Michigan Health Information Technology (HIT) Commission
Meeting Minutes

Date Tuesday, September 24, 2019, 1:00 p.m. – 3:05 p.m.

Location Grand Conference Room, South Grand Building, 333 South Grand Avenue, Lansing, Michigan 48933

Commissioner Attendance

Name	*Representing*	*Attendance*
Norman Beauchamp, M.D.	Schools of Medicine	Absent
Nicholas D'Isa, **co-chair**	Health Plans or Other Payers	Absent
Sarah Esty	Department of Health and Human Services	Present
Jack Harris	Department of Technology, Mgmt., Budget	Present
Rozelle Hegeman-Dingle, PharmD	Pharmaceutical Industry	Present
Jonathon Kufahl	Hospitals	Present
Paul LaCasse, D.O.	Doctors of Osteopathic Med. and Surgery	Present
Pat Rinvelt	Purchasers or Employers	Absent
Thomas Simmer, M.D., **co-chair**	Nonprofit Health Care Corporations	Present
Renée Smiddy, M.S.B.A.	Consumers	Present
Heather Somand, Pharm.D.	Pharmacists	Present
Jim VanderMey	HIT Field	Absent
Michael Zaroukian, M.D., Ph,D.	Doctors of Medicine	Present

Michigan Department of Health and Human Services (MDHHS) Staff:
Kimberly Bachelder, Erin Mobley, Meghan Vanderstelt, Trevor Youngquist

Guests:
Umbrin Ateequi, Rosalin Beene-Harris, Brianne Carpenter, Cynthia Green-Edwards, Robin Hepfinger, Helen Hill, Larry Jessup, Alyssa Jones, Jim Kamp, Sharon Kim, Ryan Koolean, Tesia Looper, Julie Lowry, Brian Mack, Bruce Maki, Rebecca Miller, Jerry Morin, Drew Murray, Arun Natarajan, Liz Palena-Hall, Shreya Patel, Heather Sprague, Jackie Sprout, David VanderKlok, Phil Viges, Joel Wallace, Lindsey Weeks, Jason Werner, Forrest White

Minutes: The regular Health Information Technology (HIT) Commission meeting was held on September 24, 2019 with nine (9) commissioners in attendance.

A. Welcome and Introductions

Presented by the commission chair

a. Co-Chair Thomas Simmer called the meeting to order at 1:00 p.m.
b. Co-Chair Simmer asked all commissioners to introduce themselves and share any updates since the last time the commission convened. The commissioners did not have any updates
c. MDHHS Division Director for Policy and Innovation Meghan Vanderstelt introduced MDHHS staff present.

B. Commission Business

Presented by the commission chair

a. **Welcome New Commissioners**
    i. Co-Chair Simmer introduced the new commissioners:
        1. Paul LaCasse, D.O., representing Doctors of Osteopathic Medicine and Surgery, is a former executive vice president of Beaumont Health
        2. Renée Smiddy, M.S.B.A, representing consumers, is the director of research and performance measurement for the Michigan Health and Hospital Association
        3. Michael Zaroukian, M.D., Ph.D., M.A.C.P., F.H.I.M.S.S., representing Doctors of Medicine, is the Chief Transformation Officer for Sparrow Health System and a professor emeritus at the Michigan State University Department of Medicine

b. **Review of the 5/28/2019 Minutes**
    i. Co-Chair Simmer asked commissioners to review and consider approving the minutes from the May 28, 2019 meeting.
    ii. Co-Chair Simmer made a motion to approve the minutes, which was seconded by Commissioner Rozelle Hegeman-Dingle. There were no objections to approving the minutes, and they were approved unanimously.

C. MDHHS Update

Presented by Meghan Vanderstelt, DHHS Director for Policy and Innovation, and Sarah Esty, Representing DHHS on the Commission and DHHS Senior Deputy Director for Policy and Planning

a. **Update on HIE Advanced Planning Document (APD) Approval**
    i. Ms. Vanderstelt explained that the state's health information exchange (HIE) APD, submitted to the Centers for Medicare and Medicaid Services, was approved earlier in the year. She also mentioned that the state's APD for its Eligibility and Enrollment (E&E) systems was approved recently. She explained that the E&E APD supports the department's Integrated Service Delivery (ISD) initiatives in the MiBridges system. The funding allows for Michigan to build out and further improve its statewide HIE infrastructure.
        1. Activity One in the APD enhances the state's core HIE infrastructure.
            a. The core infrastructure allows for further developments to the Michigan Health Information Network's (MiHIN) Active Care Relationship Service (ACRS)
            b. It also creates a MiHIN Intelligent Query Broker (IQB) service.
            c. MiHIN will also create a front-end platform for consumers and providers to access MiHIN services and electronic health information (EHI)

