ND Behavioral Health Planning Council (BHPC)

Quarterly Business Meeting

July 17, 2024

Meeting Minutes

Council Members in Attendance: Emma Quinn (Consumer- Indiv. in recovery MH); Carlotta McCleary (ND Federation of Families for Children's Behavioral Health); Andrea Hochhalter (Consumer, Family Member of an Individual in Recovery); Denise Harvey (Protection and Advocacy); Matthew McCleary (Mental Health America of ND); Mandy Dendy (Principal State Agency: Medicaid); Brenda Bergsrud (Consumer Family Network); Dan Cramer (DHHS Behavioral Health Delivery System; Melanie Gaebe, (Consumer, Indiv. in Recovery SUD; Tania Zerr (Consumer, Family Member of a Child w/SED); Kristi Kilen (Private Mental Health Provider); Heather Call (ND National Guard); Kurt Snyder (Consumer- Indiv. in Recovery); Pamela Sagness (Principal State Agency: DHHS Mental Health); Jennifer Henderson (Principal State Agency: Housing); Mark Schaefer (Private Substance Use Disorder Treatment Provider); Tim Wicks (Consumer, Veteran); Robin Lang attending on behalf of Amanda Peterson (Principal State Agency: NDDPI Education); Brad Hawk (Indian Affairs Commission) Dr. Amy Veith (Principal State Agency/Criminal Justice); Cheryl Hess Anderson (DHHS, Vocational Rehabilitation) Michelle Gayette (DHHS Aging Services).

Council Members Absent: Paul Stroklund (Consumer, Family Member of an Adult with SMI); Michelle Masset (Principal State Agency: Social Services);; Dr. Lisa Peterson (Consumer, Family Member of a Veteran); Lorraine Davis (Consumer- member at large); Michael Salwei (Healthcare Representative); Glenn Longie (Tribal Behavioral Health Representative); Carl Young (Consumer, Family Member of a Child with SED- has resigned with position now vacant); Deb Jendro (Consumer Member Indiv. in Recovery MH – has resigned with position now vacant).

Staff: Tami Conrad (DHS, Behavioral Health)

Facilitator: Janell Regimbal of Insight to Solutions

Call to Order: Vice Chair Matthew McCleary called the meeting to order at 10:00 AM CT, via videoconference and with members present at the ND Job Service office in Bismarck.

Quorum. Members introduced themselves via the roll call process. Roll call indicated a majority of members were present. A quorum was declared**.**

Approval of Minutes. MELANIE GAEBE MADE AND PAMELA SAGNESS SECONDED A MOTION TO APPROVE THE APRIL 10, 2024, BHPC MEETING MINUTES AS PRESENTED. THE MOTION PASSED UNANIMOUSLY.

Approval of Agenda. Vice Chair McCleary called for approval of the agenda with two changes requested: the report on NDPMHCA School Consortium will now be provided by Anne Williamson rather than Lyndsi Engstrom and a request from Pamela Sagness to join the timeframe of the State Hospital report due to an anticipated conflict during the 2:40 PM timeslot. CARLOTTA MCCLEARY MADE AND PAMELA SAGNESS SECONDED A MOTION TO APPROVE THE JULY 17 AGENDA WITH THE NOTED CHANGES. THE MOTION PASSED UNANIMOUSLY.

Members were reminded of the mission and goals of the BHPC.

BHPC Updates: Tami Conrad provided a brief report on membership, sharing two current consumer positions are still open, specifically for a family member of a child with SED and individual in recovery from SUD or MH. Online applications are currently being accepted. Three members were reappointed: Melanie Gaebe, Paul Stroklund and Heather Call.

Janell Regimbal provided background information on how we will proceed with the nomination process and elections in advance of our annual meeting in October. We will elect a Vice Chair who will take office following the annual meeting in October with a planned succession to Chair following a year in that position. A position is also open on the Executive Committee for an individual with lived experience or a family member. An electronic ballot will go out between this meeting and the next. The following members volunteered to have their names placed on the ballot: Melanie Gaebe, Vice Chair; Kurt Snyder and Tania Zerr, Executive Committee. The slate will remain open with Janell calling for additional nominations in September. Electronic voting will occur just prior to the annual meeting.

