HEALTH CARE ADVISORY BOARD

Meeting Summary
February 13, 2012

MEMBERS PRESENT
Marlene Blum, Chairman
William Finerfrock, Vice Chairman
Rose Chu, Vice Chairman
Francine Jupiter
Dr. Marty Lebowitz
Dave West
Dr. Tim Yarboro
Rosanne Rodilosso
Ann Zuvekas
Ellyn Crawford
Susan Conrad

STAFF
Sherryn Craig

GUESTS
Anne Rieger, Inova Health System
Mark Runyon, Inova Health System
Jennifer Siciliano, Inova Health System
Dr. Vera Dvorak, Inova Health System
Rosalyn Foroobar, Health Department
Chris Stevens, Health Department
Dr. Jean Glossa, Molina Healthcare/Community Health Care Network (CHCN)
Bob Eiffert, Health Department
John Payne, Department of Housing and Community Development
Carol Jameson, Jeannie Schmidt Free Clinic
Brenda Gardiner, Department of Administration for Human Services
Sharon Arndt, Office of the County Executive
Susan Shaw, Health Department

Call to Order
The meeting was called to order by Marlene Blum at 7:31 p.m.

November Meeting Summary
The minutes from the January 9, 2012 meeting were accepted as presented.

Revised HCAB Work Plan
Agenda items on the HCAB's work plan have shifted to accommodate time sensitive items, like the Lewinsville Expansion Project and Health Care Reform.

Inova's Community Benefits Schedule

Anne Rieger, Vice President, Community Safety Net, briefed the HCAB on Inova's FY 2012 Community Benefits Schedule. To calculate Inova's total community benefits, Ms. Rieger asked the HCAB to exclude its estimated $36 million in bad debt. Inova's FY 2012 projected community benefits total $214 million after subtracting bad debt. The community benefits schedule includes Inova's uncompensated costs in providing care.

Ms. Rieger said there were no big surprises to report, but notable items include the increasing costs of indigent care, both inpatient and outpatient, along with the uncompensated costs of Medicaid.

The Inova Cares Clinics continue to provide OB and children's services. Expansion occurred in the children's clinic with the addition of a second and larger site in Reston. The number of children being served in Reston continues to climb and the clinic has added telemedicine services to increase patients' access to care. Inova experienced a slight increase in its women's clinic. To recapture service efficiencies, Inova has changed the way its delivers care, using group care models (e.g., centering) and preventive health practices (e.g., diabetics).

Inova's Juniper program was expanded to include transitional care management referrals. Electronic Medical Records (EMRs) were also implemented.

Ms. Rieger also announced that the National Committee for Quality Assurance (NCQA) has certified the Inova Care Clinics for Children and Inova's Juniper Program at the highest level of certification for medical homes. Certification for both programs will continue through 2015.

Inova's Health Equity Division will experience the largest investment in FY 2012 with the expansion of interpreter services and services for the hearing impaired.

Inova continues to provide cash donations or in kind infrastructure support to the Loudoun Community Healthcare Center, Loudoun Free Clinic, Loudoun Cares, Loudoun WIC Program, and Loudoun Child Advocacy Center. Inova also provides space for NOVA Scripts and the Center for Multicultural Human Service.

George Washington University (GWU) Pediatric and OB/GYN residents continue to rotate through Inova, but Ms. Rieger will follow up on the use of GWU urology residents.

With Inova's divestment of its long term care operations, Marlene Blum inquired about the increase in its Long Term Care (LTC)/Home Care Medicaid expenses for FY 2012. Ms. Rieger said that Inova budgets the cost of bed holds in its schedule of benefits. Inova will pay a nursing home to hold a bed for a patient it anticipates to discharge.

Likewise, Inova has budgeted startup costs to implement the Program for All Inclusive Care for the Elderly (PACE).

Ms. Rieger briefed the HCAB on the success of Promotores Health Salud. This program, organized around faith-based and community based organizations, trains volunteers to provide perinatal education to low income populations. Inova hopes to expand this program as part of its chronic disease community outreach education initiatives.

HCAB members should have received letters inviting them to participate in interviews for Inova's Community Health Needs Assessment. Dr. P.J. Maddox is working to gather data from local jurisdictions, including Fairfax, which completed the Mobilizing for Action through Planning and Partnerships (MAPP) process. The deadline for collecting baseline data and surveys is the end of 2012. Inova will then develop implementation plans for each facility, per the Internal Revenue Service's (IRS) regulations. Inova will be conducting community interviews with key stakeholders in addition to hosting a Survey Monkey-type instrument that collects internal feedback on community health care needs.