2. Activity Two creates a MiHIN statewide electronic Consent Management Service (eCMS)
    a. She mentioned that Shreya Patel, MiHIIN National Health and Priacy Policy Advisor, will present on the state's effort to implement this system later in the meeting.
3. Activity Three creates MiHIN statewide directory and customer relationship management tools for Coordinating the Care Coordinators
    a. The tools will establish a MiHIN registry for non-licensed care coordinators (e.g. chronic disease managers, success coaches, etc.)
    b. The platform will allow for information to be disseminated to these professionals and create a statewide "phone book" for care coordinators
4. Activity Four creates an alert and notification system for direct secure communications, in partnership with the University of Michigan School Department of Learning Health Sciences
    a. This system will create prediction models to identify patient risk for poor health outcomes and for potential treatment failures
    b. Initial demonstrations of the system include detection of potential treatment failure for beneficiaries on complex medication regimes, early warning on opioid usage, and identifying target areas for direct anti-viral agents for hepatitis C virus

b. **Update on Resolutions**
    i. Ms. Vanderstelt updated the commission on the standing resolution to "work to create a 5-year roadmap for which the HITC will use to guide activities and functions."
    ii. Ms. Vanderstelt noted that department has been working alongside its partners, such as federal Health and Human Services and the Michigan Chapter of the Health Information and Management Systems Society (HIMSS), to develop plans for updating the state's last HIT roadmap, called the Conduit to Care.

c. **Creation of a Statewide HIT Strategy**
    i. To update the state's strategy for HIT, Commissioner Sarah Esty described the two initiatives to support this work.
        1. Commissioner Esty described the MDHHS initiative to updates its internal data strategy.
            a. She explained that the department is working to understand data needs across its administration, such as identifying opportunities to share enrollment files for program evaluation, cross enrollment, and detection of fraud, waste and abuse.
            b. She described how the Policy and Planning Administration is looking to engage with other agencies

to identify opportunities for intra- and inter-departmental data sharing partnerships.

   c. She mentioned the department's initiative to form a data science center of excellence, in order to maximize analytics potentials, leverage expertise and streamline coordination on data projects.

2. Commissioner Esty detailed how an internal MDHHS data strategy will inform the creation of an updated statewide HIT roadmap.
   a. She mentioned that the current HIT strategy, called the Conduit to Care, was last updated a decade ago.
   b. Working alongside the Policy and Planning Administration and partners, she described how an updated road map would:
      i. Provide a 5+ year vision and plan for improving HIT in the state
      ii. Engage commissioners and a broad set of stakeholder groups across the continuum of care to establish priorities. She described how stakeholder convenings would look to assess what the needs and priority projects are in the state and look to understand what the baseline is for interoperability and use case integration.
      iii. Work alongside MiHIN in its creation of an implementation companion, in its Advancing Interoperability (AIO) initiative
      iv. Seek grant funding to expand resource capacity and to provide stakeholder convenings with a neutral third-party
   c. Commissioner Esty presented the commissioners with a draft list of stakeholder groups to engage in the HIT roadmap planning process.
3. Commissioner Esty laid out proposed plans over the next six (6) months to develop the state HIT roadmap.
   a. She asked commissioners to envision what the ideal state of HIT and HIE would be. She stated that stakeholder convenings with business leaders in the broader healthcare ecosystem will explore this topic.
   b. She asked commissioners to consider what the barriers are to HIT adoption and prioritization of HIE in organizations. She explained how stakeholders will be asked to consider barriers and collaborate on potential solutions.
   c. She stated that, as part of stakeholder convenings, legal and technology barriers to interoperability will be explored.

d. She mentioned that the HHS Office of the National Coordinator for Health IT (ONC) has offered the state technical assistance in pursuing an updated roadmap. She stated that their expertise can assist the state in leveraging best practices identified in other states' pursuit of long-term HIT strategic planning.
e. She challenged the commissioners to consider how they would like to be involved in the creation of statewide HIT roadmap.

