Quality Improvement Steering Committee (QISC)
January 23, 2019
1:00 p.m. – 2:30 p.m.
Conference Room 400 A & B
Agenda

I.	Welcome	T. Greason
II.	Introductions	T. Greason
III.	Approval of Agenda	T. Greason
IV.	Authority Updates	Dr. B. Butler
V.	Quality Improvement a. QAPIP Annual Evaluation (FY 2017-2018) b. Quality Improvement Program (FY 2019-2021) c. QAPIP Work Plan (FY 2018-2019)	A. Siebert/T.Greason
VI.	Utilization Management a. Utilization Management Evaluation (FY 2017-2018) b. Program Description (FY 2019-2021)	S. Ruza
VII.	Complex Case Management a. Complex Case Management Evaluation (FY 2017-2018) b. Complex Case Management Program (FY 2019-2021)	T. Forman
VIII.	Strategic Plan Update	C. Mann
IX.	Other	
X.	Adjournment	

Quality Improvement steering Committee (QISC) Meeting
Wednesday, January 23, 2019
1:00 pm – 2:30 pm
Conference Room 400 A&B
Meeting Minutes
Note Taker: Aline Hedwood

Committee Chairs: Barika Butler, DWMHA Chief Medical Director and Tania Greason, QI Network Administrator

Member Present:

Dr. Barika Butler, Tania Greason, Dana Lasenby, April Siebert, Brad Klemm, Starlit Smith, Eric Doeh, Tina Forman, Fareeha Nadeem, Allison Smith, Gail Parker, Nakia Young, Crystal Palmer, Sherri Ruza, Winifred Williamson, Dhanetta Brown, Karen Sumpter, Bernard Hooper, Sherri Ruza, Lezlee Adkisson, Taquaryl Hunter, Allison Lowery, Steve Jamison, Natasha King, Melissa Elbridge, and Jacquelyn Summerlin.

Members Absent:

Kip Kliber, Kimberly Flowers, MicheleVasconcellos, Mignon Strong, Corine Mann, Nasr Doss, Lorraine Taylor-Muhammad, Andre Johnson, Angela Harris, Dr. Bayley Zito, Bill Hart, PhD, Dr. Sue Banks, Gray Herman, Hubert Hubel, M.D., Jim Kelley, Judy Davis, Michael Hunter, Ortheia Ward, Donna Coulter, Robert Spruce, Sandra Ware, Virdell Thomas, Dorian Reed, Latoya Garcia-Henry, Sarina Oden.

Staff Present: Tania Greason, April Seibert, Fareeha Nadeem, Brad Klemm, Starlit Smith and Aline Hedwood.

1) Item: Welcome: Tania Greason

2) Item: Introductions – Tania Greason

3) Item: Approval of January 2019 Agenda: Revised

4) Authority Updates: None

5) Item: Complex Case Management (CCM) Program Description FY 2019-21 – Tina Forman

Goal: Review and approval of the CCM Program Description FY 2019-21

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce

NCQA Standard(s)/Element #: X QI #2 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decisions Made	Assigned To	Deadline
Tina Foreman discussed with the group that Case Management Society of America defines case management as a collaborative process that includes assessment, planning, facilitation and advocacy. However, it is a complex case management type service that complex case managers are completing; also, it is time limited and different then what you may think of as typical type Case Management Service. When the Authority developed this program we utilized the "Institute for Healthcare Improvement's Triple Aim" which talks about the three areas of focus to include: 1) Improving the person experience of care 2) Improving the health populations 3) Reducing the cost of healthcare DWMHA CCM program is currently available to children, youth, and adults who are eligible for Medicaid, dual eligible members with both Medicaid and Medicare including MI Health Link, SED and Autism Waiver benefits. **The goals for the Complex Case Management (CCM) program are to:** • Improve medical and/or behavioral health concerns • Provide early intervention to reduce recurrence crisis and hospitalizations • Facilitate communication between the members and their behavioral health and medical care providers • Connect members with community resources • Improve adherence to treatment • Gain skills for self-management • Access to community resources and better understanding of medical and behavioral health concerns. **Services Offered:** • Care Coordination to support and assist person • Coordination of Care between medical and behavioral health providers • Referrals to community resources • Education and promotion of self-management • Advocacy to ensure needed service are received • Support to meet goals identified in the Plan of Care For additional information please review PowerPoint DWMHA "Complex Case Management" on the following topics: a) Eligibility b) Criteria for Adults c) Criteria for Children/Youth d) Referral Process/Submission of Referrals	IHC Unit	Complete

