ILLINOIS EMERGENCY MEDICAL SERVICES FOR CHILDREN
ADVISORY BOARD
Meeting Minutes
June 29, 2012

Present: Paula Atteberry, Jessica Choi,* Mark Cichon,* Susan Fuchs (Chair), Jeanne Grady, Joseph Hageman,* Mike Hansen, Kathy Janies, Ruth Kafenzstok, Chris Kennelly, Dan Leonard, Evelyn Lyons, Martha Pettineo,* Laura Prestidge, Bonnie Salvetti,* Glendean Sisk,* Mike Wahl, Terry Wheat, J. Thomas Willis (Co-chair), Carolynn Zonia

Excused: Darcy Egging, Sam Gaines, Sheree Hammond, Herbert Sutherland

Absent: Young Chung, Kim Gudmunson, Roy Harley, Vyki Jackson, Vince Keenan, Steve Lelyveld, Bridget McCarte, Jerrilyn Pearson-Minor, Michael Pieroni, Amy Stanfill, Kathy Swafford, Scott Tiepelman
*Via teleconference

TOPIC	DISCUSSION	ACTION
Call to Order	Susan Fuchs called the meeting to order at 10:10am	None
Introductions	Introductions were made	None
Review of 03/09/12 Meeting Minutes	Minutes from the March 9, 2012 meeting were reviewed and approved	Minutes approved
Announcements/ Updates	The following announcements/updates were reviewed: • Welcome new EMSC Advisory Board members o Sheree Hammond, MSW, RN, IL Department of Children & Family Services o Jessica Choi, Director, SafeKids Illinois, Lurie Children's Hospital • Open Meetings Act Training – all EMSC Advisory Board members must complete this training • National EMSC Updates o Funding – Evelyn reported that the House awarded $21.9million in funding for the Federal EMSC program; the Senate has yet to approve an amount. o National EMSC Pediatric Readiness Project – this is an online survey recently piloted in California that will be utilized by the Federal EMSC program to send to all acute care hospitals beginning this fall. Hospitals are asked to self-assess based on guidelines outlined in the AAP/ACEP/ENA 2009 Joint Policy Statement. The survey for Illinois is scheduled to roll out in March 2013. Sue reported that the Joint Commission sent out a related survey asking if hospitals were interested in pediatric certification. Sue has heard that hospitals were not interested in pediatric certification from TJC. There is limited funding for the Peds Readiness Project, but there is strong support from the Federal EMSC program. All EMSC programs are being asked to support and bring awareness to their hospitals. To assist states, Evelyn mentioned the Federal EMSC program has moved up the due date (Sept. 26th) of the State Partnership Grant. Carolynn asked if it would possible to ask if hospitals are facility recognized on the Readiness survey. Evelyn said this may be possible since she already requested that NEDARC integrate some other Performance Measures-related questions to the Readiness survey. • Ron W. Lee, MD – Excellence in Pediatric Care awards for 2012 were announced: o *Lifetime Achievement: Kay L. Saving, MD, FAAP* o *Lifetime Achievement: Patricia Metzler, RN, TNS, SANE, CPN*	FYI Send any new announcements to Evelyn Lyons for future meetings Congratulations to all of the deserving recipients.