ii. Commissioner Esty concluded by asking other commissioners for feedback or questions.
1. Commissioner Renée Smiddy asked what type of data sharing the HIT roadmap would consider.
    a. Commissioner Esty stated that the roadmap would focus on a plan for the development of the state's HIE infrastructure. This infrastructure includes health information sharing use cases, data sharing agreements, core services, and technologies not yet realized that could help to support care coordination.
2. Commissioner Smiddy asked about what type of patient data would be considered in this initiative, such as in-patient data, out-patient data or nursing home platforms.
    a. Commissioner Esty explained that, for instance, the department maintains technologies that are adaptable to a diverse range of datasets and use cases, such as its Care Connect 360 platform. She stated that elder care would be central in conversations about the future state of HIT, and that solutions could include evaluation of new opportunities to support the work of Area Agencies on Aging and their access to information about residents served.
3. Co-chair Simmer discussed the single statewide "network of networks" system currently implemented in the state. He stated that the roadmap should consider ways to ease excessive unloading and repackaging of information shared. He stated that skilled nursing does currently participate in HIE, through the MiHIN ACRS. He mentioned that the roadmap should consider how to add value to health information sharing and participation in the infrastructure, such as leveraging reporting for many services (e.g. to disease surveillance systems, to Emergency Medical Service systems, etc.).
4. Commissioner Paul LaCasse stated that the department has the expertise to lead in this initiative, alongside the commission. He discussed how the diverse representation on the commission will help to guide the process along the way.

iii. Ms. Vanderstelt read comments shared with her from Commissioner Jim VanderMey, who was not able to attend the meeting.
   1. She stated that Commissioner VanderMey expressed interest in a subset of the commission leading this initiative. She stated that Commissioner VanderMey envisioned this subcommittee of the commission serving as a more involved sounding board outside of meetings.
   2. She suggested that Commissioner VanderMey could act as a liaison between the commission and any outside engagement pursued by a subcommittee.
      a. Commissioner Esty stated that a subcommittee could offer a range of opportunities for inclusion in road map activities. She suggested that the department could share a schedule of stakeholder engagement sessions with commissioners.
      b. Commissioner Esty asked the commission to consider how to best structure stakeholder engagement sessions for the roadmap. She implored about the best method to structure meetings and how to schedule (e.g. by geographic region, by sector, etc.).
         i. Commissioner Michael Zaroukian discussed his background with HIMSS and his willingness to help in this effort. He suggested that the roadmap planning should consider how to make use cases more relevant in the long term.
         ii. Commissioner Smiddy suggested that representation from dental be included.
   3. Ms. Vanderstelt offered Commissioner VanderMey's suggestion of including non-licensed providers in roadmap planning activities, as well.
   4. Co-chair Simmer suggested that home-based care providers and other specialties be specifically called out in the list of groups to engage.

iv. Commissioner Esty explained that stakeholder convenings would explore what the business priorities are across the various sectors. The goal would be to produce a prioritized set of goals to pursue, which would support a state vision for HIT, and to increase buy-in of statewide solutions. A state vision for HIT could include:
   1. Focusing on support of "all point to all point" infrastructure
   2. Developing a fully integrated system with optimized systems that reduce provider administrative burden

v. Commissioner Zaroukian added that the roadmap should focus on addressing trends that are upcoming, such as the rise of telehealth and the next frontiers of research in medical schools. He stated that HIE supports a big ecosystem, and that the state needs the analytics capacity to identify who is falling through the cracks.

vi. Commissioner Esty stated that pre-planning work to begin the roadmap has already started. She said that the schedule of stakeholder convenings will be shared the commission, as it is created. She concluded by saying that a report on emerging themes relevant to roadmap creation will be shared at the next meeting.

