STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Date: August 31, 2017

To: Secretary of the State's Office
Lead@ct.gov

From: Raffaella Coler, R.N., MEd., Paramedic
Office of Emergency Medical Services

Re: Mobile Integrated Health Working Group

I am filing with your office the upcoming meeting schedule for the Mobile Integrated Health Working Group.

Below is the schedule:

Tuesday, September 5, 2017, 9:00 AM – 11:00 AM in Room 1D of the Legislative Office Building

Tuesday, September 19, 2017, 9:00 AM – 11:00 AM in Room 2D of the Legislative Office Building

Tuesday, October 3, 2017, 9:00 AM – 11:00 AM in Room 1D of the Legislative Office Building

Tuesday, October 17, 2017, 9:00 AM – 11:00 AM in Room 2D of the Legislative Office Building

Tuesday, November 7, 2017, 9:00 AM – 11:00 AM in Room 1D of the Legislative Office Building

Tuesday, November 21, 2017, 9:00 AM – 11:00 AM in Room 1D of the Legislative Office Building

Tuesday, December 5, 2017, 9:00 AM – 11:00 AM in Room 1D of the Legislative Office Building

Please do not hesitate to contact me at 860-509-7975 should you have any questions.

Cc: Raul Pino, M.D., M.P.H., Commissioner

Connecticut Department of Public Health

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Mobile Integrated Health Working Group

December 5, 2017

Location: Legislative Office Building Room 1D

Time: 9am

Agenda

1. Welcome
   a. Welcome
   b. Review of room Logistics
2. Approval of Minutes from November 21, 2017
3. Presentations by subject experts:
   a. Home Health and Hospice Regulation/licensing/scope of practice — Tracy Wodatch
   b. MIH Initiatives with Hospice — Chris Santarsiero
   c. Department of Social Services — Dr. Balaski
4. Next Steps
5. Public Comment
6. Adjourn

Mobile Integrated Health Workgroup

Minutes

Date: December 5, 2017 Time: 9:00 a.m. Location: LOB Room 1D

Chair: Raffaella Coler, Director OEMS,

Attendees: Gregory Allard, Marybeth Barry, Bruce Baxter, Joshua Beaulieu, Kristin Campanelli, Jennifer Granger, Susan Halpin, Shaun Heffernan, David Lowell, Jeannie Kenkare, David Lowell, Mary Jane Williams for Kimberly Sandor, James Santacroce, Chris Santarsiero, Carl Schiessl, William Schietinger, Kelly Sinko, Tracy Wodatch, Michael Zanker

Agenda Item	Issue	Discussion	Action/Responsible
Welcome		Raffaella Coler welcomed the workgroup members	
	Housekeeping	Review of Room Logistics and Introductions	
Minutes	Review of the November 21, 2017 minutes	There were two edits to the minutes under Home Health Care and Hospice. Revision made to read Some differences is home health care will assign at least a nurse or a therapist whereas, hospice will be a full team approach. The third bullet under things to consider was removed. All were in Favor of those two changes; Opposed- none	
Presentations	Home Health and Hospice Tracey Wodatch Continued from last meeting	Provided a recap for those who were not at the last meeting. The differences between licensed home health care and homecare	

		Some of the gaps identified were • When does the home health provider get out for the first visit once a patient leaves an acute care setting? Within 48 hours or sooner if ordered by M.D. • Only an M.D. can order home health care or hospice. • Home Health staff cannot push IVs Homecare non-licensed non skilled. They do not follow M.D. orders. Gaps: Area for education where skilled home health could be referred as EMS may be first entry when they don't know where to turn. Hospice Have to be licensed by DPH as Home Health Care Agency and then add hospice services and certified by Medicare. They are comprised of multi-disciplinary teams. Prognosis is 6 months or less and there needs to be sign off by two M.D.s. Reminded the group that the Connecticut Hospital Association has an advisory group called Care Decision CT and it was discussed a previous meeting that it would be a good opportunity to have representation from EMS. Went over some of the triggers for referrals. Reimbursements is on a per diem, all-inclusive rate (visits, medications, DME, tests, transportation)	
	MIH Initiative and Hospice Chris Santarsiero	Presented on what they are doing in Texas. There are medium risk and high risk assessment tools they are using that they put their patients on. There are tools are in place for high and	

