Franklin County Office on Aging (FCOA)
2017 1.3 Mill Renewal Levy with .45 Mill Increase Proposal

HSLRC Meeting Minutes
December 15, 2016

The Human Services Levy Review Committee (HSLRC) meeting was called to order by Jessie Hemphill on December 15, 2016 @ 3:07 pm.

ROLL CALL

HSLRC members present: Jesse Hemphill, Denise Bronson, Zak Talarek, Jean Carter Ryan, Nathan Wymer and Jerry Friedman.

HSLRC members absent: Jim Bowman.

Office of Management and Budget (OMB): Heidi Hallas.

REVIEW AND APPROVAL OF MEETING MINUTES

Mr. Hemphill stated the next agenda item is the review and approval of the December 1, 2016 minutes. Mr. Wymer made a motion to approve the minutes. Ms. Carter Ryan seconded the motion. All members voted "Aye" and Mr. Hemphill said motion carried.

FINALIZE HSLRC FCOA LEVY REPORT

Mr. Hemphill: The next item on the agenda is the finalization of this draft of the report that will be in its completed form. Heidi, I have been through the report and I think it's a very good job, so congratulations to you and the staff. Does anybody have any discussions relating to the content of this draft report?

Ms. Hallas: I did receive feedback from several numbers via email and I did incorporate them as best as I could into this draft. Jerry had a few adjustments, but mostly it was typos, commas and minor errors. Jerry had a few in the recommendations, I don't know if you want to talk about it or make changes.

Mr. Friedman: I think the one that I've actually looked at a little more deeply is around assessing the need.

Mr. Hemphill: What page is that on?

Mr. Friedman: Page twenty-three, issue three (3). I think Heidi captured what I had indicated about leveraging collaboration with some of the local public health systems. But I've looked at this a little more deeply and they really have a comprehensive community wide initiative. It's called Health Map 2016. Whether it would be required in the future under the ACA which is what the hospitals have to comply with, but it's very comprehensive and looks at a lot more detail breakdown of our population and their health issues then the material that was being used by FCOA. It does indicate that there are representatives from representing aging, and they got COAA on there and then they have the State Department of Aging, but I think having the County Aging folks would be important and it doesn't appear to recognize the levy as a resource. So I think that maybe the forum for them to effectively do that leveraging and I would just say call that out a little more specifically.

Ms. Hallas: What was that called again?

Mr. Friedman: It's called Health Map 2016, and it a project that the Central Ohio Hospitals Council. But it's got the City Health Department, all the hospital systems, the Department of Health and it seems we shouldn't have to reinvent the wheel again and try to extrapolate from the work of the Scripps Center or just national kinds of surveys because it really does drill down into that. Also, it importantly talks about their focus and one of their top five focuses is chronic conditions. Within chronic condition it breaks out priority areas and a couple of them are pretty substantial within the aging community. Obviously Alzheimer, which is their first whether it's alphabetical or not, but it is 95 percent. Then you got Cardiovascular and some of the other activities. I think that segues into looking at resource collaboration. I think you do a good job of talking about there's been a reluctance for the hospital systems to contribute, but why would they contribute when they're getting the service for free. I think there has to be some level of discussion and I think Health Map forum is a starting point but then some more explicit discussions. I think the one party that isn't mentioned in the report is the Health Insuring Organizations, the HMO's. When we talk about providing some benefit to the hospitals in terms where they're not being penalized for re-admission surveys, but increasingly the health care insurers are the ones who are going to be more on the hook in terms of trying to keep people healthy as opposed to waiting until they get sick. Again I think bringing them into the mix. I think they have been able to skate out of this to a large degree because they have pushed it on to the provider community. But we're now talking about in terms of the services that the levy are providing not really medical services and I think that's where we see the resource shift happening. Less about fixing people after they get sick and more about what to do about keeping them healthy, which I think has been the objective all along in terms of the levy. So it's time I think some of those resources were shifted over in effort to diversify our funding base.

Mr. Hemphill: So this issue three (3) is a section of the report that you're suggesting that we make reference too.

Mr. Friedman: I just think being a little more explicit about the existence of this other activity and the resources that are available.

Ms. Hallas: And getting to the table with them from the county's perspective.

Mr. Friedman: And then I think that's the segue to talk about how we address the issues of shortfall and revenues and I think again that's a diversification.

Ms. Hallas: And that might be on page twenty four, twenty five where we talk the hospitals, Medicaid and Medicare, but we also need to talk about the insurance.