D. HHS/Office of the National Coordinator for Health IT (ONC)

Presented by Arun Natarajan, ONC Senior Policy Analyst

a. Arun Natarajan, Larry Jessup and Liz Palena-Hall introduced themselves to the commission. They explained their relation to HHS, with ONC reporting to the Office of the Secretary.
b. Mr. Natarajan expressed the dedication of HHS to Michigan's pursuit of an updated HIT roadmap.
c. He mentioned that ONC has assisted other states in establishing their HIT roadmaps, such as in Colorado (CO) and Rhode Island (RI).
    i. He stated that HIT roadmaps are an incredibly beneficial planning activity for states to pursue.
    ii. He explained how roadmaps are beneficial to states:
        1. By addressing the "health IT stack"
        2. By gaining buy-in from stakeholders
        3. By bringing stakeholders together to connect on common goals
d. He explained the modular functions of HIT, as expressed in the "stack"
    i. He described how a fully functioning healthcare ecosystem occurs at the beneficiary level (i.e. person, patient), at the provider level, at the payer level, at the state level, and at the federal level.
    ii. He detailed how the "health IT stack" needs to support all five levels in the healthcare ecosystem.
        1. He explained the data sources coming in from all systems, including:
            a. Electronic health record (EHR) systems
            b. Non-provider systems that support care coordination
            c. Social determinant of health (SDoH) information, such as from:
                i. Education sources
                ii. Corrections sources
                iii. Human services sources
        2. He described the foundation on which the stack resides
        3. He detailed how effective data sharing use cases should work.
            a. A clear business case is needed to move the data, with incentives to support its operation.
            b. Business arrangements, such as agreements and standards, need to be in place to support the use case's operation.
            c. Legal and financial supports are foundational to a use case's success.
            d. Use cases need rules of engagement.

        iii. He asked the commissioners if any clarification on terms listed on the stack were needed.
    e. He explained how state HIT roadmaps are beneficial, for reasons including:
        i. Roadmaps can guide future state government investments.
        ii. Roadmaps can implement sustainable services that support private and public business.
            1. He explained how ONC has no preference on whether HIE services are publicly or privately owned.
    f. He explained how CO created and implemented a HIT roadmap.
        i. He described how CO benefits from the strategic planning.
            1. It allowed for internal and external feedback on where state investments should be made for HIT.
            2. It ensured that the community's needs (e.g. across the healthcare ecosystem) were being met by government.
            3. It allowed for more frequent updates on strategic planning prioritization. CO convenes stakeholders quarterly to reevaluate priorities.
            4. CO secured $30,000,000 in CMS funding through APDs from its consensus-driven HIT strategic planning.
                a. State-match dollars could better utilize private sector funding, given the buy-in from roadmap planning.
    g. He explained how RI is currently in the process of updating its HIT strategic plan.
        i. RI initiated a Request for Proposal to secure a neutral third-party consultant to facilitate strategic planning across the state's healthcare sectors.
        ii. The consultant will assist in:
            1. Developing a project plan
            2. Conducting an environmental scan of the state's HIT infrastructure
            3. Convening the state's HIT stakeholders
            4. Developing a gap analysis to identify where improvements are needed
            5. Developing a road map that will be presented to the state's HIT commission for approval
        iii. He listed lessons learned from RI.
    h. As Michigan looks to update its HIT strategic plan, he mentioned some of the quick wins from other states who started the same process:
        i. Better cooperation and coordination among HIT vendors and health information networks (HINs) by convening to discuss successes and barriers in a neutral setting
        ii. Managed Care Organizations have better understanding of value when convened to discuss their point of view and goals pertaining to HIT
    i. He stated that ONC is committed to Michigan's success in developing a roadmap and will support its development.
    j. ONC welcomed questions from commissioners.

- i. Commissioner Smiddy asked when CO and RI began their roadmaps.
    1. Mr. Natarajan stated that CO began planning for their first HIT roadmap almost 10 years ago, and that RI started pre-planning for their 9 months ago. He added the RI just awarded a contract to a consultant.
    2. Co-chair Simmer asked ONC what Michigan could be doing better in HIE and HIT.
        - a. Mr. Natarajan explained that Michigan has a strong team that understands HIT, such as in DHHS, the commission and other partners (e.g. HIMSS). He also stated that Michigan has a robust infrastructure in place. He said that Michigan will capitalize on its successes once it can convene its stakeholders to develop shared understanding of goals and priorities as part of developing the roadmap.
    3. Co-chair Smiddy stated that Michigan is a voluntary reporting state (i.e. there is no statute that requires reporting to HINs). She asked if businesses will be required to opt-in to HIE reporting.
        - a. Mr. Natarajan explained that HIT roadmaps are like lighthouses, allowing stakeholders to have a sense of what the state's priorities are. He stated that organizations have the choice to participate in HIE. He explained that HIT strategic planning allows for organizations to evaluate their role in HIE and how it can benefit them.
        - b. Commissioner Esty explained that the DHHS internal strategy is evaluating mandates and funding contingency related to HIT. She said it is looking to better understand what the collective responsibility is for HIE. She stated that the roadmap should evaluate conditions for participation and whether legislative changes should be considered.
        - c. Co-chair Simmer explained Michigan's incentive-driven model to increase the value of HIE participation. He stated that business now understands the value of HIE, aside from its incentive-driven value, and that less coercion is needed to implement health information sharing.