TOPIC	DISCUSSION	ACTION
	○ *Clinical Excellence: Mary Ann Wesoloski, RN, MSN, NCSN* ○ *Community Service: Safety Village of Western Springs Committee* • Governor Quinn signed House Bill 5114 - local school boards may allow students in grades 6-8 to receive "safety education" video instruction (CPR and how to use an AED) . Legislation was spearheaded by Dr. George Chiampas (assistant professor of emergency medicine and sports medicine at Northwestern University Feinberg School of Medicine). It takes effect immediately. Teachers do not have to be CPR instructors. Tom Willis provided links after the meeting that Evelyn will email to board members. • Safety Network State Fact Sheets – Resource provides a state snapshot of data on the injury-related Maternal and Child Health Block Grant National Performance Measures and Health Status Indicators (includes special focus on disparities based on race, gender, and rural/urban residence) • CDC MMWR Vital Signs: Unintentional Injury Deaths Among Persons Aged 0–19 Years –Although the annual rate is declining, unintentional injury remains the leading cause of death among children and adolescents in the U.S., led by motor vehicle–related deaths. Death rates from infant suffocation and teen poisoning are increasing. NOTE: Illinois' death rate is significantly lower than overall U.S. rate. Federal EMSC encourages EMSC programs to link with state injury prevention programs. Jessica Choi is now the Advisory Board SafeKids representative and can provide guidance for injury prevention advocacy. • Pediatric Education for Prehospital Professionals (PEPP), 3rd Edition – Sue said this version is currently being edited, and is expected to be published by Nov – Dec 2012 Other organizational reports/updates: • MCHC – Mike Wahl reported MCHC sent out notifications to their members announcing the EMSC Pediatric Mock Codes workshops to help increase attendance. IPC provides monthly reports on calls to the Attorney General's office. IPC collects the brand names and can associate symptoms with the brands (i.e., identify the most toxic products). IPC tries to get the name of the store that sells it. The AG's office then works with local law enforcement to purchase the products and have a discussion with the store owner of the consequences of selling designer drugs in their store. Last summer, IPC received calls on synthetic marijuana at a rate 33% greater than the national average on a population basis. Since this program, and subsequent legislation making it more difficult to sell, we are now over 50% below the national average. • SafeKIDS report – Jessica Choi is excited to be an Advisory Board member. The current focus is on summer safety messages (hyperthermia, drowning, bike safety, etc.). If you need any IP messaging, contact Jessica (jchoi@luriechildrens.org). • Red Cross – no report • Mike Hansen reported HB 5880 is pending the Governor's signature. SB 3261 went to the floor with 2 amendments; to the House with 2 amendments. It reached committee, but no further. There is concern in rural areas re: recruitment and retention. Continuing education requirements are going from 120 to 150 hrs. More hours spent in education may lead to less road time for rural providers. There is a concerted effort to get this issue before the legislature in veto session. Additional EMS funding is between $10 – 70 million. Educational Opportunities: • Westplex Pediatric Conference August 15, 2012 (Warrenton, MD) • Pediatric Fundamental Critical Care Support September 2012 (St. Louis, MO) • 2nd Annual Disaster Conference: "Weathering the Storm" October 16, 2012 (Whittington, IL)	

TOPIC	DISCUSSION	ACTION
	• EMSC courses – *Pediatric Seizures* course will be on http://www.publichealthlearning.com by July 2012. It has been approved for 1.5 continuing education hours. • EMSC Online Courses, University of New Mexico, Department of Emergency Medicine, http://hsc.unm.edu/emermed/PED/emsc/training/course.shtml • Other educational opportunities at http://www.luhs.org/emsc/special.htm	
IDPH, Division of EMS & Highway Safety Report	Paula Atteberry reported: Legislative Update: • The Trauma Fund and EMS Fund rule will be filed with Secretary of State's office next week for adoption. The EMS fund is amended to authorize IDPH to use a portion of the fund for licensing/testing/certification fees, administration, oversight and enforcement of activities authorized by the Act. Trauma Fund rule is amended to require that trauma fund money collected in an EMS Region be distributed back to that region. • Amendments to the EMSC rules Appendix L and O were approved by the EMS Advisory Counsel and will be sent to first notice next week. The amendments update the ED equipment list by removing gastric lavage equipment and by updating the PCCC sections of the EDAP equipment checklist. EMS Grants Update: • The Department awarded just under $100,000 in EMS Assistance Grants for FY2012. • FY 2013 EMS Grant guidance/applications went out in February; due back from EMS Region Advisory Boards to the Department on June 30, 2012. All applications have been received except for Region 9. • Heartsaver Grants Update: The State did not fund the Heartsaver Grants for FY2012 • EMS Week 2012: May 20-26; EMSC day celebrated May 23 - **EMS, More Than a Job, A Calling** • IDPH sent out over 2000 years of service certificates. EMS Instructor award given to Doug Sears (Dixon, IL). The Public Education awards were given to Rachell Sierzega (Argonne, IL) and Norma Loos (Payson, IL). The EMS hero award was given to Grand Ridge Volunteer Fire Department (Grand Ridge, IL). Trauma Site Survey Updates: • IDPH completing new contracts with out-of-State Trauma Surgeons; will initiate Trauma Site Surveys this fiscal year. • IDPH conducted initial on-site visits at two Trauma Centers in WI that have applied for designation. A new Trauma Center application for a hospital in Evansville, IN will also require a site visit. • The annual data submission to the National Trauma Data Bank had to be validated by the NTDB this year. All of the hospitals with the exception of 11 trauma centers submitted data to NTDB. IDPH has been working on re-platforming the existing Trauma Data base to an IBM Supported Platform. Hospital Preparedness Program: • 2013 federal grant application was submitted and approved for $10,936,885. Grant applications were sent out to 151 hospitals throughout the state, and were due back to us by June 15th. • 14 hospital site visit surveys were conducted throughout the state during the month of May and June. No major areas of concern were noted. • Office of Preparedness and Response and the HPP program attended multiple planning meetings/calls for the NATO Summit in Chicago. Region 7 -11 EMS coordinators, and RHCC coordinators for these regions, participated with CDPH. Chicago Fire Department and the Secret Service were the leads during this event.	FYI