		medium discharge. The key is to have an open line of communication with the EMS providers and hospice so if they don't call hospice there has been an introduction and they can 911 to do their job and to also call hospice to get the nurse out there as soon as possible. Hospice and home care agencies provide comfort packs to their patients and EMS providers can look out for that pack which has everything the hospice patient needs in it to comfort them. It is a useful tool for EMS providers to attend to a patient immediately until a nurse can get out to the patient. There was discussion of how the dispatch occurs between VITAS and MedStar. If VITAS receives a call and depending on the situation they may contact MedStar to go the house until a nurse can arrive. How long the paramedic stays with the patient until the nurse arrives is different depending on the situation. VITAS does have a financial arrangement with MedStar. Easier in the Fortworth as they are the only provider covering that specific area whereas CT has numerous providers. Carl Schiessel will be happy to circulate through the Chair information on Care Decision CT. Any statistics in CT how big the problem is with revocation? Is it in pockets or wide spread? Any statistics that could demonstrate the ethicacy of the relationship with Medstar in terms of revocations rate prior to and the impact.	Tracey Wodatch will look at the revocation piece Chris Santarsiero
	Next Steps:	Reminded the group of the charge of the public	

		act. Any additional Education: DSS will be presenting <u>Suggestions for next steps:</u> Will need to look at education for paramedics and home care • scope of practice • competency Discharge plan from hospital- discharges have a wide variety of outcomes. In some cases, home health is not set up and potential for referral is there. Have someone from a hospital present to the group about discharge plans. Group needs to develop the gaps – agree to them and then work on the education model. Small group will identify some of the gaps: Mobile Integrated Health under Advisory Board is looking at educational models across the country and what additional requirements are needed. Need to take into consideration insurance coverage and reimbursement along with are the providers properly trained and how to pay for the solutions. Need to identify what is or isn't in existing legislation Meeting schedule will go out in the next couple of weeks.	DSS will be presenting Lead: Greg Allard Joshua Beaulieu will be ready to share in the next couple months.
Public Comments		No public comment	
Adjourn		11:00 a.m.	

Mobile Integrated Health Working Group

November 21, 2017

Location: Legislative Office Building Room 1D

Time: 9am

Agenda

1. Welcome
   a. Welcome of new members
   b. Review of room Logistics
2. Approval of Minutes from November 7, 2017
3. Presentations by subject experts:
   a. Dispatch Centers — Rep. J.P. Sredzinski
   b. Home Health and Hospice Regulation/licensing/scope of practice — Tracy Wodatch
   c. MIH Initiatives with Hospice — Chris Santarsiero
4. Next Steps
5. Public Comment
6. Adjourn

Mobile Integrated Health Workgroup

Minutes

Date: November 21, 2017 Time: 9:00 a.m. Location: LOB Room 1D

Chair: Raffaella Coler, Director OEMS,

Attendees: Gregory Allard, Christian Andresen, Marybeth Barry, Bruce Baxter, Joshua Beaulieu, Michael Bova, Kristin Campanelli, Jennifer Granger, Susan Halpin, Shaun Heffernan, Dr. Kamin, David Lowell, Dr. Maybelle Mercado-Martinez, Mary Jane Williams for Kimberly Sandor, James Santacroce, Chris Santarsiero, Carl Schiessl, Kelly Sinko, Tracy Wodatch, Dr. Donna Balaski on behalf of Dr. Zavoski

Agenda Item	Issue	Discussion	Action/Responsible
Welcome		Raffaella Coler welcomed the workgroup members	
	Housekeeping	Review of Room Logistics and Introductions	
Minutes	Review of the November 7, 2017 minutes	The minutes were accepted and seconded as written. All was in Favor; Opposed- none	
Presentations	Dispatch Centers: Rep. J.P. Sredzinski	Presentation was given on dispatch centers. Some key talking points were calls currently go through the 911 system, Emergency Medical Dispatch Centers are established by statute and is a tiered response established by agency. How does Emergency Medical Dispatch (EMD) work and what happens when you call 911? The call comes in to a Public Safety Answering Point (PSAP) for Emergency Medical Dispatch (EMD). Coordinated Medical Emergency	