Mr. Friedman: Right. Again, I think it's the same issue we talked about last time. We're not in the business under this levy providing medical services, but the question becomes are some of the services we're providing medical and if so can we shift that to someone else of if there is a more efficient way to deliver it, is there a way to bill for it? You read about the immunization coalition. Its great there's immunization coalition for people to get their flu vaccine, but that's covered by most insurers. Are we essentially relieving them that responsibility, is there a way to claw back those dollars that we put out up front in terms of getting that back?

Dr. Bronson: Do you know if there are any examples Jerry, where that's happened? Where people had made the case that we're providing these preventive services and because of that you're spending less?

Mr. Friedman: Sure, they're all over the place.

Dr. Bronson: Because I wonder if that would help them if they had some examples or people to contact to do that so that they're not trying to fight that battle on their own. Because if sounds like a big battle to me.

Mr. Friedman: It is, but it's one that's going on within the entire industry.

Dr. Bronson: I understand, but I was wondering if there is some way to kind of help them through that process, with folks locally who successfully managed that.

Mr. Friedman: I think United Way has been active around addressing social determents of health. I think the Healthcare Collaborative of Greater Columbus has put together a medical neighborhood mechanism that incorporates social service agencies. I think that was the other issue in terms of those other kinds of match ups. We need to be in better alignment with what's coming out of medical care side of things and I that's really where the challenge is. If someone has a medical care and treatment plan, what aspect of that care and treatment plan are not able to be met by the individual and their resources and how can we match up with that. That was something the agency itself brought to us in their main report, saying we had to have closer alignment, but yet I don't think they saw a pathway to get past some of the issues relative to HIPAA privacy and that interface. I think the Healthcare Collaborative of Greater Columbus has been working on that, around creating that parallel base system that can have some interactions and I think the issue is more so the information getting back to the healthcare systems as to works available and what's being provided.

Dr. Bronson: And you think that if they were a part of this Health Map 2016 that would give them a kind of that foot in the door to have those conversations?

Mr. Friedman: You'll be at the table with folks and we're not at the table now and I think that discussion at that table is about what are the problems, what are the resources, where are there gaps in terms of resources to address the problem and if they're not seeing this as a resource, then maybe missing each other, in terms of either duplicating or not addressing gaps that exists. And again, even if they just go or even if the just take the map and the report off of the website, they would have by zip code where the issues are.

Dr. Bronson: So even if they don't sit at the table, they still can access…

Mr. Friedman: Yep, just the map itself talks about where the high impact chronic disease conditions issues are and look at when they make their grants for community based services, maybe that's someplace they can emphasize a community resource that could help them address those chronic conditions. That is a big push in terms of certainly Medicaid and to some degree Medicare around management of chronic conditions and I think what we've seen in the literature is those chronic conditions are as much caused by social and economic shortfall as it is by actual disease condition. So I think they recognize that, but I don't think actualize it in terms of a strategy. So just try to push them to do that.

Ms. Hallas: I'll specifically address it.

Mr. Friedman: I think broadly we cover it and I think those resources are available and could probably help them.

Ms. Hallas: Ok.

Mr. Hemphill: With Jerry's discussion of the resources that would be enough information to explore those resources and modify the report accordingly.

Ms. Hallas: Yes. I think just adding a few more sentences for the specific available groups and then utilizing the existing data. I mean they did have some data sets on poverty, but not necessarily this specific. So yes, I think just another couple of sentences.

Mr. Hemphill: I think in total, Heidi, you and your staff did a good job in capturing the discussions and all of the issues that we feel are relevant to the report, so kudos to you and your staff on what we've got so far. Any other members of the committee have comment regarding the draft report?

Mr. Friedman: I have one other, and I apologize for missing last meeting. I thought your discussion in the minutes of best practices was very helpful and I think the question for me is less about process and more about outcomes. Of the stated outcomes they're trying to achieve that could be compared to other counties. Their major outcome is keeping people out of nursing homes and that's pretty broad, but in the context of other counties can we look at that, is that a legitimate benchmark for senior levies as they exist within other counties in Ohio? Is there some other more granular outcomes that we could look at to measure, social functions, to measure quality of life as to oppose to broadly saying best practices? I think the difficulty and again within health care you can be on track with the best practices in the industry and be first in line to the glue factory. If the industry doesn't have any direction, then comparing yourself to the other folks doesn't necessarily accomplish what you're trying to accomplish. Who's the ultimate beneficiary? It's the senior citizens who are served and how can we more grandly understand whether or not we're really doing anything that impacts their lives, that addresses the needs that we're envisioning are important for them to function. I think the conversation you had is that we're spending a lot more than anybody else. But have we really anything to compare it to relative to what we are getting for our dollars spent?