<table>
<tr><th>TOPIC</th><th>DISCUSSION</th><th>ACTION</th></tr>
<tr><td>Pediatric Preparedness Workgroup (Disaster Preparedness)</td><td>Laura Prestidge reviewed the following:
• FY2013 HPP Pediatric Preparedness grant initiatives:
  ○ Pediatric & Neonatal Surge Annex – June 28th planning committee meeting went well. The role of the Pediatric Medical Care Expert will be defined. 3 new subcommittees were formed to develop additional components. The plan is take the annex around the state for input and recommendations.
  ○ Pediatric Medical Resource Data Report – this report will be specific to pediatric surge capacity/resources based on the 7 Public Health & Medical Services Response Regions. Goal: develop a report that will be updated annually as data is available (expand during subsequent grant years to selected topics of interest, such as healthcare utilization associated with mental illness)
  ○ Pediatric Hazard Vulnerability Analysis (HVA) – CDPH developed and in process of pediatric HVA program in Region 11. We are looking into the feasibility of expanding to rest of the state.
  ○ Regional Pediatric Resource Directory – will update annually and post on the EMSC website
  ○ Assess hospital EOPs for the inclusion of pediatric considerations during pediatric facility recognition site surveys. A regional summary will be shared at their regional RHCC meetings.
  ○ Pediatric Preparedness Workgroup – EMSC will continue to facilitate and coordinate the activities that identify pediatric preparedness needs within our state, oversee development and distribution of pediatric preparedness resources and guidelines, and identify/share promising models and practices.
  ○ Educational programs – Assist in at least 5 train-the-trainer JumpSTART workshops targeting healthcare professionals; conduct at least 6 SNEC courses; assist at least 10 EMS Systems with conducting a PEPP course; support other educational programs as identified by the Pediatric Preparedness Workgroup. In addition, investigate bringing in a Pediatric Disaster Life Support Course (PDLS) from the University of Massachusetts
• DRAFT Caring for Children in a Disaster: A Guide for Non-Medical Professionals and Volunteers – this has been approved by Pediatric Preparedness Workgroup with minor changes (including lists of age appropriate supplies and toys/distractions).</td><td>FYI

Send comments/ suggestions to Laura lprestidge@lumc.edu</td></tr>
<tr><td>Education</td><td>Chris Kennelly reported:
• School Nurse Emergency Care (SNEC) course – 7 student courses are being offered; 2 new course instructors were offered. 99 nurses attended courses so far.
• Critical Issues Days update – Chris attended 2 sessions sponsored by Illinois Dept of Human Services.
• Pediatric Mock Code Train-the-Trainer Workshop – has been offered in several regions. To date, 99 participants representing 38 facilities have participated. According to the evaluations, the workshop has been a very well received. Future workshops:
  ○ July 18, 2012 (Springfield)
  ○ July 26, 2012 (Urbana)
  ○ July 30, 2012 (Rockford)
  ○ August 8, 2012 (Peoria)
  ○ August 15, 2012 (Maryville)
  ○ August 16, 2012 (Mt. Vernon)
• DRAFT Child Abuse guidelines – received materials from Patty Metzler and Meryl Paniak as requested by the committee. However, the committee has not met again to review and incorporate this material yet.</td><td>FYI</td></tr>
</table>

