DRAFT

Oregon Health Authority
Northwest Regional Newborn Bloodspot Screening Advisory Board

Meeting Summary — December 4, 2024

Location
Videoconference

Quorum
Board attendees constituted a quorum for most of the meeting. No decisions were made by the Board when a quorum was not present.

Board Members Attending
Marilyn Hartzell, M.Ed., Board Chair, Family Representative
Andrea Keating, LDM, CPM, Representative of a statewide association of midwives
Sherly Paul, Representative of a statewide association of nurses
Amy Yang, MD, Contracted medical consultant
Angela Douglas, MD Representative of a statewide association of pediatricians
Elizabeth Powers, MD, FAAFP, Representative of birthing center or hospital
Mort Murry, MD, Advocacy association regarding newborns with medical or rare disorders

Board Members Absent
Kara Stirling, MD, Representative of a birthing center or hospital
Charlene Lai, MD, Representative of Oregon Pediatric Association
Jill Levy-Fisch, Advocacy association regarding newborns with medical or rare disorders
Rusha Grinstead, Representative of Medicaid or insurance industry

NBS Program Staff
Patrice Held, Newborn Screening Program Manager
Amber Gamel Miller, Public Health Nurse, Newborn Screening Program, OSPHL
Jennifer Anderson, OSPHL, Interim Legislative Coordinator
Sarah King, OSPHL, Client Service Coordinator
Dejon Grittman, OSPHL, Quality and Safety Coordinator

Guests
Charina Walker, OHA Government Affairs

Members of the Public
Mandy Edwards
Cheryl Grabham
Carolyn Lee, State Rep. Susan McLain's Office
Cherie Wilson

Jensen Strategies Facilitation Team

Erik Jensen, Facilitator
Emily Rehder, Operations Manager

ACTION ITEMS

A. Adopted the NWRNBS Advisory Board Charter amendments related to the group's decision-making process and clarity regarding proxy voting.

MEETING AGENDA ITEMS

1. Welcome

Chair Marilyn Hartzell opened the meeting welcoming all the participants and asked Board members and OHA staff to introduce themselves.

2. Approval of Meeting Summary

Advisory Board Facilitator, Erik Jensen, reviewed the meeting summary from the September 4, 2024, Board meeting and asked if there were any revisions necessary. It was noted that Sherly Paul's affiliation was listed incorrectly and should be "Representative of a statewide association of nurses."

Decision: Since quorum was not present, the decision to approve the September 4, 2024, Meeting Summary was deferred.

3. Facilitator's Update

Advisory Board Meeting Schedule: Erik reminded the Board of the schedule for the remaining 2024-25 Board meetings and key topics currently on the agenda for each meeting. The meetings are all scheduled to be held virtually from 9:00am to Noon:

December 4, 2024:
- Charter Revision Proposal
- Legislative Process & Advisory Board Role
- Long-term Funding Discussion

March 4, 2025:
- Krabbe Scientific Review Report and Deliberation

May 28, 2025:
- Continuation of Krabbe Review (if needed)
- Advisory Board Chair and Vice Chair Selection

Krabbe Review Scheduling Options: Erik offered three scheduling options for the review of Krabbe which would follow the Board's four step condition review protocol and asked for the Board members' preference. Step 2, the scientific review was already scheduled to be presented at the March 4th meeting. The options varied by which of Steps 3 (public input) and 4 (evaluation and recommendation) could occur at the March 3rd and/or the May 28th meeting. After a discussion, the Board members agreed that Steps 3 and 4 should be addressed at the March 3rd meeting, if the Board decided the criteria in Step 2 warranted further review.

Review of Attendance Requirements: Erik reminded Board members on attendance requirements. The Advisory Board Charter states that if a member misses two sequential meetings it is considered a resignation. If a member is going to miss a meeting, they should notify the facilitator (Erik), or co-chairs (Patrice or Marilyn). Absent members may submit written comments on agenda items but may not give proxy votes.

Board Membership Updates: Although the Board had a vacancy at the time of the meeting for a representative of association regarding newborns with medical or rare disorders, Cheryl Grabham has been nominated to fill it.

November 25th Onboarding Session: Erik shared the second Board member onboarding session was held on November 25th and thanked those that participated. He noted that the general onboarding PowerPoint was emailed to the Board. All Board members are welcomed to attend any session which are held online.