Ms. Carter Ryan: I guess the question in my mind is I don't really consider that to be our job or our purpose to help them figure that out. That's what they need to figure out and tell us what they're doing. I think you're right, it is what are the results versus the activities and how do the activities help get to the results. Then, are they the right things and what are they doing to make the move back and forth. I thought that's what we were going with the best practice because to me it's always about how are the best practices you're getting to a better outcome.

Mr. Friedman: I think that's their last levy proposal which is moving the needle. What's the metric that we're measuring with that needle? If it's solely keeping people out of nursing homes, I'm not sure that we aren't bailing out with a thimble. What is it really that we need to do to go up stream and how do we measure whether or not dollars were spending are effect on that prevention side. I agree it's not our job to dictate that, but I think to give them the direction of understanding. You also mentioned like a dashboard, is that dashboard something that could give us a sense of less than two and half to three years into the levy where those moves are being taken.

Mr. Hemphill: What I'm hearing is keeping seniors out of nursing homes is too broad. Can there be any specific outcomes that are measurable as a metric?

Mr. Friedman: It really is a return on the investment.

Dr. Bronson: I do believe they listed a bunch of these things, and I can't put my hand on it.

Ms. Hallas: The published literature on this is pretty limited, believe it or not, on return on investments. It's a mixed bag. You improve their quality of life, they live longer, and it's costing more.

Mr. Friedman: From an economist perspective, you want to buy them cigarette, right? (laughter)

Mr. Talarek: I had a high school teacher who would say that. Save social security, buy your friends cigarettes. (laughter)

Ms. Hallas: It's definitely a group that's hard to measure, because they're aging and they are going to end up in a nursing home or pass away at some point. All the literature that I found would say it saves some money, but because they're living longer and going to the doctor more. It literally said it's a societal issue on what's important to us in maintaining life.

Dr. Bronson: In Appendix C where they talk about their association with all these different organizations and what the expected outcomes are and how they are measuring. It is more than just keeping people out of nursing homes. It's social connections, its nutrition and transportation, it's all those things that allow them to stay in their home and provide for a higher quality of life. So its satisfaction measures and quality of life measures that was a part of this whole thing.

Mr. Friedman: So are those comparable across counties?

Dr. Bronson: That I don't know, but I don't want them to think we haven't read this closely enough. We don't know they aren't looking at some of these other more fine tuned measures. And this is a hard thing to measure.

Mr. Friedman: I understand that, but from a research perspective, can we do a pre and a post, do we do an individual assessment of an individual to look at if whether or not there has been any improvement or whether or not we've been able to stabilize the individuals.

Ms. Hallas: They do those every year.

Dr. Bronson: Again it's the situation, you know it's not necessarily improving and maintaining, they still may be declining.

Mr. Friedman: But have we litigated the rate of decline? There ought to be some way.

Ms. Hallas: They do those assessments within their own participants. When they come in, they do the ADL and the quality of life. Depending on the level of service, it's reassessed six (6) months or every year. They have pre-post. They just don't have it in a query format, again that's a system limitation, and it's in case notes. So it's not in a way that they can say here are our results. But they do that in order to determine if they can remain in the program because you have to have some function limitation and they do track their progress on that at least a year and I do believe the higher end ones get every six (6) months.

Mr. Talarek: And it depends on the situation too, if it's a hospitalization that they know is short term and I think they plan that accordingly as well.

Ms. Hallas: I don't think they're utilizing their data to the capacity that they can and that's always been my argument. I'm hopeful with the new case management system it's not just notes that we could make that case but also have something to compare it to. Again back to the HIPAA and getting a comparison data set.

Mr. Friedman: Even for purposes of comparison to themselves you could create three (3) cohorts, high risk, moderate and low risk and or people moving from high risk to low risk. It's kind of a gross way to look at it, but that's kind of the way you want to move. People come into the program at a certain level and if the program is affective you are going to decrease the potential of going into a nursing home and that's going to be based on either improvement of their social circumstances, improvement of their care giving and a variety of things we're spending money on. But gives you some sense of where that change is occurring

and why it's occurring. I don't think we understand the nexus right now between the services that are being provided and what the outcome of being achieved is.