		Dispatch (CMED) is the connectivity between the EMS Service and the hospital. Please note that in some parts of the state the PSAP and CMED may be combined and in other areas of the state the PSAP and CMED are separate. When you call 911 a determination is made on what level of service will be dispatched. There are three key items- • Case Entry- question regarding patient location, phone number, patients age and what is happening (i.e. difficult breathing etc.) • Key Questions- If they are having difficulty breathing is the patient alert or confused etc. • Dispatch- will determine what resources are needed. The determinate levels can vary from town to town. There is quality assurance as each EMS service is required to have medical oversight from a sponsor hospital. Each sponsor hospital provides QA/QI to the services. There are 169 Towns and over 100 Public Safety Answering Points (PSAPs) however dispatch is done differently across the state. Things to consider: • There would need to be a process established for individuals that utilize 911 when the call is determined to be low priority and non-life threatening. • Additional training would be needed however consideration needs to be given to not put any unfunded mandates on the cities or towns.	

		• Current existing resources and the availability of them • Developing a process that meets the standard of care appropriate to the standard of medical care. • Workforce availability • Is the current training sufficient enough?	
	Home Health and Hospice: Tracy Wodatch	Presentation on homecare and hospice was given. There are two types of homecare, licensed and unlicensed. Home Health Care Agencies are licensed and they provide skilled services. A hospice has to be licensed as a home health agency before they can get a hospice license. Some differences is home health care will assign a nurse or at least a therapist as a lead whereas hospice will be a full team of staff. There is a huge volunteer network and provides support to both the patient and the family whereas home health's focus is more on the patient. Things to consider: • Dispatchers would need to be educated • Time frames in which home health comes out to a patient-could be same day or up to 48 hours. • Scope of practice (i.e. RN's in homecare cannot push IVs) • Care Decisions CT group - it does not appear that there is any EMS representation.	
	Next Steps:	Tracy Wodatch will continue her presentation at the next meeting followed by Chris Santarsiero to present on MIH Initiatives with Hospice. Dr. Balaski will present on Social Services.	

		Future meeting dates will be discussed at the December 5, 2017 meeting.	
Public Comments		No public comment	
Adjourn		11:00 a.m.	

Mobile Integrated Health Working Group

November 7, 2017

Location: Legislative Office Building Room 1D

Time: 9am

Agenda

1. Welcome
    a. Welcome of new members
    b. Review of room Logistics
2. Approval of Minutes from October 17, 2017
3. Presentations by subject experts:
    a. Community Care Teams, CT, cont. — Carl Schiessl
    b. CCT, Middlesex County Experience — Jim Santacroce
    c. MIH Experiences, Nationally — Greg Allard
4. Future Presentations:
    a. Dispatch Centers — Rep. J.P. Sredzinski
    b. Insurance Considerations — Kristin Camapanelli
5. Next Steps
6. Public Comment
7. Adjourn

Mobile Integrated Health Workgroup

Minutes

Date: November 7, 2017 Time: 9:00 a.m. Location: LOB Room 1D

Chair: Raffaella Coler, Director OEMS,

Attendees: Gregory Allard, Christian Andresen, Marybeth Barry, Joshua Beaulieu, Michael Bova, Kristin Campanelli, Jennifer Granger, Susan Halpin, Dr. Kamin, Dr. Kenkare, Dr. Maybelle Mercado-Martinez, Kimberly Sandor, James Santacroce, Chris Santarsiero, Carl Schiessl, Kelly Sinko, Dr. Michael Zankerf, Dr. Donna Balaski on behalf of Dr. Zavoski

Agenda Item	Issue	Discussion	Action/Responsible
Welcome		Raffaella Coler welcomed the workgroup members	
	Housekeeping	Review of Room Logistics	
Minutes	Review of the October 17, 2017 minutes	The minutes were accepted and seconded as written. All was in Favor; Opposed- none	
Presentations	Community Care Teams (continued)	An overview from the previous meeting was given. He discussed the integrated care concept and how the demands are different from town to town. It was identified that EMS is not currently integrated into the Community Care Teams and should be regardless of the outcome of this committee. Jim Santacroce talked about his experience and what is being done in Middlesex County.	