Erik recapped the protocols for discussion and decision-making at the Board meetings.

4. Proposed Charter Revisions

Erik proposed changes to the NWRNBS Advisory Board Charter to streamline decision making processes in cases where the 1-5 consensus tool is not necessary (e.g., meeting summary approvals, Board responses to inquiries, etc.) and provide greater clarity (e.g., proxy voting). Changes are bolded with Section Title and numbering from the current Charter.

Meeting Logistics and Operating Procedures:

I.c. *Absences:* Board members must inform the co-chairs in advance of a Board meeting if they will be unable to attend. If a Board member knows they will be absent, they can submit written comments to the NWRNBS Manager in advance of The Board meeting **but cannot delegate a proxy vote**.

II.a.i. *Quorum:* A majority of the voting members of the board constitutes a quorum for the transaction of business. Each Board member has one vote and cannot vote in absentia **or by proxy.**

II.a.ii. *Consensus*: The Board will strive for consensus on recommendations provided to the NWRNBS Program and the Legislature.

II.a.iii. *Vote Required:* The express approval of a majority of a quorum of the Board is necessary for any Board decision. Exceptions can be made to require a consensus of the quorum of the Board for the purpose of disorder review protocols should the Board formally adopt the process in advance of such decisions.

Discussion

- Comment: Revisions seem straight forward and don't see any down sides and seems very reasonable.

Decision: The Advisory Board, by strong consensus, **approved** the proposed charter revisions. The decision was made using the 1-5 consensus tool with all members responding with 1's. A quorum was present for this decision.

5. Legislative Process & NWRNBS Advisory Board Role

Charina Walker, OHA Government Affairs, gave a presentation on how the legislative process works, role that advisory boards and individual board members can advocate during the legislative process, and any information on proposed legislation/bills to be introduced for the 2025 season.

Legislative Process: A summary of the legislative process was described noting odd years have a long legislation session, even years have short. Majority of bills are submitted in a long session. The following legislative schedule was shared for 2025:

- Jan 10 Bills released (very tentative)
- Jan 21 First day of session
- Mar 21 First chamber posting deadline*
- Apr 8 First chamber work session deadline**
- May 9 Second chamber posting deadline*
- May 23 Second chamber work session deadline**
- June 29 Constitutional Sine Die (last day of session)

  * Bills must be scheduled for a vote in committee by this date

  ** Bills must be voted on by a committee by this date

The Oregon Legislature website is a resource to get information on bills, legislators, and committees. On the Oregon Legislative Information System (OLIS) bills can be looked up by number, key work, or sponsor, watch committee meetings, and find written testimony and fiscal revenue statements.

Role of the Advisory Board

Charina reviewed what Board members can and cannot do as a Board representative and as an individual. She described the difference between educating elected officials and advocating for a position. Education involves the provision of information without value judgements or seeking legislative action. Advocacy is intended to argue for, defend, or recommend for a cause or proposal. Board members can advocate as individuals for a position but may not represent themselves as NWRNBS Board members.

Questions related to the presentation included:

- Q: I can go to the Legislature and advocate as an individual but not as a Board member, is that correct?
  A: Yes, unless a committee asks you to come and share information as a Board member. However, it would be best to represent yourself as an individual.
- Q: With some of the legislation that we have heard about, can the Board weigh in as a group, and if so, how does that work? We have been hearing about some potential legislation that would require the Board to review certain conditions, but the Board has strict protocols and criteria for reviewing conditions – including that the condition be on RUSP. In these cases, we have shared the protocols with the legislators. However, if such legislation moves forward, and the Board wishes to share a position on it, how does that happen?
  A: As a Board it must take no-position- only provide factual information. In this case it is highly recommended the Board work with Patrice and Government Relations on how to come up with a message that the Board can provide. If you want to advocate, you can only do that as an individual.
- Q: To confirm, when bills drop for a legislative session, if there is a bill that goes against the condition review protocol and the Board provides educational information, but the legislation remains under consideration, Board members may provide input during public input opportunities as individuals?
  A: Yes, that is correct. Also, if there are other organizations that Board members are working with, that would be another opportunity. If the legislation would negatively impact the Board's work OHA Government Relations could work with the legislator(s) to develop an amendment.
- Q: A lot of the Board members represent advocacy groups an association or other group. Can a Board member go back to their organization and suggest they take a position on such legislation?
  A: The Board cannot ask organizations to lobby for them - but can give information about the legislation and its impact should they want to take a position.
- Q: We can give information to people who would be impacted by the legislation and, if they choose, they can represent themselves at the Legislature, correct?
  A: Yes. And you can provide tools such as talking points for people to use if it is strictly educational.
- Q: How is the Program funded, is it federally or state funded?
  A: The Program is nearly completely fee based- providers purchase cards and that funds the Program. There is a small amount of General Funds for special projects, and a small amount through federal grants.
- Q: The information that is given to us from experts that is primarily scientific –is that something that the Board can share?
  A: Yes, those summaries are publicly available.
- Q: If I'm hearing correctly, I cannot do any sort of lobbying as a member of this Board but in my separate role of a different organization- I can use information collected here to inform the other organization that has a shared interest if that delineation is clear? Is that correct?
  A: Yes, just make sure you are clear on what role you are representing.