Mr. Hemphill: Well maybe just as an example, hospital admissions, is there a way to monitor the population of seniors in there being served, monitor the hospitalizations, so that we can say, it was X, this year is Y, and see some prompt to continuous decrease in that population.

Ms. Hallas: If we had a sophisticated data set and the staff to do it, I believe its self reporting at this point, but those folks would have to share the medical data again, and I don't know how much of that we have.

Dr. Bronson: I'm not always sure that those things are under the control of FCOA or even the clients in the program. There are medical procedures that take over in these situations having experiencing some of this in our family issues. When they don't want to go to the hospital but they're taken to the hospital because a squad is called. There are so many variables in all of this and I'm not sure that one of their goals really is to decrease hospitalization. If somebody needs to be hospitalized, they should be hospitalized. We have to be careful of what we're kind of setting out as a goal. I'm not disagreeing with you Jerry, in terms of having them tracking the variables that have been shown to increase length of stay in homes and they can track how long people are staying in their homes. I think it gets really tricky when you start thinking about the comparisons and measures of improvement for this particular population and I think that's one of the challenges in this whole field is to track those kinds of things. It's not that you're necessarily going to see people getting better, you don't…

Mr. Friedman: Well, you want to limit inappropriate hospitalizations.

Dr. Bronson: Yes, but now we've got a suggestive factor incorporating this.

Mr. Friedman: But we also have programs, I think Upper Arlington has a program where if someone is a repeat caller for a squad, they then follow up with someone who has more social worker oriented; understand what the limitations and are you using this as a backstop in terms of other resource deprivation that you have.

Dr. Bronson: The comparison would be those who are not receiving FCOA services and those who are.

Mr. Friedman: Potentially. Maybe this is just a natural evolution given where this small house with all these added rooms on. Maybe just getting them in the room with all these other resources so that they have the actual information about hospitalizations and for what reasons within this population it would help them to focus. I certainly don't want to get into this level of granularity, but I think some of the more specific direction under the assessment and then the collaboration would be a way to start this going. I think it's up to them to find their way, I think there are other resources out there that could be brought to various populations.

Ms. Carter Ryan: To your point, how do we incorporate that? We are at the report stage right? So we're talking about they need to take not to look just at best practices but to look to their overall goals and objectives and measuring those and be able to write a report on that. Isn't that what we're talking about?

Mr. Hemphill: I think more specifically what we're talking about is an outcome that's greater than just keeping an individual out of the hospital or greater than keeping individuals in their homes. Something that is more measurable that we can supplement.

Ms. Hallas: I think, and this is just my opinion, I think once they do this operational piece and get a better handle on their data and their Business Service Officer that they are hiring that is also going to be in IT, I

think these thing can occur. I had these conversations with them when we were doing this almost five (5) years ago and they couldn't get me the data, it was in text fields and we had to pull each record and cut and paste. It was just ridiculous amounts of time. I think maybe when they come back mid levy and we see where they're getting to the point where they can put this data together. Making sure that they're getting it in way where they can query and pull a report that drives their decision making, I don't know if now, maybe now isn't the time in their report, but keeping an eye on that as they move forward, with their other operational implementations to make sure that they're keeping that in mind as they move forward. I mean that's just my thought. They have a lot to do with that operational assessment, but I do want them to keep in mind the goal. Because I know even County Administration is to get that data.

Mr. Talarek: I think all these two (2) are interrelated. I think like you said even in the last report I think what the first thing was to identify and refine their outcome measures, we do that annually in the budget process. Like you said having better outcomes and better data helps you on getting grants. It's all there, even if its recognition where, when you identify best practices, could you refine your outcomes or identify other outcome measures as you're doing it and just kind of reference it because I do think it doesn't hurt because they're all connected. In one case I thought it was implied if you have a best practice you're going to have outcomes in it, that's going to be reported and we're going to need that for grants it's kind of there. If we wanted to be explicit, we can add a sentence in addition to identifying best practices, other outcomes are refined, outcomes that are developed which is also tied to the new system. I mean they're all related.

Ms. Hallas: Their outcomes now are very short term. It's counts and how many are we serving. They really don't go after what is the long term outcome or even the intermediate and that's what I hear you saying.

Dr. Bronson: I would say differently. I would say the long term outcome is keeping people in their homes. It's the intermediate and the short term that are in place to social contacts and access to transportation, those are all of the short term goals that are going to allow people to say in their homes.

