



MEDICAL ADVISORY COUNCIL MEETING MINUTES

CHILDREN'S SPECIAL HEALTH SERVICES

May 17, 2008

Present from the North Dakota Department of Health: Terry Dwelle, MD, State Health Officer, North Dakota Department of Health.

Present from the Children's Special Health Services Division (CSHS): Tamara Gallup-Millner, Division Director; Robert M. Wentz, MD, Medical Director; Devaiah Muccatira, SSDI Program Coordinator; Sue Burns, Program Administrator; Kora Dockter, Program Administrator; Melissa Evans, Eligibility & Claims Administrator; Denise Kirsch, Office Assistant; and Diane Bruley, Administrative Assistant.

Present as Medical Advisory Council Members: Marcus M. Fiechtner, MD; Jacob Kerbeshian, MD; Thomas Mausbach, MD; Dennis Sommers, DDS; and Thomas Jacobsen, MD.

Present as Guest: Jennifer Restemayer, Family Advisory Council member.

Absent: Lois Freisleben-Cook, MD; Thomas D. Carver, MD; William Klava, MD; Bruce Levi, ND Medical Association; Joanne Luger DDS; Siriwan Kriengkrairut, MD; Ellen Ketterling, MD; Myra Quanrud, MD; Gary Betting, MD; and Alicia Phillips, CSHS.

WELCOME & INTRODUCTIONS

Tammy Gallup-Millner gave a warm welcome and thanked the Medical Advisory Council members for their assistance during the past year. Introductions were made and the agenda reviewed.

OPENING REMARKS

Terry Dwelle, MD, State Health Officer welcomed Children's Special Health Services to the Department of Health (DoH). CSHS is located in the new Special Populations Section of the DoH, which currently includes the Children's Special Health Services Division and the Office of Health Disparities. Dr. Dwelle thanked Children's Special Health Services staff for the leadership provided on behalf of the children with special health care needs population and relayed appreciation for multidisciplinary services such as the asthma clinics.

CSHS UNIT OVERVIEW

Tammy Gallup-Millner provided an overview of the CSHS Division. The Division's mission is to improve the health of children with special health care needs. It functions with eight full-time staff and the part-time services of Dr. Wentz, the CSHS Medical Director. CSHS also utilizes county social services staff that help with eligibility and care coordination activities. CSHS administers MCH Title V Block Grant funds devoted

to children with special health care needs. CSHS shares funding from this federal grant with other divisions in the Health Department. The Title V Block Grant award to North Dakota for FFY 2008 was about \$1.8 million, which was a cut of about \$18,000 from FFY 2007. Of the total amount awarded through the block grant, one-third, or approximately \$605,000 is earmarked for CSHS. CSHS also receives federal funding from a State Systems Development Initiative grant, which supports MCH data related activities such as needs assessment, performance monitoring, data linkages, surveys/registries, etc. The CSHS Division budget for the 2007-2009 biennium, which is a combination of federal and state matching funds, is about \$2.4 million. With current funding, CSHS has the ability to make small adjustments but not implement changes that have a major budgetary impact.

Tammy shared some programmatic highlights. Last year, CSHS served over 2,000 children through a variety of service programs. The demographics indicate about half of the children served are under the age of 5, the majority are white, but close to 7% were American Indian and there are slightly more males served than females. Eighty-eight percent of children served had a source of health care coverage. About two-thirds were covered by private insurance. Time-intensive coordination of benefits is often required. The availability of other programs such as Healthy Steps, the Caring Program, and Medicaid is making a difference for children in our state. In the last couple of years, a decrease in the children with a known source of health care coverage served by CSHS was noted. When the division began to include individuals served through information and referral services, the source of health care coverage was often unknown.

In the last year, about 314 children were served in the Specialty Care Diagnostic and Treatment Program. These programs help pay for medical services for eligible children. Financial eligibility is at 185% of the federal poverty level or \$39,220 for a family of four. A \$20,000 per year maximum per client is allowed and only a few children have reached this limit; however none in the last year. CSHS has paid about \$190,000 in claims in the last year. Conditions CSHS paid the most for during the year were handicapping malocclusion, diabetes mellitus, heart conditions, cleft lip and palate, asthma, and leukemia.