e) Evaluation/Overall Results		
Discussion	**Assigned To**	**Deadline**
• Brad Klemm inquired if the CCM Process is independent of the assessments and completed while the members are receiving services through our provider network. **Answer:** it's totally separate • Karen Sumpter inquired about SUD services that are in addition to mental illness when identifying chronic Asthma what was the determining factors to choose the services provided. **Answer:** it was a real problem in the City of Detroit and surrounding areas after IHC met with representative from Children Hospital to identify protocol. • Sherri R. suggested to the group that maybe we need to revisit the standards for the Referral Process because historically UM was referring stickily though the MI Health Link population. However since we brought in SMI and IDD population as well we need to revisit the standards for generation of referrals. • Eric Doeh asked what has been done to assist with lowering ED usage. **Answer:** we do face to face with the members, contact members by phone or letter, IHC accompany the members at their CMH visits on an occasion. However, the overall engagement and interaction with the members help to reduce the ED visits. • Eric Doeh asked are you referring the members to other clinical services and what are you doing instead of having the member going to ED. **Answer:** we are completing an overall engagement and referring the members to their CMH.	IHC Unit	Complete
Action Items	**Assigned To**	**Deadline**
The Complex Case Management Program Description was approved per Dr. Butler and the Committee with no revisions	IHC Unit	Complete

6) Item: Quality Improvement Plan FY 2019-21 – April Siebert

Goal: Review and Approval of the QAPIP for FY 2019-21

Strategic Plan Pillar(s): □ Advocacy □ Access □ Customer/Member Experience □ Finance □ Information Systems **X Quality** □ Workforce

NCQA Standard(s)/Element #: X QI #2 □ CC# ___ □ UM #____ □CR # ___ □ RR # ___

Decisions Made	Assigned To:	Deadline
April Siebert informed the group the Quality Improvement Plan is the vehicle for improving quality of care for the members that DWMHA serves. QI has highlighted some of the changes made to the plan, which include removal of MCPN language. In addition, we revised the QI purpose because we wanted to ensure that our focus for FY 2018-19 is to move forward with true Systems Transformation. QI has also added language regarding documentation for serving a culturally and linguistic membership, which is a NCQA requirement. The QAPIP also contains the core functions of DWMHA's Strategic Planning pillars (six pillars and seven-focus areas). In addition, the six Pillars are on page 7 of our QAPIP plan along with the Strategic Planning Forces areas. QI has highlighted in the QAPIP our plan to identify Holistic Care providers. DWMHA has begun transforming its role in the behavioral health system from funder of care to manager of care with the Holistic Care approach, which will continue to provide behavioral and physical health interventions and focus on social, economic, spiritual and housing services. These interventions will improve and expand care for mental health and SUD services within Wayne County. For additional information, please review the attached PowerPoint "DWMHA Quality Improvement Plan FY 2019-21.	IHC Unit	Complete
• **Eric** questioned the efforts done thus far for preparing and educating DWMHA consumers/providers for the HCBS Final Rule, because it could potentially be a very significant change for DWMHA's Providers Network. **Answer:** the most important thing for our network is to assist with training and educating our providers about the Final Rule. Providers have completed the HSW and B3 surveys conducted on the final rule by MDHHS. QI is currently assisting and working with our provider network to complete the Plans of Corrections for the HSW services. QI will begin to work with providers within the next month to complete the Plans of Corrections for the B3 service surveys. More providers meetings and forums to educate providers on the requirements that will allow for compliance with the Final Rule will be forthcoming. • **Bernard** asked have you worked on a communication plan with those managers to facilitate and explain to them exactly what their rights are under the Finale Rule. **Answer:** QI have had meetings with the Case Managers and are currently completing audit reviews to discuss the final rule concept. Case Managers have begun to revise the IPOS to incorporate the requirements for the Finale Rule. In addition, MDHHS has coordinated and submitted surveys to the providers regarding the finale rule to deem where providers are with the required changes; QI is working with providers to answer POC's as required.		
Action Items	**Assigned To**	**Deadline**
The Quality Improvement Plan FY 2019-21was approved per Dr. Butler and the Committee with no noted revisions	QI Unit	Complete