Ms. Rieger assured the HCAB that Inova is not duplicating, but rather building upon Fairfax and Arlington counties' MAPP processes. Because it is incorporating MAPP data from its community partners, Inova will not be starting at square one. Moreover, Inova's Community Health Needs Assessment must be conducted every three years.

Following up on Dr. Flint's comments in January that Inova will be opening a new adult safety net clinic, Ms. Rieger stated that this proposal is currently under evaluation. With an increasing portion of the uninsured population becoming eligible for Medicaid under health care reform, Inova is exploring the feasibility of partnering and developing a new primary care clinic site organized under an existing Federally Qualified Health Clinic (FQHC). Ms. Rieger will keep the HCAB informed as developments warrant. Rosalyn Foroobar also shared that the County is still pursuing an Exceptional Medically Underserved Population (MUP) designation.

A question was asked about Inova Cares for Children and Women clinics. Ms. Rieger said that there is no limit on the numbers or percentage of Medicaid/FAMIS or charity care patients the clinics will take. Budgeting for Inova's pediatric clinics includes the costs of care after Medicaid reimbursement. Mark Runyon stated that Medicaid covers 60-65% of Inova's care costs, leaving 35% that is unreimbursed.

Inova's 35% self-pay discount is not considered part of its community benefits schedule. Ms. Rieger did not know if this discount would be extended to the Inova Medical Group's (IMG) billing structure.

As a follow up to the HCAB's charity care discussions in the fall, Jennifer Siciliano is working to identify a date to convene the first Charity Care Workgroup.

Mr. Runyon answered a question about the bond market's effect on Inova's Capital Improvement Plan. Mr. Runyon said that the bond markets are very favorable and that Inova has not spent down all the money from its last borrowing. While there are limits on when additional financing can be secured, Inova is hoping to take advantage of the favorable rates and obtain financing in the spring. Mr. Runyon said that Inova wants to be opportunistic and position itself for financing as early as it can.

Inova's Transitional Care Management (TCM) Program

Vera Dvorak, MD, Medical Director, Care Coordination, presented on Inova's Transitional Care Management (TCM) Program, which targets unmanaged Medicare, Medicaid and indigent/self-pay patients diagnosed with congestive heart failure (CHF), acute myocardial infarction (AMI), diabetes, and/or pneumonia/chronic obstructive pulmonary disease (COPD). The goal of TCM is to reduce each disease population by 3 percentage points by July 2012.

The program currently accepts all inpatients, those in observation, or those in the Emergency Department (ED). Patients receiving dialysis, skilled nursing, assisted living, and hospice care services are excluded from the program, but followed by skilled home care. In developing the program, Inova chose not to follow managed care patients, assuming these patients would have access to disease management resources.

The TCM Model is a hybrid of the Colemen model of self-management and Inova vision. The four pillars of the program include:

- Medication reconciliation to mitigate any complications from what patients were taking prior to their hospitalization and what they may need to take post-discharge.
- Doctor follow-up appointment in 7-10 days post-discharge, which has been shown to reduce patients' rates of readmission.
- Patient and/or caregiver education on the warning signs of illness.
- Patient centered record to encourage ongoing communication between patient and provider.

TCM follows patients for 30 days post discharge. Contact occurs telephonically (minimum of five calls) using "call scripts" by disease. Calls are made on Saturdays allowing the program to capture patients discharged over the weekend.

The long term goal of TCM is to educate patients about their illness and how to manage their disease. Workers identify gaps in patients' care and make efforts to secure the services/resources they need. The program also conducts palliative care screens, depression screens, and Advance Directive planning. Workers will then track, assign, refer and document interventions using Allscripts/ECIN Referral Manager Plus.

TCM relies on Registered Nurses (RNs) and Case Managers (CCMs) as well as Health Coaches (HCs). The program employs 5 RNs and 1 non-RN, Licensed Professional Counselor. These workers review patients' medical records for appropriate referrals, identify issues, assign referrals, coordinate medication reconciliation with HCs, provide daily HC oversight and mentorship, and follow high risk cases.