In the Multidisciplinary Clinic Program, over 1,100 kids were served. This is more than half of all the children served through CSHS. CSHS currently supports 10 different types of clinics, three of which are managed from the state office. These include the Cardiac Care for Children Program, Scoliosis clinics, and Cleft Lip and Palate clinics. The cardiac program continues to grow, but there are ongoing challenges with access to pediatric cardiologists in the state. The scoliosis clinics have recently been discontinued while the cleft lip and palate clinics continue to hold steady. CSHS funds seven other multidisciplinary clinic types which are managed by various contract entities within the state. Families indicate high satisfaction with services, which is assessed through family interviews and telephone surveys. About 99% of families reported that clinics helped them manage their child's condition. Eighty percent of clinic recommendations were met.

Case management services through the Care Coordination Program continue to be provided through county social services, CSHS state staff, and one public health unit. Twenty-four individuals were served over the last year through the Metabolic Food Program. State law requires CSHS to provide formula to all eligible individuals with Phenylketonuria and Maple Syrup Urine Disease. CSHS also provides low protein food for Medicaid-eligible clients with Phenylketonuria.

The division continues daily operations of an Information Resource Center. Activities such as a toll-free number, information requests, division e-mail, presentations, outreach mailings, etc, are ongoing. A lot of information is provided to new birth families.

Currently, two children are enrolled in the Russell Silver Syndrome Program, but CSHS has paid for growth hormone treatment and medical food for only one individual in the last year.

BUSINESS

Minutes: Dr. Fiechtner moved to approve the 2007 meeting minutes. Dr. Kerbeshian seconded the motion and all were in favor. The minutes were approved.

Provider Qualifications

Recertification of medical specialists

Melissa Evans informed the council she has been checking certification on CSHS providers. Some of the certification boards require physicians to re-certify. Thirty-five letters had been sent. Of the CSHS approved providers that responded, four have not re-certified and two are no longer employed with the facility they were with when they enrolled. One physician stated that re-certification can be hard for those who are not familiar with a computer and could pose problems for rural areas. CSHS policy requires physicians to be licensed in North Dakota and a diplomat of American or Canadian boards in their specialty, or have completed the formal educational training to take the final exam or been admitted for their final exam.

Doctors of Osteopathy are now starting to do their own Board Certification. It was recommended that CSHS monitor the certification process as the training must be done in an academy approved setting and the certification must come from a national accrediting board. Verification of appropriate certification should be through the American Board of Medical Specialists rather than a separate osteopath board.

Currently CSHS requires board certification at the time of enrollment. If the provider does not recertify after enrollment, CSHS encourages continued certification but does not require it. Dr. Kerbeshian recommended that CSHS only require board certification at the time of enrollment. This would eliminate the need to monitor the ongoing certification status.

Qualification of dentists providing conscious sedation

CSHS has received a request to cover conscious sedation to treat a child with multiple

cavities. The child could be treated in the dental office with conscious sedation or be taken to an out-patient surgery center for treatment. The child was eligible for Medicaid; however, it does not reimburse for conscious sedation. Currently, Medicaid reimburses only the cost of the medication. CSHS did approve a one-time coverage of the conscious sedation for this child.

Dr. Wentz stated that some standards do exist. He recommended that providers notify payers about their standards so the payers know what criteria needs to be met in order to authorize services.

Dr. Sommers conducted research on what qualifications are needed to offer this service. The American Dental Association has established guidelines for conscious sedation. The ND Board of Dental Examiners regulates and maintains a list of dental providers who meet the guidelines. A current list was provided to CSHS. There was discussion about asking the ND Dental Association to approach Medicaid and other payers for approval of this service.

Dr. Jacobsen asked if any children have died as a result of conscience sedation. It was stated that children in other states have died after being sedated.

Dave Peske asked why the board developed the guidelines. Dr. Sommers stated there has been some movement to try and regulate the care and to assure that providers are trained and equipped to provide the service. The board has moved to regulating this procedure in the last five years.

Qualification of mental health professionals

CSHS was asked if a Doctoral psychology student could fill in for a child psychologist at a cleft lip and palate clinic and be reimbursed at the level of a Masters prepared professional. Dr. Kerbeshian stated the provider must have their PhD and psychology license. A student should not be paid or working without direct supervision as the student would be practicing without a license. He relayed that Medicare has guidelines that most clinical organizations adhere to. The guidelines address different levels of supervision that are required for medical students and residents. It was suggested that CSHS should follow the Medicare guidelines.