6) Item: Quality Improvement Evaluation FY 2017-18 Tania Greason

Goal: Review and approve the Quality Improvement Evaluation FY 2017-2018

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce

NCQA Standard(s)/Element #: X QI #2 ☐ CC# ___ ☐ UM #____ ☐CR # ___ ☐ RR # ___

Decision Made	Assigned To	Deadline
Tania Greason stated the purpose of the evaluation is to analyze QI performance related to the goals and objectives developed by the DWMHA Board of Directors Strategic Plan and to review the UM activity for FY 18. Tania thought it was important to include the "Population Served by Funding Source" Race, Age, and Disability Designation because this breaks down our cultural diversity and helps to identify any identified barriers. 51% of DWMHA members are allocated to Medicaid funding source and 22% through Healthy Michigan the data presented in the evaluation is effective for last FY 17. The FY 2017/18 QAPIP highlights are aligned in accordance with DWMHAs Board of Directors Strategic Plan. The evaluations includes each of the Pillars and identified focus areas listed below. The evaluation includes each of the Strategic Plan (6) Pillars: 1) Customer Services 2) Access 3) Workforce 4) Finance 5) Quality 6) Advocacy QI Strategic Plan Focus Areas by Definition: 1) Increase community inclusion and integration 2) Enhance crisis management and response 3) Expand capacity for improving practices 4) Enhanced recovery oriented system of care 5) Achieve operational excellence 6) Implement integrated care 7) Improve Health and safety For additional information please review PowerPoint "DWMHA Quality Improvement Evaluation FY 2017-18"		
Discussion		
• The group had a few questions regarding the data for services provided. **Answer:** Tania will review the data for accuracy and make the necessary changes. • Bernard asked is there anything in the plan specifically for Children hospitalizations? **Answer**: Through MMBI, we separate data for each of the required indicators for children and adults.	QI Unit (T. Greason)	February 2019
Action Items	**Assigned To**	**Deadline**
The Quality Improvement Evaluation FY 2017-18 was approved per Dr. Butler and the Committee with no noted revisions.	QI Unit	Complete

7) Item: Annual Review of DWMHA UM Program Descriptions – Karen Sumpter (UM Notes Taken Sherri Ruza 1.24.2019)

Goal: Review and approve the DWMHA UM Program Description

Strategic Plan Pillar(s): □ Advocacy □ Access □ Customer/Member Experience □ Finance □ Information Systems **X Quality** □ Workforce