TOPIC	DISCUSSION	ACTION
	• DRAFT Pediatric Pain Management in the Emergency Department module – this is a 2nd edition of the 2002 publication, which was in a narrative format. This edition has been formatted into PowerPoint. Chris reviewed: module objectives (will not cover procedural pain in depth), current stats and demographics, regulatory agencies and professional organizations that provide oversight, current joint commission standards, core principals of pain management from *"Optimizing the Treatment of Pain in Patients with Acute Presentations*," common painful presentations, pain physiology, common myths, metabolic effects of pain, and pain memory experience/mitigation. Suggestions: incorporate AAP/ACEP/ENA 2009 Joint Policy statement support of pain management policies; suggest adding a picture of a nasal atomizer.	Chris will incorporate AAP/ACEP/ENA 2009 Joint Policy statement support of pain management policies; add picture of a nasal atomizer.
Facility Recognition Committee	Carolynn Zonia and Evelyn Lyons reported: • EDAP/SEDP rules changes – These changes are intended to assist hospitals meet current standards and consistent meet EDAP/SEDT requirements, not just during their renewal site visit every 3 years (e.g., assigning a Pediatric Physician Champion). Neighboring states - an Indiana hospital re-applying for recognition is promoting the program with their associate hospital. In the past, St. Louis hospitals have focused on IL trauma recognition. Try to promote their application for IL facility recognition. Both Cardinal Glennon and St. Louis Children's send representatives to the Region 4 QI Committee meeting, and have been invited to begin attending Regions 3 and 5 QI Committee meetings. Regions 3, 4 and 5 are currently consulting with St. Louis area pediatric physicians on their regional QI projects. • Exit interview – When a hospital formally withdraws from the facility recognition program, Evelyn conducts an informal interview to determine the reason. Typically, the reason has to do with lack of physician and/or administration support. During this renewal cycle, one hospital in Region 4 reported that maintaining the requirements were too time-consuming for their staff. In their case, the person filling the PQC role also has responsibilities for their Hospital Preparedness Program, which has funding attached. Mike Hansen commented that they are seeing burnout with EMS Coordinators tasked with more Trauma and STEMI responsibilities. Bigger hospitals can spread out responsibilities, but smaller hospitals have a few people doing many jobs. Another issue is coming from hospitals that utilize physician contract groups. Rural and small hospitals cannot find local physicians to work in the ED. Some of these contract groups are based out of state; physicians fly into work for a few days to do shift work (for example, one ED Medical Director lives in Texas). This lack of local resources/commitment makes it difficult for nursing to advocate for real practice changes. Another issue is getting physicians to meet their CE and QI responsibilities. EMSC offers online education to meet CE requirements, and lends a lot of QI support. However, we may have to create a lower/base level that has minimal requirements for QI to help address those challenges (based on the current TI Grant recommendations). Sue Fuchs reported that the national ACEP representative at the TI Grant meeting noted that some large contract groups are assigning one person to act as Pediatric Quality Coordinator for all of the hospitals in that group. Will need to keep that in mind moving forward. Carolyn noted that hospitals are pushing back more frequently on the policy requirements (e.g., time response for back up physician) and hospital administration support of Pediatric Quality Coordinator. It is the work of the PQC that has demonstrated the most effective practice changes through the regional QI committee structure. • Site Surveyors – Evelyn is looking for more site surveyors. Potential new surveyors could buddy up on the upcoming Region 11 site visits to get experience.	FYI Contact Evelyn for more information re: site surveying