Qualified specialists that do not enroll as Medicaid providers

Providers participate in CSHS clinics that have a Medicaid number, but will not accept Medicaid or CSHS payment for eligible children that need follow-up. CSHS is only able to use the Medicaid number to pay the provider an honorarium for clinics and not for treatment services. This situation places CSHS and the clinic team in an awkward position. When there is a shortage in the number of providers that will participate in the clinics, CSHS has continued to use the provider knowing this may impact families covered by CSHS or Medicaid.

Dave Peske recommended discussing the concern of not accepting Medicaid or CSHS with the provider. They may decide to see the child since they are part of the clinic team. CSHS staff acknowledged that some team members accept children seen at the clinic.

CSHS Medical Eligibility

The council has had ongoing debates over the years on what conditions to include on the eligible list. An update on the conditions that have recently been added follows.

Acquired Brain Injury

Traumatic Brain Injury is currently an eligible condition. CSHS staff recommend expanding this condition to Acquired Brain Injury. It would then include both traumatic and non-traumatic injuries to the brain. Traumatic brain injuries may include closed head trauma and penetrating wounds to the head. Non-traumatic brain injuries include injuries to the brain from toxins or anoxia (e.g., brain damage from a stroke, meningitis or near drowning). Perinatal types of injuries are excluded under this condition as the focus is on a normal brain that has been injured. This type of injury could likely be covered under cerebral palsy.

The council recommended acceptance with consideration of the following: 1) it is hard to see stroke as acquired, and 2) wording may need to be changed to non-traumatic brain damage and traumatic brain injury.

Immunodeficiency States

Immunoglobulin deficiency is currently eligible. CSHS staff recommend expanding the condition to include Immunodeficiency states. Examples of covered disorders that involve deficiency in the antibody portion of the immune system include:

- X-linked agammaglobulinemia, common variable immunodeficiency, selective IgA deficiency and selective IgM deficiency
- Deficiency in the cellular components of the immune system which may involve a reduced capacity to produce the cells or an impairment of the cells ability to kill microorganisms. An example of this type of disorder is AIDS, which is acquired as result of infection with HIV and results in impaired number and function of T-cells.
- Mild immunodeficiency with normal immunoglobulins, that do not have associated clinical relevance, would not be covered.

The council recommended acceptance with consideration of the following: 1) HIV should be clinically relevant to be covered as it can be a mild immunodeficiency.

Syndromes

Coverage of syndromes will be addressed on a case-by-case basis and is limited to those that require ongoing medical treatment. Syndromes that are covered must meet the following established CSHS criteria:

1. Chronicity - the medical needs associated with the condition are long term or lifelong.
2. Medical management - care requires periodic consultation by a medical or dental specialist or management by a multidisciplinary team.
3. Complexity - treatment of the condition requires at least two or more of the following:
 - prescription medication
 - special equipment, braces, prosthetics or supplies
 - therapy (occupational, physical, speech or respiratory therapy)

- related services (developmental, educational, mental health, home health, family support, social, or nutritional services)
 - surgery or hospitalization
4. Effective interventions are available that have a reasonable probability of benefiting the individual by improving health and function or extending longevity.
 5. Seriousness – the condition greatly impacts a child’s life, such as daily living activities or there is a high likelihood that the condition would have an impact if not addressed.

Behavioral/developmental syndromes such as Asperger Syndrome are excluded as are minor syndromes which result in minimal morbidity or disability (e.g.) Horner’s Syndrome – drooping eyelid, small pupil and lack of sweating on one side of the face.

Dr. Kerbeshian recommended careful use of the word syndrome. This could be done by using ICD 9 and ICD 10 codes as guides. He also recommended looking at the specific aspects of the condition.

Dr. Jacobsen suggested that saving all syndrome applications and having a conference call every three months to discuss which syndromes and services should be covered is an option.

When talking to families regarding eligibility, Dr. Mausbach suggested using the five criteria that must be met (i.e., chronicity, medical management, complexity, interventions, and seriousness). He also suggested adding “Meeting Criteria” or add limited to the condition heading.

After discussion, it was recommended that CSHS try to implement this policy for the next year and report back to the council at its next meeting.

Uncovered Conditions

Morbid Obesity

CSHS staff worked with the Healthy Weight staff in the Department of Health to identify services available for obesity.