E. MiHIN Shared Services: "Advancing Interoperability"

Presented by Drew Murray, MiHIN Senior Community Engagement Director, and Brianne Carpenter, MiHIN Writer and Communications Specialist

- a. Drew Murray described the engagement MiHIN has initiated as part of its Advancing Interoperability (AIO) project.
    - i. He detailed the goals of AIO, including:
        1. Convening stakeholders to understand what interoperability is

        2. Exploring how MiHIN can better communicate with stakeholders about use cases
        3. Gain a deeper understanding of the strategic intent of health information sharing across sectors
    ii. He stated that AIO will enhance the organizational impact of a HIT roadmap
    iii. He described the history of AIO.
        1. AIO began in February 2019, based on the National Academy of Medicine's report called, "Procuring Interoperability: Achieving High-Quality, Connected, and Person-Centered Care"
        2. MiHIN invited stakeholders to a workshop to explore the possibility of an organizational interoperability pledge.
            a. The goal was to identify organizational champions and align for use case planning.
            b. Stakeholders were not ready to commit to a pledge at that time.
            c. Stakeholders wanted a long-term statewide strategy to support HIE initiatives, such as AIO.

b. Brianne Carpenter described subsequent conversations MiHIN pursued with stakeholders following the pledge workshop, including:
    i. Organizations wanted a better understanding of what interoperability is
    ii. The state needs more alignment of HIE initiatives and funding for it
    iii. Organizations wanted more opportunities to provide feedback to the state and HINs
    iv. Organizations wanted more data usability and to leverage best practices for integrating EHI into their workflow

c. She described the deliverable from AIO.
    i. AIO would develop companion resources to the state HIT roadmap to compliment its implementation. Elements of the AIO resource could include:
        1. An interactive web-based tool
        2. Self-assessment component for organizations to evaluate abilities and identify barriers
        3. Mechanisms to identify where barriers and opportunities exist in advancing towards systematic interoperability

d. She concluded by asking commissioners how the next round of stakeholder engagement, slated for early 2020, should include, how it should be done and ways to best elicit feedback.

e. Mr. Murray mentioned that stakeholder engagement for both the roadmap and AIO will include a variety of groups.
    i. He stated that stakeholders who have traditionally been involved in conversations about HIE, such as provider organizations and payers, are accessible through many other workgroup platforms
    ii. He explained that organizations who support social and human services will need to be onboarded to HIE conversations quickly. He explained the challenges in this pursuit.

f. MiHIN invited feedback from commissioners.
    i. Commissioner Esty asked whether AIO stakeholder engagement would include technological or programmatic organizational leaders.
        1. Mr. Murray stated that engagement thus far has focused on technological leaders.
        2. Ms. Carpenter added that the next round of engagement would focus on technological and provider voices.
    ii. Commissioner Esty stated that non-clinical providers have a different understanding and baseline of information sharing. She added that an online tool may not engage them in meaningful ways.
    iii. Commissioner Zaroukian explained how interoperability can be useful but can also infuse junk data into workflow. He challenged both the roadmap and AIO initiatives to explore:
        1. What the bright spots in HIE are, and where HIE is working
        2. Areas of health information sharing that are not working and hidden into workflow processes through delegation to support staff
    iv. He expressed concern in focusing on technical elements of HIE. He stated that the real drivers for strategic planning should focus on who receives the most benefit from effective health information sharing and the information it provides (i.e. clinical providers).
        1. Commissioner Esty stated that it may be useful to explore technical elements of HIE in setting where the state is removed as the convener. She provided the example of the state Prescription Drug Monitoring Program (PDMP).
            a. Commissioner Zaroukian shared the evolution of the PDMP, and how it has benefitted providers over time.
            b. He stated that the workflow processes of the PDMP have improved and that its modularity is a great asset for integration into provider workflow.
    v. Co-chair Simmer challenged MiHIN to continue exploring the baseline of HIT and where organizations want interoperability to go next.