TCM uses four allied health professionals – one licensed practical nurse (LPN) and one social worker (SW) – to provide telephonic coaching using Coleman's pillars. The Health Coaches are responsible for accessing gaps in patients' care, escalating concerns, providing case management/coaching, and making referrals.

The potential safety risks of patients transitioning from the hospital to their homes include:

- A lack of medical follow up for patients who are uninsured or who do not have a primary care physician (PCP).
- The safety and security of a patients' home environment is unknown.
- Identifying patients whose diagnosis is unclear (i.e., symptoms may present as other diseases/conditions) may leave some individuals to fall through the cracks.
- The lack of a shared medical record makes accurate medication reconciliation challenging.

Making doctor appointments for TCM patients is tough, since so many do not have a PCP and there is a shortage of physicians in the community willing to accept Medicaid and indigent patients. Inova Care Clinics have stepped up to the plate and are seeing TCM patients. The program also developed three strategies for working with patients that lack a permanent centered home.

First, Inova's VNA Home Health workers provide "eyes in the home" in cases where there is a sensitivity to a patient's home safety or there is a need to observe the patient. VNA Home Health is geographically varied and uses existing nurse staffing and scheduling to identify and train specific nurses. VNA Home Health provides 1-3 home visits (non skilled) as needed to evaluate patients' home situation and complete medication reconciliation.

Second, the Inova Juniper Program, a nationally recognized medical home for HIV services, has been expanded to include chronic disease management and will continue care for patients requiring more than 30 days follow up post discharge. Inova Juniper provides comprehensive medical care, pharmacy assistance, case management and education to patients who are uninsured and have no access to medical care. An RN with the Inova Juniper program has been assigned specifically to work with the TCM population.

Ms. Rieger stated that many patients are held over in the Inova Juniper program because there are waiting lists at many of the area's safety net clinics. Inova is working

with the Community Health Care Network (CHCN) to find additional slots to enroll those who are eligible but wait listed. Inova has also made significant investments in the Arlandria clinic and hopeful that the clinic's newer, larger space, and the addition of another physician, will improve patient enrollment. Ms. Rieger is having similar discussions about capacity with the Loudoun Community Health Center. Carol Jameson with the Jeannie Schmidt Free Clinic announced that JSFC did not have a wait list and had capacity to serve patients with diabetes or hypertensive disorders. On a related issue, the TCM staff are working with Alexandria's EMS workers to identify patients with high 911 call volumes in attempts to better manage their illnesses.

The last strategy is the Emergency Department. Inova's TCM program is one of only a few programs in the country that has the ability to harvest patients with comorbid conditions from the ED. In the past, ED patients, including those treated in a HealthPlex, would not be identified for TCM. Program staff began tracking the number of ED referrals ending October 2011. Sixteen percent of referrals to the TCM program were identified while in the ED (i.e., not admitted). Using ED software, patients are identified and flagged for follow up during hospitalization.

The TCM Program received 1,190 total referrals for July 5 – December 31, 2011. Referrals by disease type included:

- Diabetes – 485 referrals (41%)
- CHR – 315 referrals (26%)
- COPD – 245 referrals (21%)
- Pneumonia – 123 referrals (10%)
- Asthma – 22 referrals (2%)

Total accepted referrals by payer for July 5 – December 31, 2011 included: Medicare (62%), Uninsured (35%), and Medicaid (3%).

The disposition of patients discharged from the TCM program were:

- 25% completed the program
- 24% were unable to be contacted
- 19% declined to participate
- 17% partially completed the program
- 9% were readmitted to the hospital
- 6% were characterized as "other"

Relying on hospital case managers to identify potential TCM patients is limited. Other lessons learned include the need to identify referrals in the ED, provided a diagnosis is evident at the time of evaluation. Dr. Dvorak reminded the HCAB that patients are admitted with symptoms, not a diagnosis. TCM workers must also educate patients' direct care staff (RNs, Registered Dieticians (RDs), and MDs) in order to increase referrals and improve discharge planning. Patients must be engaged before they leave the hospital.