Ms. Hallas: Correct. I think that's the assumption. They're not talking about here is how many we kept in their homes or we kept people in homes this much longer. It's we're doing all these that prove in the literature are the supportive services needed.

Dr. Bronson: Until you don't provide services to somebody, you can't make that comparison. They can look at the data coming out of this Health Map for those who don't receive the services and are they going into more restrictive living situations sooner. You can't do it with those you are serving because you can't begin to project when they would have gone into the hospital or nursing homes had they not had services. Yes this can be done whether this is their job to do it. Now they can certainly compare non-served populations to those that are served. If that's what we want them to do, we can ask them to explore that possibility. I'm trying to figure out how we can give them some guidance on this without expecting them to run a research project on this which I don't think is their job. They need to tell us what they're doing and we've talked about the process measure in all of this, we've got lots of information on that. They have provided information on more short term, well they're actual outcomes, but they haven't provided the comparative information, that's a whole other project for them to do that unless those data exists somewhere already. If you think they already exist in the Health Map then we can ask them to look at that.

Mr. Friedman: Either in the Health Map or within the organizations that come together that put the Health Map together.

Dr. Bronson: Ok, if it exists elsewhere, then they can begin to look at that.

Ms. Hallas: Is that something we want to specifically ask them to do? Like Zak said, you are kind of dancing around it with all the pieces, but we don't say do this that year. The agency will argue those dollars should go to services and not a study.

Dr. Bronson: If the data already exists, either through the Map, or through Scripts or through somebody else as to, there are so many variables. Anyway, if there is a way to compare those who receives services in some reasonable way with those who have not receive services hold into account all these other factors that will play into this whole thing and they can show that being a member or being served by these providers is going to keep them in homes longer. Then there's a fiscal benefit to the county to see that it happens. It really comes down to it costs a lot less to serve people in their homes then it does to serve them in a more restricted setting. So we do have those dollar amounts, they've talked about that.

Mr. Friedman: You're talking about averages?

Dr. Bronson: Right. But I think that's what we have to work with.

Mr. Friedman: They also pulled it out of either home or nursing home.

Ms. Hallas: What else is there? Because home is also daycare.

Mr. Friedman: Do we need to develop more congregate living circumstances.

Dr. Bronson: Well there are congregate food services.

Mr. Friedman: I just get the sense there's a strategy.

Dr. Bronson: For assessing outcomes?

Mr. Friedman: For success indicators, other than keeping people out of nursing homes. Which isn't particularly a benefit that accrues to the county?

Dr. Bronson: Financially it does.

Ms. Hallas: But that's a bigger argument. We know that Medicaid and Medicare are going to more home based services now themselves, and to me they've study it. There's already proof that these types of services in fact some of the trial studies they're doing now, such as social worker and handyman, Medicaid is paying for that and they're doing that in Maryland right now. They're getting it, but we're paying it, they're benefitting. We know it works, we know it's cheaper and we know it's what folks need and I think the bigger systems are going there but it's that conversation that we talked about in the assessing Issue No. 5, we relying on the property of the local taxpayer and if we want to talk just financial, they're not the only beneficiary and so it almost comes back to that. I really believe and know in the literature that what they're doing is appropriate and it's what people want and the systems are shifting to more to in home care. So I don't think they are doing it wrong, it's just who the appropriate payer source is and who's benefitting. We've just embraced it as a community before most anybody else has. I don't know what they're doing is wrong and that not going to a nursing home is not a good outcome, I think it's a great outcome and most people want it. AARP just did another survey where eighty percent are saying, heck no I want to stay in my home, so it's what the people want. I don't know how to say it. I don't think they are doing anything that's not appropriate when you look at the research. My hang up is the local taxpayer burden and how do we start those conversations, not that they're doing it wrong.

Mr. Friedman: The operational assessment includes a new Case Management System, a new tracking system?

Ms. Hallas: Because their current system may not be supported too. Somebody bought them out and services haven't gone well, so this is definitely on their short list to do.

Mr. Talarek: So going back as Jean said to the original thing, do we make a reference to identifying outcomes or do you think it's kind of encompass elsewhere in the report?

Mr. Friedman: Well do we actually talk about best practices in here, is that in two?

Dr. Bronson: Identifying comparison agencies is even in here.

Mr. Friedman: What page are we on?

Mr. Talarek: Twenty-two. To me, I think the section might be toward the end of that paragraph where it talks about identifying senior services. Even putting if there are any updates, findings, or measures associated with best practices. Again, depending on what's available.