TOPIC	DISCUSSION	ACTION

	• Regions 4 & 5
	  o Site surveys are scheduled in June and July
	  o Region 4 – one hospital has withdrawn
	  o Region 5 – a hospital that previously withdrew from the process has reapplied; and an EMS Resource Hospital in Indiana is in the process of applying
	• Region 11
	  o Renewal applications are due June 29, 2012
	  o Site surveys will be scheduled sometime between October – December 2012
	  o Evelyn is looking for surveyors
	• Regions 1 & 10 – Educational sessions in each region are planned in Fall 2012
	• Current participation in facility recognition (106 hospitals)
	  o PCCC/EDAP level = 10; EDAP level = 81; SEDP level = 15
	  o Note: 2009, 90.1% of 0-15 y/o admissions to PCCC/EDAP/SEDP hospitals (Source: IHA Compdata)
	• EMSC Targeted Issue Grant (2010-2013). Kathy & Dan reported:
	  o Expert Panel Forum (June 18 & 19, 2012) – The 2-day meeting went very well, and was well received. Kathy reviewed the draft recommendations that came from the group. These recommendations will be further refined by the Expert Panel over the course of the TI Grant cycle. Expert Panel also offered suggestions to enhance the proposed toolkit elements. Example recommendations include:
	    ▪ Equipment/Supplies - For rural/tribal facilities – recommend prehospital equipment guidelines as minimal standards (will need to allow for flexibility)
	    ▪ Policies/Protocols - Add "Pediatric pain assessment and reassessment" as a separate policy requirement
	    ▪ Coordinator Roles - Both physician and nursing coordinator roles are critical for program success
	    ▪ Quality Improvement - Include a specific loop closure process to demonstrate follow up and show how QI work is impacting practice (both on a system/ED level and individual competency level)
	    ▪ Patient Safety - For every level, have pre-calculated dosing guidelines that minimally include resuscitation and high risk meds (per institution)
	    ▪ Hospital Categorization Levels/Definitions - Based on existing models and experience, it is recommended that states develop a categorization system comprised of, minimally, three or four levels to accommodate differences in hospital capabilities
	  o Issue of board recertification – since some board recertifications are now based on maintaining education, we need to assess what we require for submission in renewal applications.
	  o Data Measures – Dan reported on work to data re: CT scan use associated with participation in the statewide QI project. Dan also reviewed the PRISA II summary report. This score (constitutes a New Primary Data Measure) was tested for use in calculating admission rates. Based on feedback, a number of participating facilities found it useful and could use it as objective tool in their current pediatric revisit review process. Discussed possible reasons for differences between PCCC revisit results and other levels. Larger facilities may attract larger numbers of less acute patients, or PCCCs may have	

TOPIC	DISCUSSION	ACTION
	more formal policies in place to account for disease specific results/treatment decisions. Possibly, a PCCC has direct access to subspecialists to determine the need to admit vs discharge prematurely.	

Data Initiatives	Ruth Kafensztok provided an update report on the following EMSC data activities:
	• Illinois Trauma Registry Trends - Trends for selected ITR data were briefly reviewed during the EMSC Advisory Board meeting. Data from calendar years 2000 through 2010 for 9 data elements utilized the IL EMS Data Reporting System were presented. Following are the highlights described:
	  o Overall number of ITR annual admissions ranged from about 41,000 - 45,000, with an average of 43,200 admissions/year
	  o Over the years, gradual shifts in characteristics associated with trauma admission patients such as:
	    ▪ Slight increase in the proportion of female patients compared to males
	    ▪ Increase in older age groups, particularly those aged 75 and older; and a decrease of admissions among those 11 - 44 years
	    ▪ Slight increase in the proportion of White non-Hispanic population and a decrease of similar magnitude among Black non-Hispanics
	    ▪ A decrease in the proportion of patients discharged home and a parallel increase of patients transferred to another hospital or other types of facilities
	    ▪ Increase in Medicare as primary payer, and a slight increase in Medicaid-paid admissions.
	    ▪ Major shifts in primary cause of injury leading to admission were observed in falls (increase) and motor vehicle injuries (decrease).
	  o Over the years, variations in the volume of admissions per EMS Region. As of 2008 there were no trauma centers in Regions 4 and 5, and their volume of admissions was drastically reduced.
	• *IL EMS Data Reporting System* – These data sources have been recently updated: Illinois Trauma Registry (2008-2010); IDOT Traffic Crash (2010); and IHA Hospital Discharge (2010). 2008 Mortality data was received today from the IDPH Vital Records Division and the Electronic Data Warehouse. There are some inconsistencies in this set, likely due to the new layout of the file. The EMSC data staff is discussing with IDPH Center for Health Statistics to identify and resolve issues prior to updating the Reporting System. EMSC finished a pilot study with Hospital Discharge data from IDPH's Hospital Discharge program to study what it would take to replace the Reporting System hospital discharge query with IDPH originated data. Pilot will be reviewed with the program's director to move forward with the request of a full dataset.
	• *Traffic Crash "Quick Facts" Fact Sheets 2010* – were completed in early June, and are now available at http://www.luhs.org/depts/emsc/10_crash_info.htm
	• *Data Quality Studies* – EMSC continues to assist the CODES program in devising a strategy to obtain missing information on selected key data elements for fatal crash records based on data potentially available in health/medical databases. Current focus - Blood Alcohol Content (BAC) values from ITR. *Progress:* 1) report is being drafted containing a review of the ITR data to quantify completeness and selected accuracy dimensions of the data as it relates to BAC. 2) EMSC data staff is working on a protocol to discuss scope of the second phase of the project with ITR administrator. The project is moving to its 2nd year with a data linkage component, which may require a new data sharing agreement.
	• *Other Activities* – 1) April 2012, EMSC renewed its competitive application for IDOT funds to support the abovementioned activities. Funding was approved by IDOT in June, and final formalization of the grant
		FYI