	Insurance: Kristin Campanelli	Presentation on EMS transport benefits and the different payment models. Questions: Will statutes need to be changed to add a treat no transport rate category to the existing rates issued by Department of Public Health and would DPH responsible for setting that rate? Will insurance cover this service?	
	MIH Experience: Nationally Greg Allard	Presentation on existing MIH programs nationally. He went over the various types of MIH programs from fire based to hospital based and the presentation covered a variety of services by location and size. Things to look at: CT EMS providers work within the EMS 911 system and are prohibited from working outside that system. There are primary service area responders and could be potential overlapping of services in different areas. Will there be additional education requirements? It was mentioned that this will need to be regulated in statute and exist statewide. Data to look at: How many non-emergency transport services to a hospital in 2016 and how many were reoccurrences.	
Public Comments	Sean Burton: National Director of Mobile Integrated Healthcare for AMR	Spoke to the group on his experience with MIH and gave the committee some things to look at and think about as they move forward. Recognize the charge of the committee and the providers. MIH is not designed to replace existing services but to fill in gaps in service. He gave some insight on how gaps were identified. He talked	

		about how data is significant to the process and the need to identify your population. MIH is using the system l a way it had not been previously designed for. Things that were done: You get together as a group and break down the population of a community and then break it down further by complaints. You match the complaints with a community and that will help identify a lack of resource in that community. A pain point is that you have to work within available resources. The key resources are to bring to the table your struggles and then build plans to fill in the gaps. He finished by saying he would be available if the committee had any questions or needed any assistance as it moves forward.	
Adjourn		10:54 a.m.	

Mobile Integrated Health Working Group

October 17, 2017

Location: Legislative Office Building Room 1D

Time: 9am

Agenda

1. Welcome
    a. Welcome of new members
    b. Review of room Logistics
2. Approval of Minutes from October 3, 2017
3. Presentations by subject experts:
    a. Paramedic Scope of Practice — Dr. Richard Kamin
    b. Role of Dispatch Centers — Rep. J.P. Sredzinski
    c. Community Care Teams — Carl Schiessll
4. Future Presentations:
    a. Update on existing MIH programs — Greg Allard
    b. Insurance Considerations
5. Next Steps
6. Public Comment
7. Adjourn

Mobile Integrated Health Workgroup

Minutes

Date: October 17, 2017 Time: 9:00 a.m. Location: LOB Room 1D

Chair: Raffaella Coler, Director OEMS,

Attendees: Gregory Allard, Christian Andresen, Marybeth Barry, Bruce Baxter, Joshua Beaulieu, Michael Bova, Kristin Campanelli, Jennifer Granger, Susan Halpin, Shaun Heffernan, Dr. Kamin, Dr. Kenkare, Kimberly Sandor, James Santacroce, Chris Santarsiero, Carl Schiessl, Bill Schietinger, Kelly Sinko, Jonathan Steinberg, Tracy Wodatch, Dr. Michael Zankerf, Dr. Zavoski

Agenda Item	Issue	Discussion	Action/Responsible
Welcome	New members	Raffaella Coler welcomed the workgroup members	Only one empty seat left
	Housekeeping	Review of Room Logistics	
Minutes	Review of the October 7, 2017 minutes	The minutes were accepted and seconded as written. All were in Favor; Opposed- none	
Presentations	Paramedic Scope of Practice	Dr. Richard Kamin presented Protocols- There is a set of statewide protocols however; protocols in some areas of Connecticut are region specific protocols and some areas use sponsor hospital specific protocols. Curriculum – There is nationally promulgated curriculum. In some parts of the nation the curriculum is established state by state and even in some cases locality by locality.	

		Paramedic Program-1500+ hours of education in additional to 100+ hours of ride time. Since 2009 Paramedics have followed the National Education Standard. Any paramedic program in Connecticut has to be accredited by the National Association , CoAEMSP, which is far above and beyond the minimum standard and provides increased education, oversight and quality assurance. In order to run a paramedic program it needs to be affiliated with a college. Paramedics is the profession we are referring to for Mobile Integrated Health. Additional training once paramedic license is received to include precepting under another paramedic, yearly skills validation and mandatory continuing education. Each service has a sponsor hospital and their EMS staff works under the direction of a medical director at that hospital. It is possible for an individual to have more than one medical director if they work for multiple services. It is possible that a paramedic working in Old Saybrook in the morning could be working under the medical director of Middlesex Hospital and in the evening's working as a paramedic in Hartford under the medical director at St. Francis Hospital. In looking at the scope of practice for EMS professions, Paramedics are the only licensed category. Each EMS profession is defined in regulations as to what they can and cannot do. Anything above and beyond is determined by the medical director at the sponsor hospital. It is possible for one hospital to allow a certain skill and another hospital does not allow that same skill.	