Services for morbid obesity include:

1. Clinic/hospital dietary services
2. NDSU Extension Office (e.g., Family Nutrition Counseling, Kids nutrition website, etc.)
3. Maternal Child Health Nutritionists located in local Public Health Units
4. WIC staff
5. Special program such *My Weigh* at Mid Dakota Clinic and *Shape Down* at Medcenter One

Mental Health

Currently CSHS does not routinely cover mental health services. CSHS staff met with the Division of Mental Health and Substance Abuse to discuss public mental health

services. Currently, the state system serves clients through eight regional Human Service Centers which sees many Medicaid-eligible individuals and the uninsured population. Access is not always timely. There can be waiting lists to receive services and evaluations. There is a lack of appropriate mental health professionals such as psychiatrists and psychologists to meet the needs of clients. Some clients access services through emergency departments. Health systems are doing more with telehealth in order to improve access to services.

Appropriate housing can be an issue in the youth and elderly. There is a need for transitional living placement options. Youth aging out of foster care may not have a family to live with. Independent Living coordinators are creative in assisting youth/young adults through the system.

CSHS receives frequent calls regarding coverage of mental health disorders including services and medication. Staff have also received calls from families that have children with Aspergers, an Autism spectrum disorder. Kids with Aspergers are generally higher functioning and may not meet eligibility criteria for Developmental Disability services.

As kids with developmental disabilities, autism etc. get older, parents are unable to meet their needs. There is a lack of community resources including case aide services, mentors, guardians, transportation, housing and employment. Children are sometimes referred for out-of-state placements such as Copper Hills in Utah which is better able to meet the needs.

Primary care providers are being asked to screen children for mental health disorders, but once identified, it is unclear whether the system of care is available to support them.

There was a discussion that Autism has become the public focus like ADHD was a number of years ago. It's perceived that schools and parents push for this diagnosis in order to access services.

One method of treatment is applied behavior analysis which is very expensive and would need to be applied when the child is very young. Most children are not able to access this treatment because it is very expensive and few providers have been trained on its use.

Three states, including North Dakota, have received Special Congressional Initiative Funding to develop an Autism Spectrum Disorder Treatment Program. The North Dakota Center for Persons with Disabilities received a three-year grant to start this program. The goals of this program are to:

1. Establish a research and treatment team
2. Conduct community diagnostic clinics
3. Conduct follow-up monitoring clinics
4. Use telemedicine and teletherapy systems
5. Create an infrastructure to support individuals with Autism.

Gap Areas in CSHS medical eligibility

CSHS documents applications received for ineligible conditions. In the last year there have only been a handful of conditions that have been denied (e.g., mild asthma, ear infection – not related to eligible conditions, allergies, apraxia, and emotional/behavioral disorder).

CSHS also documents any phone calls that are received from families seeking services for conditions not currently eligible under CSHS. When reviewing those files, the conditions that were ineligible were extensive dental caries – without an eligible dental condition, Autism, ADHD, Anxiety and Depression. Usually when a family calls requesting services, they are encouraged to send in a report to determine medical eligibility and referred to the county to complete an application.

Financial Eligibility

Cost Share Reduction Policy

CSHS has developed a cost share reduction policy. This policy would allow transportation expenses, when related to the child's eligible condition, to be used to reduce the family's share of the costs if they are above CSHS income guidelines. This policy was developed as a starting point that would allow CSHS to gain experience with travel related expenses.

Dr. Jacobsen motioned for approval of the cost reduction policy and Dr. Kerbeshian seconded the motion. The motion was approved.

Experience Since Implementation of the \$20,000 Limit

CSHS did not have any children that reached the \$20,000 limit in the last year. In previous years there have been two children that had reached this limit.

Requests for Uncovered Services

CSHS also tracks requests for uncovered services by checking phone logs and reviewing administrative decisions made at staff meetings. In the past year, requests were received for lodging/travel and a mouth swab genetic test for celiac disease. At this time, CSHS only covers the biopsy when making the diagnosis of celiac disease. The other requests were for clients served through the Medicaid program. These requests were for a home health aid/personal care attendant, transportation coverage and payment for placement at the Anne Carlsen Center for Children.

Newborn Screening, Diagnosis and Treatment

A handout was provided listing the newborn screening data for various disorders. The data includes all resident and non-residents infants that are born in North Dakota.