Newborn Bloodspot Screening Legislative Concepts for 2025

- LC 1951 (Rep. Nelson): Adds long term follow-up to the Program to track patients who had tested positive for conditions to ensure they have access to information on organizations and treatment throughout their lifespan
- (Reps. Owens, McLain, Nosse): The legislative concept is a funding request to support GAMT, MPSII, Krabbe, and DMD testing on Oregon's Newborn Bloodspot Screening panel
    - Carolyn Lee, Rep McLain' Office, added that this bill would be sponsored by Reps. McClain and Owens, but Nosse has not signed on and this legislative concept is not a requirement for addition to the panel - just a funding request.
    - Patrice added this is a legislative concept we have been watching since GAMT and MPSII have been recommended to be added to the screening panel and Krabbe is still pending and up for discussion in March. DMD has not been added to RUSP and is not eligible for consideration. This is a case where OHA may want to give some input to the legislators on how the funding would be used.
    - Q: If the Board wants to share information when should that happen?
    - A: Will follow up with Em regarding that.

6. Program Updates

Patrice provided updates on the NWRNBS Program.

Redesign of NBS Card: Information and implementation approach to using the newly redesigned card includes:

- Delineation of the place of birth, submitter of the NBS specimen, and follow-up (PCP) care provider
- Removed race, ethnicity fields from the card
- Include three options to designate sex (male, female, indeterminate)
- Inclusive language (birth parent/guardian)
- A new campaign is underway to have a NBS card for every baby. New cards include a "blood not collected" field with providers selecting reason: transferred, deceased, refusal. Families can sign the back of card indicating refusal

Questions and comments from the Board included:

- Q: Is there any conversation about changing the composition of the card or somehow helping to reduce the number of rejected specimens? Has seen clinics and hospitals taking photos as evidence on what they did – and the sample still comes back as refused. One of the problems is that it is difficult to collect. Is there an alternative or a better filtration paper that has a better success rate?
  A: There are only two manufacturers for cards in the US. Every lot gets sent to the CDC's as well as the company's quality assurance. Many facilities and states struggle to get a quality sample.
- Q: What is the reject rate statewide.
  A: About 5%

- Q: That's pretty high. Do you have a sense of what is the break down by hospital? What are they doing at the state level to try and optimize that?
  A: Every month, submitting entities receive a report on the number of submissions they had each month and what percentage were unsatisfactory. OHA Public health nurse Jacqui Umstead travels the state to provide education and training especially to facilities not performing well and anyone who would like training. She just completed a video on how to collect spots that is being released this month.
- Comment: I don't think they are collecting it wrong; the filter paper is hard to do, the tolerance level is very small.
  A: Hospitals can request photos of why they were rejected. Jacqui can give real time feedback on why they were rejected and tips/tricks on how to avoid. Sometimes the cards have been swapped out cards in case they have been compressed or damaged. Those that have seen a lot of rejections can enter into a conversation with Jacqui to address any issues. This is not an uncommon issue with other states.
- Q: Are there different ways we can collect this? Can it be a blood sample instead of a filtration paper?
  A: Can't be a blood sample because of the lab's automation process it wouldn't be able to have 300 tubes. There are other ways like you can collect with a capillary tube, although it is not recommended - you must be careful not to scratch the paper. Working with Jacqui to investigate options for the facility is recommended.
- Comment- I recommend Jacqui's presentation- has have information on the cards that was really illuminating about storage of the cards that may improve the samples.
- Q: What does the second specimen card look like?
  A: They are the same.
- Q: When a baby is born in one hospital and they have a two-step screen and they are transferred out, do we send both or just send the first?
  A: The ideal situation is to complete the first card, identify the reason the sample wasn't submitted, and then send the card to the lab. More details will be provided regarding this new "blood not submitted" policy.
  Q: On the receiving facility- if the patient comes without the first card- would they pull a single card?
  A: The process looks different if the baby is transferred before or after 24 hours. Additional provider education is needed and the Program will work towards this request.