TOPIC	DISCUSSION	ACTION

	contract is in progress. 2) Dan and Ruth continue to participate in the EMS Data Improvement Workgroup initiative, which is developing a workplan for continuous improvement in Prehospital data collection.
	• *Reporting system:*
	  o Mortality – 2008 data reviewed; a few issues with consistency of data are currently being investigated
	  o Traffic Crash – 2010 data processed for web application and pending update on IDPH production site
	  o Hospital Discharge – 2010 data processed for web application; pending IDPH production site
	  o Trauma Registry – 2008-2010 data processed for web application; pending IDPH production site	

Quality Improvement	Kathy Janies reported:
	• Regional QI Update – due to time constraints, this report was postponed
	• DRAFT Pediatric Sepsis QI tool – due to time constraints, this tool was sent to the Advisory Board members for review after the meeting
	• Pediatric Publications Update – Per Joe Hageman, both Connie Taylor and Stephanie Carapetian are drafting additional seizure manuscripts.
	  o Abstracts Accepted as Poster Presentations
	    ▪ Kennedy E, Hageman J, Lyons E, Leonard D, Janies K, Duck S, Fuchs S. (2011). *Pediatric diabetic ketoacidosis management in the emergency department*. 2011 Pediatric Academic Society Annual Meeting, Denver. Abstract 3839.436.
	    ▪ Carapetian S, Hageman J, Lyons E, Leonard D, Janies K, Kelley K, Fuchs S (2011). *Improving simple febrile seizure management in the emergency department*. 2011 American Epilepsy Society Annual Meeting, Baltimore.
	    ▪ Lyons E, Prestidge L (2012). *Improving pediatric preparedness in Illinois hospitals.* 2012 Annual Public Health Preparedness Summit, Anaheim.
	    ▪ Lyons E, Weber E, Flament L (2012*)* *Considerations in pediatric disaster surge: mass casualties, critical transport and the technologically dependent child.* 2012 Integrated Medical, Public Health, Preparedness and Response Training Summit, Nashville, TN.
	    ▪ Patel P, Lyons E, Kennelly C, Leonard D, Prestidge L, Janies K, Fuchs S. (2012). *An assessment of Illinois hospitals' emergency department (ED) pediatric mock code/simulation practices and needs.* 2012 American Academy of Pediatrics (AAP) National Conference and Exhibition, New Orleans, LA.
	  o Abstracts Submitted/Pending Acceptance
	    ▪ Taylor C, Piantino J, Carapetian S, Hageman J, Lyons E, Janies K, Kelley K, Fuchs S. *Emergency department management of acute unprovoked seizures including status epilepticus.* 2012 Pediatric Academic Society Annual Meeting, Boston. Platform presentation in Child Neurology.
	    ▪ Carapetian S, Hageman J, Lyons E, Leonard D, Janies K, Kelley K, Fuchs S (2011). *Evaluation of emergency department workup and management of children with simple febrile seizures*. 2012 Pediatric Academic Society Annual Meeting, Boston. Poster presentation in Emergency Care.
	  o Manuscripts Accepted to *Pediatric Emergency Care*
	    ▪ Barrios EK, Hageman J, Lyons E, Leonard D, Janies K, Duck S, Fuchs S. *Current variability of clinical practice management of pediatric diabetic ketoacidosis in the Illinois pediatric emergency departments.* No publication data yet.
		FYI
		
		Please forward any comments or suggestions re the Pediatric Sepsis Tool to kjanies@lumc.edu

TOPIC	DISCUSSION	ACTION
EMS Region 4 Coalition	No report was given	FYI
2012 meeting schedule	2012 Meeting Dates scheduled as follows: **Thursday, Sept 27th, and Thursday, Dec 20th**	Meeting reminder will be emailed
Adjournment	Meeting was adjourned at 12:15 pm	None

Meeting minutes submitted by E. Lyons & K. Janies