F. MiHIN Shared Services: "Statewide Consent Management"

Presented by Shreya Patel, MiHIN National Health and Privacy Policy Advisor

a. Shreya Patel described MiHIN's history of electronic consent management (eCM) initiatives.
    i. She described the initial pilot of eCM.
    ii. She explained that the initial pilot led to a need for a more comprehensive solution to collection consent information.
b. She stated that MiHIN's Consumer Directory service, hosted as a web platform, was envisioned to have two modules to support a eCM service.
    i. One module to allow patients to manage provider relationships, maintained in the ACRS, and challenge discrepancies
    ii. Another module to complete a consent form online
c. She described the need to provide granular consent in the virtual platform, and how eCM could support that ability.

d. She provided an overview of the current eCM solution.
    i. eCM will collect patient consent in one of three ways
        1. Through a provider portal
            a. To protect patient privacy, an intake representative at a provider office will be prompted to give control of the device to the patient so that consent preferences can be reviewed confidentially
        2. Through the Consumer Directory portal
        3. On a paper form
            a. In a later phase, eCM will have the ability to collect consent information from a paper form through technology that reads scanned information
            b. The initial pilot of eCM will not include paper-based submissions
    ii. The current eCM solution collects consent to share behavioral health information. The pilot eCM will digitize the verbiage and fields found on the MDHHS-5515 form.
    iii. MiHIN will centrally store consent preferences submitted in the eCM service.
    iv. Protected information will be given a privacy tag to restrict information sharing, unless valid patient consent is documented in the system
        1. If no consent is found for a protected message, the message will not be routed to its destination and the sender will be alerted
        2. Privacy tagging in eCM will conform with Health Language 7 (HL7) international standards

e. She described how the current eCM will be scalable to other types of consent (e.g. consent for minors, for Human Immunodeficiency Virus [HIV] status, etc.).

f. She provided an overview of how proposed federal regulations (e.g. ONC's Trusted Exchange Framework and Common Agreement [TEFCA] and Substance Abuse and Mental Health Services Administration [SAMHSA] changes to 42 C.F.R. Part 2) is being considered as part of the eCM solution's development.

g. She invited questions and comments from the commission.
    i. Commissioner Zaroukian stated that there is a core data set needed in care settings (e.g. patient medication information, history of diagnoses and observations, lab results, immunizations, etc.). He implored that the sharing of these data points should not be restricted. He asked what the middle ground could be, given that there are certain data points that patients should be given the opportunity to not share (e.g. History of Present Illness [HPI], family background, etc.).
        1. Ms. Patel stated that these considerations would be incorporated into a future eCM workshop.
        2. Commissioner Zaroukian resounded that, for providers who are not provided medication history, care will be impeded.

ii. Co-chair Simmer inquired about the versioning of consent forms stored in this solution. He asked about how the service will alert providers of expired forms.
    1. Ms. Patel explained that the eCM solution will send notifications to providers of form expirations. She stated that the MDHHS-5515 form expires annually.
    2. Commissioner Zaroukian asked how to address the annual expiration of the MDHHS-5515 form, as it may be a burden to providers and patients to reissue it for updates every 12 months.
        a. Ms. Patel suggested that the commission work with the DHHS consent form workgroup to express this concern.
        b. Commissioner Zaroukian asked if the form could be more flexible to allow patients to choose an expiration date.
        c. Ms. Vanderstelt stated that the workgroup, formed in 2014 to standardize behavioral health consent forms, meets at least annually. She stated that she would bring the feedback to the next meeting.

G. Public Comment

a. Helen Hill explained National Health IT Week and extended an invitation to the Michigan Chapter of HIMSS conference.
b. David VanderKlok expressed concerns over patient privacy and consent to share EHI.
c. Jim Kamp shared additional details about the Michigan Chapter of HIMSS conference. He described the conference's presentation about the Gravity Project.
d. Brian Mack described the Great Lakes Health Connect 2019 Summit Series.
e. Drew Murray added details about the forthcoming follow-up conversations about AIO.

H. Adjourn

a. Co-Chair Simmer adjourned the meeting at 3:05 p.m