrated into their programs. Ken described a medical home pilot project in Rhode Island that this Committee might benefit from contacting. It is a multi-payor initiative, with a small number of practices, and it is gaining experience and doing well. Ken said he had recently attended an ACP meeting, and that there were some wonderful presentations given on the realities of how to implement medical homes, with physicians speaking about the pluses and minuses that have been discovered. Additionally, Ken said that Pfizer has done a lot of work in collecting information about medical home projects around the country, and they have created an informative manual. Ken has a copy of the manual, and said that he would

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contact Pfizer to see if they would be willing to send a representative to speak to the Committee, and maybe bring copies of the manual to distribute. Ellen said that she was familiar with RI's work with medical homes, and that their efforts are excellent; however they only have a small number of medical homes. Pennsylvania has a massive number of medical homes, and Ellen said that she had heard an excellent speaker from PA who she'd like to invite to speak to the Committee. Minnesota and North Carolina have also done much work on this issue. Ellen also reminded the Committee that the report of recommendations must be completed by July, and that there wasn't time to have a multitude of speakers here. One of the things to help in narrowing this down is to look around the state. Ellen also suggested contacting the Patient Centered Primary Care Collaborative, which is a collaborative of payors and business groups that are working on this initiative. Maybe hearing about their pilots and their tracking would help the Committee with time management.

Domenique Thornton said that she'd prefer to be looking at this as "person-centered" rather than "patient-centered." It is the person, as an individual, who will be directing his/her own recovery and treatment, by taking responsibility for it, and hopefully this will get them to do what they should be doing. She asked if insurance companies, as payors, would be willing to compensate the work of physicians for providing the comprehensive coordination of care, rather than the way it is now, where there is only payment for treatment. If this were so, physicians would be getting paid for moving patients down the road to wellness. Domenique also wanted to make the Committee aware of the SAMSA CMHS grant for an additional 7 million dollars for the integration of primary and behavioral health. CT was one of fourteen recipients last year; one group in Milford received \$500,000 for integrational behavioral and primary care.

An unidentified speaker mentioned a local resource, the Tripp Center at UConn Health Center. They have been working on evaluating medical home projects in NY, and might be willing to share their findings with the Committee. An unidentified speaker said that it would be helpful to him if he had a list of 5 - 7 core qualities of a medical home that the Committee agrees on, with maybe a few qualities that aren't that deep, or some core outcomes, allowing him to put things into perspective. He said that the existing list of suggestions begins with standard certification for medical homes. Starting out with accreditation as a short term goal, rather than coming up with what the homes could migrate to in a reasonable amount of time in CT, is very intimidating. The sense of the core qualities is lost, because of jumping around, due to financial reasons or for accreditation reasons. He continued by saying that a lot of excellent programs that developed around the country and in CT were based on what was doable and what made sense. The migration to accreditation occurred 5 -10 years later. He said that he likes to work with a standardized thing, so that the process is clear. Ellen said that was skipping ahead, that the Committee was still figuring out who to engage in accomplishing its mission, and in defining the medical home. She also said that maybe the Committee should hear from NCQA, to learn about the requirements for medical homes, and the different levels of medical homes.

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Joanna said that she'd like to hear from sources that bring data-driven information to the table, specifically on health outcomes and on financing issues. She felt that another item of interest is how well this would work in states that have multiple payor systems that may not have built onto medical home settings. Joanna said that she felt that this Committee needs to find a focus. Bruce Gould said that he attended a meeting recently where Multi Payor Advanced Primary Care Initiative (MPAPCI) was discussed. This initiative had been announced at a White House briefing in September. The New England Governors are collaborating around these pilot programs, looking at multi payor experiments and pilots in medical home. Bruce said that he believed that CT was the only state not participating. Ellen said that CT is a Chartered Value Exchange, and that's all about multi payor (inaudible). Bruce said that there is concern that this is one of the first times Medicare has come to the table with other payors to actually look at different models of payment that would promote transition to a different way of delivering healthcare. Bruce also said that he wouldn't want CT to be left out of this. Ellen said that there is a SustiNet Provider Advisory Committee that would be working on this. Bruce said that he just wanted to push CT into this consortium, feeling that it would be beneficial.

Tory said that he and Ellen would go through their lists and decide who to bring to the table in the new year. Tory asked Committee members to look at a list of issues to be considered. Jennifer Jaff asked that patient/education/incentives/involvement in medical homes, essentially the patient's role in the medical home, be added to the list of issues to be discussed. An unidentified speaker said that she felt that children's issues and perhaps elderly issues should be added to the list. An unidentified speaker asked which population would get priority in medical homes, asking if it would be the chronic care population. The same speaker said that the federal bill addresses some of the issues being asked here, and that some of the decisions have already been made and are included in the bill. The bill largely focuses on Medicare, and if that's where the money is going, (inaudible).

Keith mentioned the issue of population health. He said that the Committee has targeted populations here, but these are groups that might need extra attention and resources. He said that the Committee should also think about population health in general, and how to manage groups of patients so that everyone's getting the best quality care. Keith continued by saying that the Committee needs to keep track of outcomes of chronic health issues. Rick requested a copy of NCQA standards and certifications. Ellen's reply was inaudible. He also said that regarding financial support, he wondered if the Committee could consider costs for education of providers, to help with transitioning into medical homes. Ellen said that this was addressed in the federal bill. An unidentified speaker said that the NCQA standards are available on their website www.ncqa.org and recommended that all Committee members familiarize themselves with them. Judith Meyers suggested that it would be helpful if each Committee member had a notebook containing core resources, with reading materials for all to read and share. Some of the NCQA key studies could be included, along with other pertinent information. Ellen pointed out that there was valuable information posted on the SustiNet website www.ct.gov/sustinet. Tory asked that members send suggestions for relevant reading materials to the co-chairs for posting onto

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the site. An unidentified speaker said that in the North Carolina plan, they addressed coordination of health providers and human service providers, making sure that people who are vulnerable are also being assessed for food stamps or other basic needs. Drew Morton said that regarding the coordination of other providers and programs, the Committee might want to consider adding ancillary services, such as laboratories. Often labs are the central focus for duplication of efforts, and tests that don't necessarily need to be done are repeated. Outpatient centers also need to be part of this, because even though they are in the business of making money, services shouldn't be duplicated. Maureen said that it is important that each Committee member take responsibility for looking at information posted online for other Committees, so that if needed, issues can be brought to the attention of other Committees, particularly for IT and provider reimbursement. Sandi said the Committee should consider school based health centers as possibly providing duplication of services.