NCQA Standard(s)/Element #: QI □ CC# ___ X UM #1 □CR # ___ □ RR # ___

Discussion/Decisions Made	Assigned To	Deadline
Members were provided a copy of the DWMHA UM Program Description FY 2019-2021 and a power point that highlighted the revisions prior to this meeting. Karen Sumpter reviewed the following changes: ● The revised Utilization Management (UM) Program Description covers FY 2019-2021. ● Throughout the document, reference and documentation regarding the MCPNs was removed. ● The three Children's Crisis Screening entities (The Children Center, New Oakland Child, Adolescent and Family Center and The Guidance Center) are being included because they are delegated the Pre Admission Screening Review UM function. Thus, the use of the plural term "The Crisis Service Vendors" is used throughout the document. ● Section VII. DWMA's Strategic Plan and the Utilization Management Program, pages 5-6: ● The Advocacy Pillar and definition was added. *Advocacy: Establish leadership in shaping public policy for behavioral health in Michigan that fosters regional cooperation, inform, and engages local and state resources as well as stakeholders.* ● Under the Advocacy Pillar, the focus area "*participation in shaping state and regional UM policy, procedures and practices."* ● Section VIII. Section VIII. DWMHA System Transformation, pages 6-8: This section was added and provides an overview of Section 298 and how DWMHA has begun to transform its structure and role in the behavioral health system. ● Section X. Committee Structure Section, page 14: Sherri Ruza explained that in the past, the UMC has met monthly. However, changing the frequency of the meeting was discussed in the 2/8/19 UMC meeting during which Dana Lasenby recommended meeting monthly with internal staff for a shorter period i.e. 30 minutes to 1 hour and quarterly including stakeholders such as providers that meets for a longer period i.e. 1.5 hours. The members of the QISC meeting were in agreement with meeting monthly and having providers attend quarterly. ● Section XI. Program Goals, page 16-17: The goals remain the same but the appropriate pillars were added to the goals. • Section XIII. Delegation of UM Functions and DWMHA Oversight, page 22-24: This is an example of where the MCPNs were removed and the plural of the Crisis Service Vendors was used. ● Section XX. Utilization Management/Provider Appeals and Alternative Dispute Resolution Section, pages 31-40: The Crisis Service Vendors can issue medical necessity denials. However, DWMHA now handles all medical necessity appeals and alternative dispute resolution reviews. In addition, this is now only one internal level of appeal/review as opposed to having two levels previously. Dana Lasenby recommended adding the words "physician (MD or DO)" so the statement should read, "The Crisis Service Vendors' physicians (MD or DO) can issue medical necessity denials. ● For the Serious Emotional Disturbance (SED) Wavier Section, page 52-54: Per Monica Hampton, Black Family Development and Developmental Centers were added as providers so now 5 providers. ● Attachment #5, DWMAH Quality Department's Case Record Review Tool, page 65-77: Per Starlit Smith, the revised tool has been completed. The 2018-2019 case record review tool will be forwarded to UM. ● Attachment #6, Template for the UM Annual Evaluation, page 78-82: The template no longer includes the MCPNs but now it includes the plural of the Crisis Service Vendors.	UM Unit QI Unit (T. Greason)	Complete February, 2019

● Attachment #6, Template for UM Annual Evaluation, page 78-82: The MCPNs were removed and the plural of the Crisis Service Vendors is now used. ● Attachment #8, Access Center and Crisis Service Vendors UM Plan Outline, page 88-89: The MCPNs were removed and the plural of the Crisis Service Vendors is now used. ● Attachment #9, Access Center and Crisis Service Vendors UM Plan Audit tool, page 90-93: The MCPNs were removed and the plural of the Crisis Service Vendors is now used. Ms. Sumpter then reviewed the UM Department's performance activity related to timeliness and notification of UM decision making. The problem is that the UM Department has not been able to validate the timeliness of UM decision making for continued stay reviews for the SMI and IDD populations because it is a self-reported manual tracking process. The intervention is for the UM Department to replace the self-reported manual tracking system with an electronically recorded time of continued stay review decisions for the SMI and IDD populations that will generate MHWIN reports and dashboards. The outcome will be for the UM Department to use data from an objective, real time tracking system of the timeliness of UM continued stay decision making for the SMI and IDD populations. Eric Doeh recommended the UM staff begin to communicate to the providers the elimination of the MCPNs in the UM policies and procedures despite Community Living Services still functioning. Tania Greason, Co-Chair of the QISC, then asked if the members including Barika Butler, MD, DWMHA Chief Medical Officer and Co-Chair of the QISC, approved the UM Program Description FY 2019-2021, and all members approved the document.		
Action Items	**Assigned To**	**Deadline**
DWMHA UM Program Description FY 2019-21 was approved per Dr. Butler and the Committee with no noted revisions.	UM Unit	Complete

8) Item: DWMHA UM Program Evaluation FY 2017-18 – Jennifer Miller (UM notes taken by Sherri Ruza 1.24.2019)

Goal:

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems ☐ **X Quality** ☐ Workforce