Dr. Dvorak and Ms. Rieger are working to develop a system in Epic that will flag a patient. Medication reconciliation has also been a challenge in Epic. Dr. Dvorak and Ms. Rieger are continuing to look for ways to communicate back to safety net providers changes in a patient's status. Ms. Rieger was aware that many patients do not communicate to providers, like the Community Health Care Network (CHCN), their participation in TCM. Changes in how the program's case management is staffed are also under evaluation. Dr. Dvorak is looking to expand TCM referrals to other payers/diagnoses and improve relationships with potential medical home sources in the community. Finally, Dr. Dvorak and her staff are working with Skilled Nursing Facilities (SNFs) to minimize patients' readmissions to Inova.

In response to a question about patient placements into the program, Dr. Dvorak responded that TCM is currently staffed to treat more people than it has referred; the program has the potential to double its number of total referrals.

Recognizing that the larger portion of the program's payer mix is Medicare, a question was asked about the program's overall payment source. Ms. Rieger said that Inova is paying for the program. Patients are not charged for any visits. The incentives to reduce readmissions and ensure appropriate care for patients are paramount.

It is unknown how many patients who declined TCM participation were readmitted to the hospital. Dr. Dvorak did state that readmission rates declined 0.7% for Medicare, 1.6% for Medicaid, and 1.4% for indigent patients.

Health Care Reform

In the February meeting packet, the HCAB received George Mason University's (GMU) health care reform recommendations to the Fairfax County Board of Supervisors Human Services Committee. The Health Care Reform Task Force is preparing a more formal report, but it is undergoing editing, a lengthy and detailed process. Since the HCAB devotes its March meetings to the county budget, discussion on the initial set of recommendations was scheduled for the February meeting.

Brenda Gardiner, Policy Information and Policy Manager, Strategic Initiatives, provided a brief presentation on the topic of health care reform, including next steps. Legislation in the Virginia General Assembly to create health care exchanges was tabled until the fall. Activities are underway in the state to comply with federal health care reform requirements, but full implementation is on hold until the Supreme Court's ruling on certain provisions is announced. Ms. Gardiner also reminded the HCAB about the Governor's $800 million in Medicaid cuts, which will make compliance with the law even more challenging.

The County convened a task force of key stakeholders to make recommendations and develop strategies for implementation should the federal law be upheld. The task force has organized its work along five principles:

- Support individual responsibility
- Seek system integration/optimization
- Pursue sustainable system financing
- Ensure accountability, transparency, and improvement
- Pursue advocacy and stewardship consistent with the County's mission.

These principles underscore the need for an approach that allows individuals to self-navigate medical care services while building tools and systems that will ensure flexibility, accountability, and choice.

The task force is examining the County's existing infrastructure, identifying ways to maximize existing resources made available by the BOS. Ms. Gardiner also underscored the value in collaborating with community partners and regional safety net providers, in addition to leveraging the MAPP/Partnership for a Healthier Fairfax (PFHF) in developing a common community goal.

GMU is advising the County to stay the course, maintaining county programs at current levels at least through 2014. Based on a fairly comprehensive matrix of services, the County provides key health services to the community, although mapping these assets came with some imprecision. GMU is recommending that the County develop better ways to identify its cross system partners, thereby minimizing, or de-duplicating, services across agencies. GMU also advised the need to build capacity in integrated information technology and uniform assessment tools so that the system can track clients across programs and facilitate coordinated care, services and evaluation.

While the task force works to shore up its recommendations, the County should continue to pursue new federal access designation (MUP/MUA) to qualify for a FQHC. A MUP designation will expand the County's ability to draw down enhanced Medicaid federal funding.

Ms. Gardiner reminded the HCAB that there are 144,000 people without health insurance in the community. Assuming full implementation of Virginia's Health Exchanges, GMU estimated that half of the county's uninsured would have access to health insurance. If Medicaid's payment rates were adjusted, the number of individuals eligible for insurance would increase from 133% of poverty to 400%. The consultants used the Urban Institute's methodology in developing its estimates. State estimates were not used because Northern Virginia has a different mix than the rest of the state, with more people living above 133% but below 400% of poverty and a 15% foreign born population. According to Ms. Gardiner, these assumptions are stated clearly in the report.

According to GMU, the County has a strong record of identifying and enrolling eligible residents for Medicaid. With changes in eligibility and new private coverage options, outreach will continue to be important. The federal government will reimburse the state 100% for newly eligible beneficiaries within a set timeframe. Rose Chu said that in order to discourage gaming and prevent two eligibility systems, states will be reimbursed on an average rate.