Dr. Bronson: On the top of page twenty-three?

Mr. Talarek: Yes. There might be some best practices utilizing delivery of service and associated outcome measures.

Mr. Friedman: That's exactly where I was going, delivery of services and the achievement of outcomes determined by the agency. Again, I think it's up to them to set the outcomes; to identify what it is they believe is achieving their ultimate mission is moving them towards their goal, but should measure it.

Mr. Hemphill: Any additions or discussion related to the draft?

Mr. Wymer: Motion to approve.

Mr. Hemphill: Motion to approve with modifications.

Ms. Carter Ryan: Second to approve with modifications.

All members voted "Aye" and Mr. Hemphill said motion carried.

Ms. Hallas: I will cleanup this report with those few changes and then because of our timeline, since it's only changing those couple of pages, I'll probably just send those to you and say here's what I've drafted and let me know. Next our Public Affairs will make a review. Normally they don't have much comment but we just have to have them take a look at it and then I will send it to the print shop. Our date is December 29, 2016 to have it to the Commissioners. So I wanted to ask, how many of you want a hard copy of the report. I'll make sure you get electronic.

Everyone elected to have the report sent electronically.

Mr. Hemphill: Is it going to be via Dropbox?

Ms. Hallas: Yes, because once you start putting all these graphics in its too large. The next step will be the Briefings and then the General Sessions and I will need at least one (1) representative at each of the dates

listed on the agenda. So if you guys has any available to step in, I will write the script and email it to you and send you reminders ahead of time. I know Jesse normally attends.

Mr. Hemphill: Sure, I can make the four (4) sessions that are indicated and right now I don't see any problem with me making it to all four (4) of those sessions and doing the presentation from the committee.

Ms. Hallas: Ok.

Mr. Hemphill: If there is a problem, I will let you know in advance.

Dr. Bronson: Do you want moral support there?

Ms. Hemphill: Any volunteers will be appreciated.

Dr. Bronson: I thought you might want someone sitting in the back row, going yea, go Jesse! (laughter)

Ms. Hallas: If nobody else wants to go, I'll just work with Jesse. I'll send you some calendar holds and get you the script. And then the final thing for this levy, Jesse before you leave, we always have a letter of recommendation that we put into the report. I'll have you sign this before you walk out.

Mr. Hemphill: Sure.

Ms. Hallas: So you all are ready for the next one right? (laughter). In front of you is the timeline for the next levy review. Because this is our last time meeting, I wanted to get your feedback on this. I've talked to County Administration; I've talk to Jed and the staff at BDD. The two (2) dates, I actually had to change one (1) date. I worked with them on the two dates they are scheduled to meet with us and they can do those dates. It definitely would be the March 2, 2017 where they would do their presentation at their location and then the follow up meeting, we meet again to discuss and then we have a follow up on April 6, 2017. They have locked in both of those dates, so if those are okay with you guys, I will get meeting invites out to at least hold those initial meetings dates.

Mr. Friedman: I'm out of town on March 2, 2017.

Ms. Hallas: And they were out of town the following week. Anybody else know if they can do those?

Ms. Carter Ryan: As of right now, I think those are alright with me. I think trying to get a unanimous group there kind of helps to have everybody there for the initial presentations to be there.

Ms. Hallas: I know. I just feel like every time I push it, someone else falls off. For some reason, March was just not great for them and the 2nd worked for Jed and their CFO. A couple of weeks after that were just not working for them.

Mr. Hemphill: So the meetings on March 2, 2017 and April 6, 2017, are those going to be with Management and the Board or is there going to be board participation?

Ms. Hallas: They can usually invite their board; I have never done with them. The other agencies usually have their Board there.

Mr. Hemphill: One Board, one Chair?

Ms. Hallas: Yes.

Mr. Hemphill: I'm good with the March 2 and the April 6, 2017 meetings. There won't be any conflicts.

Everyone else was good with those dates.

Ms. Hallas: So what I'll do then, is let them know that you are good with those and then I'll send invites out for those couple of dates. The other ones can flex, but I know with their schedule and your schedule I just wanted to get when we can meet with them. So they'll be presenting it to their Board in February for a vote. I'll send that report to you as soon as I have it. And that's all I had. Thank you so much everybody.

CLOSING REMARKS

Ms. Carter Ryan made a motion to close the HSLRC meeting and Mr. Friedman seconded.

The meeting was adjourned at 3:52 pm.