		How does dispatch determine who to send? Dispatch operates underf protocols. Depending on the complaint it is determined the level of response and the service to be dispatched. An example of some 911 calls that do not necessarily need a transport. An individual fell out of their chair, need assistance getting back up. At times EMS arrives to a location that is not an immediate crisis but a social service crisis. An individual needs an immediate intervention and what ends up happening is that EMS will refer the individual to other services within the town. If EMS sees the same person over and over again they are referred to other programs that best suit their needs. For these individuals they use the 911 system as their first contact because they don't always realize what services are available to them or that they are even eligible for those other services. It is important to note that there is no compensation unless a patient is transported. .	
	Role of the Dispatch Centers	to be rescheduled for future meeting	Representative J.P. Sredzinski
	Community Care Teams	Carl Schiessl presented Community Care Team is a team of local medical, behavioral health, and social service providers utilizing a wraparound approach to provide patient-centered care, requiring multi-agency partnership and care planning, and the use of traditional and non-traditional supports and services. When a patient is admitted to a community care team they sign a release of information and it signed and updated periodically.	

		The primary goal is improved patient health and reducing overcrowding in the emergency departments. Currently, community care teams are funded by a resource grant, generosity of providers to volunteer; one region is a bequest from a former patient, private grants and hospital foundations. They are still looking for a sustainable revenue to fund the community care teams. There are about 6 teams that are up and running and there is no charge to the patient. Open up next meeting to continue talking about the community care teams.	
		Next Meeting: Greg Allard update on existing MIH in nation Kristin Campanelli to present on insurance Look at the charge of the MIH when it comes to presentations.	
Public Comments		No public comment	
Adjourn		11:00 a.m.	

Mobile Integrated Health Working Group

October 3, 2017

Location: Legislative Office Building Room 1D

Time: 9am

Agenda

1. Welcome

2. Review of work group info sheet

3. Discussion of:
    a. Desired Outcomes
    b. Identified Concerns

4. Establish work groups

5. Public Comment

6. Timeline for meetings

7. Adjourn

Mobile Integrated Health Workgroup

Minutes

Date: October 3, 2017 Time: 9:00 a.m. Location: LOB Room 1D

Chair: Raffaella Coler, Director OEMS,

Attendees: Gregory Allard, Christian Andresen, Marybeth Barry, Bruce Baxter, Joshua Beaulieu, Dorinda Borer, Michael Bova, Kristin Campanelli, Jennifer Granger, Susan Halpin, Shaun Heffernan, Dr. Kamin, Dr. Kenkare, David Lowell, James Santacroce, Chris Santarsiero, Carl Schiessl, Bill Schietinger, Kelly Sinko, Jonathan Steinberg, Donna Baleski for Dr. Zavoski

Agenda Item	Issue	Discussion	Action/Responsible
Welcome		Raffaella Coler welcomed the workgroup members	
	Housekeeping	Orientation to the room and to the LOB	
General Information	Agenda and Minutes	The Agenda and minutes for this committee will be posted to the OEMS website in the coming week.	
	New Members	There are a few new members to the committee. All members introduced themselves. There is one appointment pending	
	Review of the September 5, 2017 minutes	The minutes were accepted and seconded as written. All was in Favor; Opposed- none	
		An email went out on September 13, 2017 that included an informational template, paramedic report and published articles and resources to look at MIH around the nation with case studies.	

Review of Work Group info Sheet Desired Outcomes and Concerns		Did not receive information sheet form everyone, handout a set to each member of the one's that were received and reviewed them. Looked at the outcomes and concerns from each person. There was a section read from Bruce Baxter's Information Sheet – "Mobile Integrated health Care transcends EMS from being a transportation solution only to being a fully integrated collaborative member of the Healthcare system capable of fulfilling an important role in helping providers achieve the goals of enhancing the overall health of a population." The committee agrees that the statement captures the MIH theme. Some key points: MIH needs to be integrated into the existing health care system. It needs to ensure health care quality is not compromised and only improved and enhanced Topics discussed for Presentations: • Paramedic Scope of Practice and present on day to day role of a paramedic • Insurance • Frequency of Emergency Room Visits-Community Care Teams • Office of Telecommunications-regulations, statutes, and dispatching of calls • Department of Social Services-Medicaid data on alternate destinations and how do they reimburse. Do you want diagnosis codes and are they admitted or not? • Urgent Care Centers; Clinical presentation- Can they support multi focal destinations	