NCQA Standard(s)/Element #: QI #2 ☐ CC# ___ X UM # 1 ☐CR # ___ ☐ RR # ___

Decisions Made	Assigned To	Deadline
Annual Review of the DWMHA UM Program Evaluation FY 2017-2018: (UM 1, Element C): Members were provided a copy of the DWMHA UM Program Evaluation, the Executive Summary and a power point that highlighted the evaluation. Jennifer Miller stated that in FY 2017-2018, the seven (7) UM goals were aligned with the strategic plan pillars The UM Program Evaluation FY 2017-2018 includes data and information as evidence for meeting all 7 goals. She then briefly highlighted each goal as follows: ***Goal 1***: Advance implementation of standardized UM Program Description to assure effective and efficient utilization of behavioral health services through ongoing development and oversight (Access Pillar). Met as Evidenced by: The delegated entities of the Access Center, Crisis Service Vendors and the MCPNs were required to align their UM Program Plans and policies with those of DWMHA. All delegated entities' FY 17-18 UM Program Plans aligned with DWMHA's UM Program Description. ***Goal 2*****:** Promote participation and use of specialty behavioral health waiver programs. (Access Pillar) Met as Evidenced by: • Habilitation Supports Waiver maintained 95% capacity in MDHHS mandated slots 12/12 month • 1,452 cases are opened in the Autism Spectrum Disorder Benefit • Children's SED Waiver set a target of serving 65 children and 67 were served ***Goal 3***: Identify patterns of behavioral health service utilization by funding source and by monitoring over and under-utilization of services using dashboards. (Finance Pillar) Met as Evidenced By: • Review of some of the primary funding sources over the past three fiscal years shows a stable funding mix with the most significant change in General Fund. For FY 15- 16, 17% of claims were paid with GF, in FY 16-17, 12% of claims were paid with GF, and in FY 17-18, 10% of claims were paid with General Fund. This decrease over the years may be attributed in part to the active role that the MCPNs and providers are taking to enroll uninsured consumers into Medicaid/Healthy Michigan and to the Utilization Management Department oversight of General Fund requests. • The median Length of Stay for Adults with Severe Mental Illness was 7 days for each of the 4 quarters. Similarly, the median LOS for Children with SED was 6 days. The median length of stay for individuals with IDD was 10 days for the 2nd quarter, and all days for the remaining three quarters. • The number of admissions in FY 17-18 due to a lack of crisis residential beds ranged from 41 - 239 per quarter. This is a significant improvement from FY 16-17, when the range was from 271-302 admits per quarter, due to the lack of a crisis residential unit bed. The reduction is likely due to the opening of a Boulevard Crisis Residential Unit. • 637 clients received Intensive Crisis Residential services in FY 17-18, compared to 487 in FY 16/17 (31% increase). • 1,172 clients received Partial Hospital services in in FY 17-18; a 32% increase from 887 in FY 15-16. • There were 642 MI-Health Link Inpatient Admissions; 112 members were readmitted for a readmission rate of 17%. This is a 3% improvement from the previous fiscal year. • SUD members frequently receive more than one level of care. (detox, residential, outpatient) Each episode of care is considered an admission. The number of individuals served from FY 16-17 to FY 17-18 increased by 3% and the number of admissions	UM Unit	Complete

(episodes of treatment) from FY 16-17 to FY 17-18 decreased by 15%. There are numerous reasons that may account for the reduction in the number of admissions. One factor may be successful treatment outcomes.

***Goal 4*:** Assure fair and consistent review decisions.(Quality and Workforce Pillars) Met: Use of MCG Behavioral Health guidelines by DWMHA, MCPNs, Screening Entities, and ACT Providers – 12, 597 cases entered into Indicia, 220 registered users. Eighty-eight staff successfully tested in Inter-Rater Reliability.

***Goal 5**:* Engage community stakeholders in implementation of processes that promote clinical review procedures, practices and corrective actions to ensure system wide compliance with DWMHA, State, Federal regulations. (Quality Pillar) Met as Evidenced By: Several workgroups or routinely scheduled meetings provided forums for consumer and providers that addressed activities focused on improving utilization, efficiency, and overall quality of care such as the Hospital Liaison Workgroup, Bi-Monthly SUD Meetings, and Quarterly MCPN, Access and Screening Entity UM meetings.

Goal 6: Provide oversight of delegated UM functions through use of policies that reflect current practices, standardized/inter-rater reliable procedures and tools, preservice, concurrent and post-service (retrospective) reviews, data reporting (i.e. timeliness of UM decisions and notifications (Quality Pillar) Met as Evidenced By:

- Making – Delegated entities at or above 90% threshold.
- Implemented mechanisms to improve Autism and SUD timeliness- SUD exceeded 90% benchmark 7/12 months compared to 0/12 months in previous FY. Autism determinations improved in 4th quarter where 2 of the 3 months met 90% benchmark after staff vacancy filled.
- During FY 17-18, there were 96 Medical Necessity Denials, 35 appeals, 29 Upheld, 6 Overturned. There were 674 Administrative Denials, 34 appealed, 26 Upheld, 8 overturned. During the NCQA accreditation review, all requirements in this area were met with 100% compliance.