In future, screening and short-term follow-up will be done by nurses in Iowa. As of June 1, 2008, a courier service will be implemented for the transportation of newborn screening specimens, which will decrease turn-around time for results from 8-10 to 4-5

days. The newborn specimen fees were increased from \$46.50 to \$60 per screen to accommodate this new service. In comparison, Montana fees are \$111.00 and Minnesota's are \$101.00. Minnesota's may also include a fee for the newborn hearing screening. Training sessions are being provided to health care facilities the month of May to discuss the courier service and rejected blood specimens.

CSHS provides formula for individuals with PKU and MSUD and can pay for care for children who are eligible for diagnostic and treatment services. Advice was sought regarding the following:

1. More formula options (e.g.) convenience "single serve" items
2. Add-ins
3. Coverage for additional conditions
4. Coverage throughout the lifespan
5. Nutraceuticals
6. New medications

Many of the disorders that are screened for require long-term follow-up strategies (e.g.) good birth outcomes for women with PKU, access to needed treatment throughout life, formula at cost, insurance coordination issues, management within a medical home, etc.

The Newborn Screening Saves Lives Act was passed April 2008. If grant funding is appropriated by Congress, CSHS staff relayed it would be helpful if the council could recommend areas that should be addressed.

Issues Related to Diagnostic Lab costs

On two separate occasions CSHS has talked with a family that has a child with muscular dystrophy. The pediatric neurologist recommended a genetic test to make a more definitive diagnosis on the type of muscular dystrophy. The families had the labs drawn and the physician sent them to a lab. In both instances, the lab (Athena) would not accept payment from a state program such as Medicaid or CSHS. The family has been left with the bill as the provider would not enroll as a Medicaid provider. The cost of the lab test is very costly (\$3,000 -\$10,000). If families are unable to pay for the genetic testing, the lab will not release the results.

CSHS has consulted with a developmental pediatrician from Utah and has enquired about this issue. She relayed having had a similar experience. Her philosophy on how to manage the child without the genetic testing is that the test was not available five years ago. She continues to treat the child in the same manner she would have then without the additional genetic testing.

CSHS had also spoken to staff at the ND genetics program. When ordering genetic testing they verify that the lab will accept the client's method of reimbursement/payment. They have the ability to review past client records to identify labs that may accept the client's health care coverage. If the lab will not accept the healthcare coverage payment, the family must find another way to pay for the lab or manage without that information.

Blood Tests for Celiac Disease

Currently, CSHS only covers biopsy when making the diagnosis of celiac disease. There are now blood tests that can be used to screen for celiac disease. The council recommended coverage of the serum screening blood test along with the confirmatory biopsy for kids going through the diagnostic process.

Programmatic Updates

Family Advisory Council

CSHS was pleased to have Jennifer Restemayer, Family Advisory Council member, participate in the Medical Advisory meeting.

Clinic Services

In the last year, over 1,100 kids were served through the Multidisciplinary Clinic Program. CSHS supported 10 different types of clinics, three of which are managed from the state office. These include the Cardiac Care for Children Program, Cleft Lip and Palate Clinics and the Scoliosis clinic. CSHS funds seven other multidisciplinary clinics types which are managed by various contract entities within the state. Families continued to be very satisfied with the clinic services supported by CSHS.

CSHS experienced a change with the scoliosis clinic this spring. In the last year and a half, Bismarck has been the only site for scoliosis clinics. Children from the western and central portion of the state attended this clinic which was held each spring and fall. This spring the facility that hosts the scoliosis clinic contacted CSHS and stated they would no longer be able to hold the clinics unless they were able to bill for each child individually. Since clinics were not being held on a regional basis, CSHS staff opted to discontinue the scoliosis clinics and instead have worked with the local public health nurses that conduct scoliosis screening in the schools and the local county social service staff to offer CSHS diagnostic services for children that receive a referral from school screening. By continuing to offer diagnostic services to these children, CSHS has fulfilled its obligation to the House Concurrent Resolution regarding scoliosis screening and follow-up.

CSHS experienced an increase in the number of children served in the Cardiac Care for Children program. This was due in large part to the participation of a pediatric cardiologist that started a practice in Bismarck. With the move of Dr. Rios to the Children's Heart Clinic in Minneapolis, CSHS expects its cardiac numbers to decrease in the next year until another full time pediatric cardiologist is recruited to fill the position.