		Discussion took place around looking at other States that are similar in landscape and see how successful their MIH programs are. Emergency Mobile Psychiatric Services (EMPS) issues address situation where it occurs versus transport to hospital. Some EMS Service's already work with EMPS staff now. A suggestion was made to prioritize the work between presentations and workgroups and where to start. A question came up as to what is considered a "frequent flyer" which is-someone who utilizes EMS frequently. e	
		The committee agreed that the first priority would be to have some presentations and then establish the workgroups. Dr. Richard Kamin will take the lead on the scope of practice for paramedics presentation with help from the paramedics on the committee Telecommunications presentation Existing MIH programs Community Care Team	Dr. Kamin Ralf will scheduled Greg Allard Carl Schiessll
Public Comments Time line for Meetings		There were no public comments Keep the meetings every two weeks for now Question about getting the work done offline separate from being together at the meeting. Need to look into.	
Adjourn		10:13 a.m.	

Mobile Integrated Health Working Group

September 5, 2017

Location: Legislative Office Building Room 1D

Time: 9am

Agenda

1. Welcome
2. Housekeeping
3. Introductions
4. Overview of the Legislative charge:
    a. Goal
    b. Tasks
    c. Recommendations
    d. Time line
5. Public Comment
6. Next steps
7. Adjourn

Mobile Integrated Health Workgroup

Minutes

Date: September 5, 2017 Time: 9:00 a.m. Location: LOB Room 1D

Chair: Raffaella Coler, Director OEMS,

Attendees: Gregory Allard, Christian Andresen, Marybeth Barry, Bruce Baxter, Joshua Beaulieu, Dorinda Borer, Michael Bova, Kristin Campanelli, Jennifer Granger, Dr. Kamin, Dr. Kenkare, George Logan, David Lowell, James Santacroce, Chris Santarsiero, Carl Schiessl, Kelly Sinko, Tracy Wodatch, Dr. Zanker, Dr. Zavoski

Agenda Item	Issue	Discussion	Action/Responsible
Welcome		Raffaella Coler welcomed the workgroup members	
Housekeeping		Orientation to the room and to the LOB	
Introductions		Each workgroup member introduced themselves	
Overview of the Legislative Charge	Goal	The goal is to convene a working group to implement a mobile integrated healthcare program. Introduction to legislation handout was reviewed	Read legislation form other states that currently have a Mobile Integrated Health program.

	Tasks/Recommendations	Suggestions made: • Create separate focus groups for different aspects of the deliverables • Make sure everyone is on the same page and it would be helpful to know what each workgroup member does and what their role is and how it will interface with MIH. • What is the current scope of practice • Review Paramedicine Report done in January, 2017 • Reimbursement – What services can and can't we currently reimburse for Areas to look at: • Reimbursement (Insurance) • Home Health Care • Hospice Care • EMS Care • Urgent Care • Community Health Centers • Medicaid There are other healthcare providers that may also be impacted by this and may have concerns. Members were asked to share any data related to Mobile Integrated Health. Data should be evidence based, studies or analysis that may be helpful the workgroup.	Raffaella Coler will develop a template to email to the workgroup. Will need to research Raffaella Coler will email the paramedicine report from last year to the workgroup Member should forward any literature to the Chair for distribution to the workgroup

		Identify gap areas. Identify where hospitals are located in the state and then overlay resources. Build off existing work done on MIH through the CT EMS Advisory Board	 Josh Beaulieu will forward the current documents to the chair for distribution to the workgroup
	Time Line	Report regarding the outcome and the recommendations of the working group to implement the Mobile Integrated Healthcare Program	Due no later than January 1, 2019 to the Joint Standing Committee of the General Assembly
Public Comment		There was no public comment.	
Next Steps Next meeting		Once each workgroup member's current role is identified, various subcommittees can be established. Next meeting; Tuesday, September 19, 2017 9:00 a.m. Room 2D Legislative Office Building	
Adjourn		9:36 a.m.	