Goal 7: Utilizing MCPNs, Provider and Practitioner Satisfaction Surveys related to service access and Utilization Management, make recommendations for improvement regarding service provision, treatment experiences and outcomes. (Customer Pillar) Met as Evidenced By:

- CLS and COPE conducted member satisfaction surveys. Satisfaction was reported at over 90% for CLS. COPE conducted the "Perception of Care" survey for consumers and their natural supports. During FY 17-18, a total of 1,145 surveys were completed. The overall satisfaction rate, based on "Strongly Agree" and "Agree" ratings was 96%, which is a 4% increase from the previous fiscal year.
- Provider Network Satisfaction with UM was conducted in both FY 17 and FY 18. Both surveys indicate need for improvement in the authorization and reauthorization process. Timeliness issues as reported have been addressed. Improved communication and forums have occurred and will continue throughout system transformation

Ms. Miller then talked about the integration of MCG into MHWIN. She explained that based on a new Request for Proposal issued by the PIHP Parity Workgroup, MCG was awarded a contract for all the PIHPs to use MCG behavioral health guidelines in order to demonstrate use of the same medical necessity criteria across the state. Integration into MH-WIN, installation of new software, and project plans will be developed and implemented in FY 18-19. She also mentioned that the UM Department continues to collaborate with the IT Department on the development of the following dashboards:

- ✓ Standard Individualized Plan of Service to be tied to Authorizations in MH-WIN in order to monitor over and underutilization of services;
- ✓ Changes in Level of Care for Adults with SMI over the course of treatment would provide visual view of progress throughout time in treatment;
- ✓ Inpatient Recidivism and Outpatient Supports and Services – Further dashboard development is required for inpatient recidivism, level of Care Assessments, outpatient services and supports, and their impact on determining range of services authorized and UM Service Guidelines.

Action Items	**Assigned To**	**Deadline**
The DWMHA UM Program Evaluation FY 2017-18 was approved per Dr. Butler and the Committee with no noted revisions.	UM Unit	Complete

9) Item: Inter Rater Reliability Summary Report – Jennifer Miller (Note Taken by Sherri Ruza 1.24.2019)

Goal:

Strategic Plan Pillar(s): ☐ Advocacy ☐ Access ☐ Customer/Member Experience ☐ Finance ☐ Information Systems **X Quality** ☐ Workforce

NCQA Standard(s)/Element #: ☐ QI #___ ☐ CC# ___ X UM #1 ☐CR # ___ ☐ RR # ___

Decisions Made		
UM2, Element C) Jennifer Miller distributed the Inter-Rater Reliability Summary Report, and presented the report to the QISC members. Committee members were reminded that the purpose of the testing is to ensure consistent application of medical necessity criteria for all staff making UM decisions. In October and November of 2017, the UM Department, using the MCG/Learning Management System, rolled out the first administration of Inter Rater Reliability Tests to 139 staff making UM decisions. However, she went on to say the report she passed out today focuses on testing conducted with new hires after December 1, 2017 through September 30, 2018. She went on to share eighty-eight (88) staff from COPE, Carelink, DWMHA, New Oakland, and ACT staff tested and successfully exceeded the threshold of 90%. She also mentioned the annual testing of active staff is planned for February utilizing case studies from the 22nd edition of MCG. (notes taken by Sherri Ruzi 01.24.2019)		
Action Items	**Assigned To**	**Deadline**
NONE	UM Unit	Complete

10) Item: Strategic Plan Update – Corine Mann

Goal: Review Strategic Plan Update

Strategic Plan Pillar(s): □ Advocacy □ Access □ Customer/Member Experience □ Finance □ Information Systems X **Quality** □ Workforce

NCQA Standard(s)/Element #: X QI #2 □ CC# ___ □ UM #____ □CR # ___ □ RR # ___

Discussion/Decisions Made		
NONE		
Action Items	**Assigned To**	**Deadline**
Table until next meeting		

New Business: None

Next Meeting: Thursday February 21, 2019, 4th Floor Conference Room 400 A & B.

Adjournment: 3:20 pm

ah 02.07.2019