<u>Communication Plan for New Cards</u>

- Notification 1 sent September 3, 2024- OSPHL is updating the NBS card
- Notification 2 sent November 7, 2024- New card image and highlights of changes
- Notification 3 to be sent January- how to exchange unused "old" cards
- Notification 4 to be sent January/February- education on how to complete the card

Improving Access to Screening

Another Program initiative was improving access to screening. Data reviewed showed that in the case of babies who were not screened, often the method of payment for the birth was different than for the babies who were screened:

- Of those screened
    - 54% private insurance
    - 42% Medicaid
- Of those not screened (families self-paid for the birth)
    - 30% private insurance
    - 30% Medicaid
    - 37% self-pay
- The Program was awarded $250,000 of General Funds to cover the costs of Oregon families who pay out pocket for screening
- As of November, subsidized screening cards were provided to 117 families removing the financial expense/barrier and enabling access to screening.

OSPHL New Laboratory Information Management System (LIMS) Project

OSPHL initiated a 5-year project to select a vendor for a new LIMS for the state laboratory. The system is where all the Program data is stored and where all the recording is done. Lab Vantage was selected as the vendor and contracting will begin in December and hoping to have one fully functional LIMS in the next couple of years.

Rule Changes Effective November 20, 2024

Pursuant to the Rules Committee meeting on September 4, 2024, the following Rule changes have been implemented:

- Removed practitioners' manual from rule
- Updated the collection guidelines for premature and LBW newborns
- Updated to the screening methodologies used within the laboratory
- Ensured the reporting of confirmatory test results to the Program for screened positive cases. Ensures the reporting of false negative cases (missed cases) to the Program
- Changed retention of specimens from 18 months to 12 months
- Addressed inability of families to pay for newborn screening and allows for OHA to set fee exemption guidelines

OHA 2025 Legislative Concept

Patrice reviewed LC 460, that would clean-up the statute language related to the NWRNBS Program. The new bill would: allow families to decline screening for any reason, not just religion; revise language requiring Coordinated Care Organizations (CCO) to cover screening costs; require all screening information and documentation and subsequent newborn care are confidential and not subject to disclosure; establish an educational program to include information on medical conditions and the importance of screening; establish a follow-up program to improve long-term care of individuals with medical conditions (subject to available resources); and update outdated language and definitions. Patrice said she would send a copy of the bill when it is ready.

Questions and comments from the Board members included:

- Q: Will the follow-up program be left up to OHA to determine what this follow-up will look like or entail?
  A: The statute would say that we can have a follow-up program, and OHA Rules will dictate how to go about that. We haven't begun work on what a long-term follow-up program will look like.
- Q: What will the goals of the follow-up program be? Would it try to ensure that the medications/supplements that are needed?
  A: The current statute doesn't even say that there needs to be any follow-up, even for the short-term. We are updating it to say there will be a follow-up program. We already have short-term follow-up; the long term will need to be developed. We want to get the language in statute so we have the statutory mandate.
- Comment: Nationally states are looking to setting minimum expectations on long term follow up. We are actively watching to get additional guidance on what that could look like from a standards perspective.
- Q: What has been the national trend so far?
  A: It is very different state to state. Not many states have a long-term follow-up program. However, there is a recognition that as a public health program we haven't been able to see the investment in the Newborn Screening program because there hasn't been the long-term tracking. Some states are collecting data, others are doing case management approaches by identifying barriers, and making sure families have access to care. States differ on the long-term care duration: through age 5, age 20, or through adulthood. There is a national group working on this issue.

Screening for Primary Hypothyroidism: The screening algorithm for primary hypothyroidism is being modified. This change doesn't require Board approval but the Program wanted to be transparent and share the details with the board.