Additionally, GMU also recommended that the County consider ways to work with the private provider community and the medical society in order to share the burden of uncompensated care. The consultants acknowledged that a lot of work needs to be done among the insurance community and the state to ensure adequate reimbursement and reducing the providers' costs of care.

Ms. Gardiner cautioned that providing insurance will not automatically translate into care. The County will still need to work within the constraints of the Governor's $800 million cut to Medicaid. Moreover, there are shortages within certain specialty providers, including primary care. The Virginia Health Reform Institute (VHRI) made recommendations on how the system can grow more capacity, including greater use of Nurse Practitioners (NPs) and telemedicine. However, the ability of the current health system to absorb these newly insured individuals is uncertain.

Therefore, the County will need to address the integration of care. GMU has recommended that the County modify CHCN eligibility to include patients with insurance, including Medicaid.

There are many unknowns when it comes to health care reform, including timeline and infrastructure. The state is working to grow support for exchanges and do turnkey administrative approaches. Ms. Gardiner said that steps can be taken to restructure the County's infrastructure, including using different technology to get people into medical homes, to make referrals to care, and to track health outcomes. GMU recommended that the County integrate its service delivery network and leverage what it is doing in the community to provide specialty care in a more comprehensive manner.

One recommendation, which will require additional discussion, is the creation of a new governmental entity to facilitate integration, coordination, transparency and evaluation of new delivery options. The BOS would define its goals, including relationships between community partners and existing advisory boards.

Ms. Blum briefed the HCAB on the history of this recommendation. In 2007, the BOS invoked Section 15-2-5200 of the Virginia Code to establish a Safety Net Commission. The purpose of the Commission, at that time, was to act as a vehicle for growing revenue to provide uncompensated health care in the community. This issue was last discussed in January 2008 when then Deputy County Executive of Human Services, Verdia Haywood, briefed the HCAB. The County Executive, Deputy County Executive of

Human Services, Health Director, and CSB Director were members of the Commission, but there was no community representation. The Commission met once; it was activated, but not active. A charter for the Commission was never developed.

County staff will be presenting GMU's recommendations to the County's Boards, Authorities, and Commissions, over the coming weeks. GMU's full report will be distributed to the HCAB within the week. Sherryn Craig, in distributing the report, will make sure that members have Brenda Gardiner's contact information. Concerns or suggestions can then be relayed to Ms. Gardiner and/or Ms. Blum.

While the HCAB does not usually meet the month of April, members agreed to schedule a meeting April 9. Ms. Gardiner respectfully asked the HCAB to focus on four questions:

- If there was a Safety Net Commission, how would it support the work that the HCAB does?
- How might these recommendations impact the work of your respective Board/Commission?
- Given the outline of work that needs to be accomplished, what are the Board/Commission's priorities that need to be addressed?
- What would successful implementation of these recommendations look like?

Ms. Gardiner agreed to summarize the HCAB's, as well as other BACs, concerns and suggestions. The Task Force will continue meeting through May.

Lewinsville Expansion Project

The Board of Supervisors Human Services Committee was briefed on the Lewinsville Expansion Project, and at the BOS' request, the proposal is being presented to the HCAB and Long Term Care Coordinating Council (LTCCC). John Payne, Deputy Director for Real Estate and Development, Department of Housing and Community Development, and Rosalyn Foroobar, Deputy Director for Health Services, Health Department, briefed the Health Care Advisory Board (HCAB) on the expansion of the Lewinsville senior housing and services facility located in the Dansville District.

The renovation and expansion of the Lewinsville property has been a longstanding project of the County. Members may recall that the HCAB recommended $3 million in additional funding for the facility during the FY 2010 budget process.

Originally a school, the building was constructed in 1965 and turned over to the County in 1985 to be redeveloped using multiple programs. Lewinsville was the first co-located facility in the county. Recognizing that individuals who were living or visiting the facility were consuming similar services, planners organized a spectrum of complimentary services under one site.

Since 1994, the County has expanded the site. Fifty-two additional beds of assisted living were added to the property through the County's Special Exception zoning

process. The County has continuously tried to incorporate more services so that individuals can age and live more independently for a longer period of time.

Financing the site's renovation and expansion has been challenging. The loss of federal block grants and a 42 percent decline in federal housing funds has compounded the decrease in county funding. The Department of Housing and Community Development has been working with Supervisor Foust to take advantage of recent changes to rules governing tax credits. County staff believe the project can be completed at little or no cost to the County.