Jim said that he felt it would be helpful to have definitions of many of the things being discussed. For example, what is care coordination in the Committee's view, in the medical home. He continued by saying that it would be easier to adopt NCQA standards, because that defines things. If the Committee doesn't choose to do this, there needs to be a set of definitions to help with making recommendations to SustiNet. This would also prove to be helpful in Committee meetings, so that everyone knows exactly what is being discussed. Dominique said that there was a report in the Commonwealth Fund about care management, and described it as a coordination of care; their website is www.cmwf.org. Care coordination is particularly important for people who have behavioral health issues, because they may have difficulty navigating the system on their own; but it's useful for everyone, helping to reduce costs and coordinate care. An unidentified speaker said that he wanted to agree with the importance of population based care from two aspects, for populations with special needs, and also for geographically based community health centers, which is a whole other stream of funding. He said that the closest model he knows of is in Springfield, MA. He said that another aspect is the challenge of installing a medical home in an FQAC or a hospital based Medicaid practice, which would be quite different from doing this in smaller practices. He continued by saying that he feels that the Committee needs to look at four or five practice models, looking at their goals, and developing an awareness of the differences in their capabilities. The same speaker continued, saying that in terms of NCQA, he doesn't have any problem in reaching toward their standards, but to set accreditation as the goal while this is being developed is intimidating. He felt that it was more important to get each practice up to their core values for their core outcomes.

Ellen said that the Committee needs to learn more from NCQA before deciding that their standards are impossible to reach. There need to be some standards set in order to receive reimbursement. Many states are embracing NCQA, so this Committee needs to look into their standards, to see if this will work for CT too. An unidentified speaker that there are different levels of accreditation, so that perhaps if a higher level won't work here, there will be a lower level that could be attained. Ken said that there are many practices in the state that would qualify at level 3, but they haven't gone through the accreditation process because currently there is no change in reimbursement to do so. The practices who have used the

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ACP Medical Home Builder product have found that the vast majority of them are qualifying at level 1, just because they are running good practices. Ken also said that he feels that there are many practices that would be certified at some level if given the opportunity to do so in some coordinated manner that this Committee may help to articulate. James Sterling asked if it was within the authority of this Committee to recommend a specific reimbursement strategy to SustiNet. If so, then if the Committee recommends a strategy it would allow practices and care providers and payors to jump on board. If that strategy is adopted, it would put some stability in the marketplace. James said that this could be a focus of this Committee.

Sandi said that she wanted to talk about defining the terms that are used here. She felt that it was important to have some sort of framework. For example, case management and care coordination are often used interchangeably, yet these terms are very different. In the pediatric world, there are three levels of care coordination that are recognized; she could obtain that information to share with the Committee. Ellen said that she would like to collect such information, and continued by saying that she'd also like to sort out what these terms mean, and that the Committee will need to decide what it wants to do functionally. Sandi said that she thinks that the Committee members need to all be speaking the same language. Dominique suggested that the Committee could start with the enabling legislation of Section 6 in paragraph C-2, which is the charge to the Committee, and using that, go down that line and agree to make recommendations on that basis. Drew added that the way the Committee measures its own success should be part of any evaluation done. The Committee might create a wonderful concept, but if nobody buys into it, that would certainly be a measurement of how successful the Committee had been in designing and selling this. The work of the Committee should be measured as well as that of the participants. Les Holcomb said that he agreed, and suggested that one of the things the Committee could do is to count the number of meetings remaining until July, and then work the agenda backwards to meet certain thresholds at certain times. Ellen said that a timeline has already been established. Les also said that the Committee should take some of the elements of financial support and payor savings, including the state, and create a third one, then take some of those out and break them into some of the things that have already been said about reimbursement and incentives, and make that a separate category. Rick asked if under the category of coordination with other providers and programs, would this include state agencies, such as DPH and DSS, in reporting certain diseases. Ellen said that the coordination referred to was care coordination, but that if those agencies have a role in treatment, they should be included. Ken said that local health departments and districts provide many different services, and that it would be helpful to coordinate with them.

Ellen emphasized that any links to resources should be sent to the SustiNet website where it will be filed under recommended reading materials. Any information to be used for meetings should be sent to Ellen or Tory. Tory reminded all members that meeting minutes will be posted on the SustiNet website www.ct.gov/sustinet and asked everyone to review them before the next meeting so that there can be a vote on whether to accept the minutes. Tory said that the next step for this Committee is to decide on which groups to consult,

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focusing on the ones that will help the Committee to define and set parameters around what the group wants the medical home to be. Ellen pointed out that she is going to try to get access to technology to assist with things like cancellations due to weather, and also in viewing presentations, because there is no funding for travel to bring people in from other states. If this isn't possible, the Committee will conduct conference calls. Tory said that there would be a doodle link sent to Committee members in order to schedule the next meeting.

Meeting was adjourned.

Next meeting TBD.

DRAFT