The reason for the change is that the current algorithm is generating a lot of false positive results (e.g., 199 out of a cohort of 455 in 2023) from the babies are screened positive with either a low T4 and/or elevated TSH. There is a significant unreliability of the current algorithm for primary hypothyroidism.

Patrice shared the following statistics based on the current algorithm in 2023:

- 62,561 babies screened (OR, NM, Guam, other entities)
- 455 babies screened positive with either low T4 (<= 5ug/dL) OR elevated TSH
  - 373 babies had normal TSH over the course of testing (only T4 was low)- at risk for central hypothyroidism
  - 82 babies had elevated TSH over the course of testing- at risk for primary hypothyroidism
- From the cohort of 455 babies:
  - 39 babies were confirmed to have primary CH
  - 5 babies with TBG deficiency, a benign condition
  - 0 babies with central hypothyroidism
  - 199 babies were determined to have false positive results

- 46 babies expired before testing could be completed
- 166 babies were lost to follow-up
  (LTFU, referred to PCP but no conclusion, closed based on normal first screen results)

Questions and comments from the Board members included:

- Q: Seems like a high mortality rate - 46 out of 455?
  A: Yes, but often babies that are critically ill usually have an abnormal thyroid level
- Q: Wonder if the false positive rates have something to do with the sampling population and not the testing in itself? Do we need to think about the protocol for collecting samples in critically ill children?
  A: Even though there are 62,000 babies most will likely have had two screens, the NICU babies would likely have three screens. Reported babies might have flagged on any of the screens.
- Q: Maybe we shouldn't be testing critically ill babies because we only want to have tests that have results, we can act on? Why are we doing the first screen? Not do the first and wait for two or four weeks? Screening in a different way.
  A: There are some conditions that need collection within 24 hours to detect and treat in a timely manner. Hypothyroidism is a struggle with a lot of false positives with the early collection even the way the TSH changes over time is significant. However, with a kid with MSUD, galactosemia, or another metabolic condition will need a 24-hour collection.
- Q: Have there been any studies on this? The mortality rate and testing in ill babies and how do we justify that from an equity perspective? The rescreens seem to account for the false positives or just do a delayed screen specifically for the ICU babies.
  A: Don't know of any studies but can investigate it. Can give data in future meetings of what the profiles of kids that are critically ill that ultimately pass in the first week.

Patrice described the issues with the current algorithm noting that T4 in lowest 10% is needed to trigger the TSH test. However, TSH is a better indicator of primary hypothyroidism. The current algorithm prioritizes detection of central hypothyroidism, by testing T4 first. However, T4 and its use in detecting central hypothyroidism has a high false positive rate, which is very stressful for the families. In addition, there is a significant impact to lab resources with the false positives. Finally, the lab also receives many unsatisfactory specimens due to a lack of sufficient amount of blood for both the T4 and TSH testing. All these issues suggested a need for a new algorithm.

In the new algorithm, TSH is the only marker used for primary hypothyroidism, and as such, cases of central hypothyroidism will not be detected. Looking at data between 2017 until now, there were 11 cases of central hypothyroidism. With the new algorithm those cases would not be identified. Of those cases two were identified by clinical attention, five of them would likely have been identified clinically, and four would likely have been missed without the screening.

Questions and comments from the Board members included:

- Q: Is there not a low TSH threshold for flagging in the new algorithm? If the TSH is low- you don't care in terms of the newborn screening?

A: Correct.

Patrice reviewed the guiding principles for the decision to change the algorithm. These principles included improving testing sensitivity and specificity; primary hypothyroidism is on the RUSP and the Oregon NWRNBS panel while secondary hypothyroidism is not; TSH is the best marker for primary hypothyroidism; T4 is an imperfect marker leading to a high number of false positives; false positive results lead to undue stress on families and increased costs for the Program, and; as a public health program it is imperative to target and optimize testing for panel conditions.

Questions and comments from the Board members included:

- Q: Did you work in consultation with the pediatric endocrine group?
  A: Yes, met multiple times with our endocrinologists. They are not in favor of this decision because they want to detect all cases of central and primary hypothyroidism. Since central hypothyroidism is a treatable condition, the Program has taken their input and consulted with other states and programs. The decision was ultimately made the to target only primary hyperthyroidism.
- Q: Do you know what the estimated new false positive rate will be with the change?
  A: No, we don't know that number.
- Q: Is there a reason we can't have the lower TSH cutoff as well because it will pick up a few of those central hypothyroidism patients?
  A: We can investigate it.
- Q: Curious in terms of duty to report, if the lab sees a TSH that is 0, isn't that a duty to report out that it is very abnormal?
  A: Yes, right now, the way we process is to flag things above our cut off. We wouldn't even see it so we would have to set a threshold to catch that. Great suggestion and will look more into it.