CSHS staff also participated in an outside review of multidisciplinary clinic services. This review was conducted by staff from the Utah Children with Special Health Care Needs program/ULEND project. During the review, staff reviewed clinic services, quality assurance measures, and some of the concerns or obstacles experienced in ND. The review was held in the last month so recommendations are not yet available. CSHS did find out that ND offers more services than many other states and could likely reduce some of its quality assurance activities.

ND Early Hearing Detection and Intervention (EHDI) Report

Staff continues to participate in the Early Hearing Detection and Intervention (EHDI) program. The program is funded through federal grants that have been awarded to Minot State University through the North Dakota Center for Persons with Disabilities. A new federal grant was received in April (Hear Now). This grant will continue to focus on enhancing the EHDI program by increasing the collaboration of community partners and the involvement of audiologists in the state on-line tracking system. North Dakota continues to have a great screening rate prior to hospital discharge (96%). Like other states, we experience difficulty in the children that are lost to follow-up. These are children that have been screened for hearing loss prior to hospital discharge and are referred for a re-screen. Currently 41% of the infants needing an outpatient screening did not return for the screening. Of the infants that did return for a re-screen, 64 of them were referred for a diagnostic evaluation. Of these 64 infants only 8 had diagnostic information reported in the web-based system. Currently, not all audiologists are using the system. Only one infant was identified as having a hearing loss in the web-based system. ND's screening and refer rates meet or exceed national benchmarks. The remaining measures show a need for continued support. These measures are dependant on many community systems (e.g., birthing hospitals, hearing screening providers, audiologists, families family support agencies, etc.) to achieve the targets and benchmarks. EHDI grant staff continues to work with community systems in an effort to improve results for these measures.

Dr. Fiechtner shared that it is beneficial to know if the child had hearing at birth (passed the screening) and then later developed a hearing loss. Knowing that the child had hearing at one time decreases the amount of testing that is required at time of diagnosis.

One of the goals of the program is to sustain the EHDI once federal grants are no longer available. One method of sustainability being discussed is to have a legislatively mandated EHDI program. EHDI stakeholders are determining whether a separate bill would be helpful. CSHS also submitted an optional budget request for an EHDI program. Priority initiatives have not yet been selected within the Department of Health.

NDCPD applied for a grant to increase the data integration of EHDI, Vital Record and the Newborn Screening Program data. Integration will help staff address infants that are lost to follow-up. If the grant is received it would be effective July 2008.

Medical Home Report

Activities are occurring around medical home in ND. Blue Cross Blue Shield has initiated an advanced medical home project. CSHS provided funding to the ND Chapter of the American Academy of Pediatrics to support medical home infrastructure. Many training opportunities are now available.

A major stumbling block is the lack of funding to support medical home implementation. The North Dakota Center for Persons with Disabilities applied for an Integrated Services Grant that focuses on the six system performance measure for Children with Special Health Care Needs, including Medical Home. If awarded, the grant would start June 1, 2008. An optional budget request to fund a Medical Home program was also

submitted by CSHS within the Department of Health. Funding to support medical home implementation in ten primary practices was included in this proposal.

System of Care for Children with Disabilities

Changes occurring in the system of care for children with special health care needs have a potential impact on CSHS. Recent changes affecting health care coverage include the following:

Waiver and Buy-In Program

SB 2326 provided funding for a new Medicaid waiver for medically fragile children and a Medicaid buy-in program for children birth through age 18 meeting SSI disability criteria up to 200% (net) of the federal poverty level. With the buy-in program, private insurance premium payments will offset the “buy-in” premium. The maximum premium will be 5% of a family’s gross income.

Medicaid is currently taking applications for these programs and there is a need to notify families about these coverage options.

CSHS staff provided the new Genetics State Plan with Medical Advisory hand-outs. The plan includes a list of recommendations, objectives, and action items.

CLOSING REMARKS/WRAP-UP

Four physicians have terms that will be expiring this year. They include: Drs. Carver, Kriengkrairut, Cook, and Mausbach.

Dr. Mausbach will forward suggestions for his replacement. CSHS will recruit providers to fill the other vacant positions.

Dr. Wentz closed the meeting after giving a warm thank you to the committee for all their hard work and support.