Mr. Payne stated that now is a good time for the redevelopment community to restructure itself. Developers are ramping up to catch the curve while prices are still low and opportunities are available. The County would lease the property to a private vendor, bringing significant equity to the project. Seventy-seven units of independent senior living would be developed by the vendor using tax credits. When the tax credits expire, the vendor would bail out of the lease and the property would be returned to the County.

A project on the site of the Government Center is being financed and developed in a similar way: The County has a 99 year lease with a private developer to build 270 housing units. Likewise, the County is pursuing a similar program in the Crescent Housing Community at Lake Anne to increase the number of affordable and work housing units. Mr. Payne stated that Olley Glen, which used 4% tax credits and was fully occupied in one year, and the waiting list at Morris Glen, speak to the success of using tax credits.

County staff have determined that greater efficiencies will be gained by reconstructing, rather than redeveloping the building. More units can be built, thereby enhancing the overall benefit to the community. The project will be developed through a solicited Public Private Educational Facilities Infrastructure Act (PPEA) procurement and will consist of two phases: one for the affordable housing component, using low income housing tax credits, and the second for the community support building.

The Lewinsville site is located within the interior of the Beltway off of Route 123 at the intersection of Lewinsville and Great Falls Road. County planners are using the same footprint that currently exists in the neighborhood. The solicitation will relocate current users of the facility. The athletic and playing fields on the site will remain in use and the child care center will continue to operate. Should the PPEA approach fail, the County is prepared to work with Public Works to develop a design for the site and bid out the development.

The County is also exploring the possibility of implementing an innovative building design that supports a more integrated approach to service delivery for older adults. According to Ms. Foroobar, County staff are evaluating a new service model that would

consolidate publicly provided services – a Senior Center, a Senior+ program, and an expanded Adult Day Health Care (ADHC) – to include later stage dementia care, under the management of one operational unit. This change should allow the County to provide long term and respite care services more cost effectively and efficiently. Additionally, the HCAB was briefed on the possibility of adding task-based services for residents of the independent living units, which should enhance their ability to live independently for a longer period of time.

Individuals age 62 years and older with moderate incomes are the project's target population. Mr. Payne referred to the County's market research, which showed unmet demand for long term care services among moderate income levels. Mr. Payne explained that the County will take measures to ensure that the services provided at Lewinsville are affordable to and benefit the population it is seeking to reach. Fees will be below market rate and stipulated in the contract between the County and any potential vendor.

There was some concern raised about including later stage dementia care into the new service model. However, Ms. Foroobar said that there was great demand for the service. She noted that more adult day health care participants have a greater degree of dementia than they did 15 years ago. In meeting with service providers in the community, Ms. Foroobar felt there was adequate capacity to ensure quality and dignified care. She said that there were numerous examples of later stage dementia care being provided successfully in other jurisdictions.

Ms. Foroobar explained that some individuals living in the facility's independent units need an extra level of support. The demand is not great, but the need is still there. Ms. Foroobar explained that task-based services would allow these individuals to live longer in an independent setting.

A question was asked about assisted living. Mr. Payne said that it was financially less feasible for the County to develop assisted living units. Ms. Foroobar and Mr. Payne recognized that the current proposal for Lewinsville does not support a full continuum of long term care services. Instead the County is trying to develop more supportive programs in the independent setting to make the services more compatible with the continuum model.

Ann Zuvekas made a motion to send a memo to the Board of Supervisors stating the HCAB's support of the development process, but also signaling its disappointment regarding the lack of affordable assisted living services for low and moderate income residents and encouraging the Board of Supervisors to continue exploring opportunities that will provide more assisted living services and programs to the community. Ellyn Crawford seconded the motion.

During discussion, the proposal was compared to the construction of an apartment building at a tax advantaged status. There was some concern that if task-based services were provided, there may be difficultly in moving individuals, for whom the independent setting is not an appropriate level of care, out of the facility.

With respect to the task based services, the HCAB requested additional detail. Ms. Foroobar recognized that not everyone will need these services, but they can be made available at a fee that people can afford. She agreed to come back to the HCAB as the service component of the project is more fully developed.

The motion passed: Nine in favor, one opposed, and one abstained.

There being no further business, the meeting adjourned at 10:25 pm.