Appreciate feedback and comments- this was a hard decision for the Program. Due to financial constraints and the sheer follow-up workload. Many cases are lost to follow up or false positives. The Program felt that this was the best decision, to change the algorithm to TSH as the primary and only marker.

The Program is moving forward but doesn't mean we can't change the algorithm in the future. The Program is committed to reporting back to our endocrinologist how things are rolling out and we can revisit if need be.

- Q: Will there be provider education/information going out about this?
  A: Yes, materials should be going out this week.
- Comment: Recommends follow up assessment during the implementation phase.
- Q: Curious about the four central hypothyroidism cases that would have been missed, I'm wondering if there is a potential TSH pattern that we could potentially figure out. Hopefully you are circling back with the pediatric endocrine group and teasing out some of those pieces because they are probably most worried about those four cases.

A: Regarding those four central hypothyroidism cases from 2017 to current, the actual incidents would be maybe one a year, more rare than primary hypothyroidism. The testing labs and data is sometimes incomplete and need complete records on these pieces. The data you would want to be able to see is not available to us.

7. Long-Term Funding Presentation & Discussion

Patrice provided a presentation on long-term Program funding and some background on NBS Program funding across the country. She reviewed the financial data about the Oregon NBS collection kits which fund the Program. The vast majority of NBS programs across the country, like Oregon, are funded primarily from screening test fees. Some receive state General Funds, Title V funds, and other sources.

The screening test fees vary between states and have varying factors that are taken into consideration such as number of tests per patient, services provided by each program, IT infrastructure, metabolic formula, and types of funding sources. While Oregon's screening test fees are $175, other states range from no cost (because the program receives General Fund monies) to $240. Most programs charge between $100 - $150 per screening test.

The other difference between states is how the fees are collected. NWRNBS collects the fees upfront and pre-sold through the collection kit purchase. Most states bill the providers or insurance after the screening test is complete, but they also have greater difficulty with reimbursement.

Questions and comments from the Board members included:

- Comment: Excited to have a recording of this because I get a lot of questions. This presentation is detailed and helpful.

Patrice reviewed the several options for funding the Program including General Funds, grants, screening efficiencies to reduce costs, conducting only a single screen test, charging for unsatisfactory specimens, contract changes with partners, and/or fee increases. None of these options sound good but gives a sense of what the Program is thinking for the Program's funding options. As funding options are discussed, the Board will be consulted.

Erik facilitated a follow-up discussion asking the Board if they had other options that might be considered for funding. The following questions and comments were offered:

- Q: Do you see if that we went to a single screen if there will be cost saving?
  A: It's a very hard question to answer. While you might think that could cut supplies in half or reduced personnel, that isn't always the case. The Program would have to go back and look at each algorithm for all the diseases and then determine the impact if there was only one screen. One screen states often do significant second tier testing to decrease false positives. A cost savings is uncertain.

- Comment: I know there has been a lot of manpower used chasing down the second screen, but I can see from a perspective of cut offs, if you only have one screen, changing the cut off may increase the burden down the road.
- Q: What are the plans if the current funding is not sustainable?
  A: The Program relies on fees, because General Funds are not guaranteed. However, providers carry the funding burden.
- Comment: The presentation clarifies and crystalizes the problem. It is a tight bind. It is easy to raise fees but that places a burden on the families and the hospitals. I can see and understand why the fastest way to implement new conditions is to raise the fees. It would be more sustainable as whole although branching out to find cost savings and helping those who self-pay are positive actions. See more clearly is that when we vote for conditions have to consider a fee increase.
- Q: Are we able to get grants from entities like OSHU or Providence? Or does it have to come from government?
  A: When I think about grants – I think about coming from the federal government. Could look at private entities.

8. Public Comment

No comments were presented.

9. Wrap-up

Erik asked the Board again to approve the meeting summary from September 4th but there was not a quorum at that time in the meeting. It was not approved.

Chair Hartzell thanked everyone for the robust meeting and adjourned the meeting.