Summary Report of ND Behavioral Health Strategic Plan and Future Activities: (PPT slides provided) Bevin Croft of the Human Services Research Institute. Ms. Croft reviewed recent achievements aim by aim of the thirteen stated aims of the ND Behavioral Health Strategic Plan which came out of the 2018 comprehensive study of the system. BHPC members who are liaisons on the various aims were thanked for their work.

Aim 1	April 2024 dashboard is live; July 2024 under development.
Aim 2	Two new prevention goals are under development.
Aim 3	Brain injury system study nearing completion; 988 communications continue.
Aim 4	School based service grants and BHERO continuing for coming school year; CCBHC goal underway.
Aim 5	New System of Care Lead Administrator; working to dev. family peer support into SOC efforts.
Aim 6	Integrating trauma reform projects info DOCR strategic plan.
Aim 7	New position at BHD focused on workforce issues; summit focused on university partnerships planned for October 2024; developing new goal focused on peer workforce.
Aim 8	Tele-behavioral health crisis enhancement goal underway.
Aim 9	Initiated person -centered practices self-assessment process with BHD policy team.
Aim 10	Working on a new goal focusing on lived experience involvement with BH initiatives.
Aim 11	Working on expanding access to training resources in tribal communities
Aim 12	Exploring options for strengthening and expanding financial support for peer support.
Aim 13	Developing HHS guidance on best practice for data collection in support of id and tracking disparities.

In response to a question regarding permanent supportive housing and what is being done for persons with mental illness, Ms. Croft responded the recommendation in the plan is for an expansion of evidenced based culturally responsive supportive housing for people with MI/SUD. Much of the plan has focused on developing financing for these models and quality standards. There is a quality checklist that has been developed for any permanent supportive housing sites receiving funding with Heather Brandt of DHHS lead staff on this. The tool and checklist have not yet been fully incorporated into the financing model yet. Ms. Croft was asked if there are any aims that will need advocacy in the upcoming legislative session. She indicated the system of care work and the certified community behavioral health clinics (CCBHC). Both pieces are very comprehensive and evidenced based practice models for modern behavioral health systems.

BHPC Policy and Procedure Handbook Review: Janell Regimbal, facilitator. Regimbal reminded members that this process began as we identified items last year in our bylaws that were no

longer accurate and in need of change. Upon consultation with the Governor's office, we were advised it would be best to transition from a bylaw driven group to one of the policies and procedures manual to allow for more detailed and adaptable guidelines. This advice was congruent with the best practices document shared by SAMHSA for state behavioral health planning councils. The process employed included the Executive Committee taking the lead in reviewing and providing direction on draft policies and procedures that were based upon the content of the current bylaws. Following their review and edits the draft went to the full BHPC with a 30-dayreview period in May. Those comments were taken into consideration for the final draft sent to the BHPC members via email on June 27 in preparation for today's discussion about finalizing their adoption if the membership deems ready. The bylaws will stay in effect until they are formally repealed. CARLOTTA MCCLEARY MADE AND MELANIE GAEBE SECONDED A MOTION TO REPEAL THE CURRENT BYLAWS IN ORDER TO ALLOW FOR THE ADOPTION OF A POLICY AND PROCEDURE MANUAL WHICH WILL BE USED TO GUID OPERATIONS AND GOVERNANCE OF THE GROUP GOING FORWARD. THE MOTION PASSED UNANIMOUSLY. Following discussion of 03-01 Abstention, related to concerns of not clearly have defined conflict of interest as well as the need to consider a policy and procedure which lays out the process by which future policy and procedures can be amended or added, ANDREA HOCHHALTER MADE AND TIM WICKS SECONDED A MOTION FOR THE ADOPTION OF THE DRAFTED POLICIES AND PROCEDURES AS PROVIDED WHILE WE CONTINUE TO REVIEW FOR EDITS 03-01 AND CONSIDER HOW TO BEST INCOROPRATE THE PROCESS BY WHICH FUTURE CHANGES ARE MADE TO THOSE PROVIDED WHICH ARE ROOTED IN THE BYLAWS AND WERE PROVIDED FOLLOWING FEEDBACK FROM MEMBERSHIP. THE MOTION PASSED UNANIMOUSLY. The two issues raised for further consideration will be on the October agenda. Mandy Dendy agreed to provide recommended language for conflict-of-interest.

DHHS FY26-27 Budget Overview & Needs, Pamela Sagness, Executive Director/Behavioral Health, NDDHHS. Ms. Sagness shared the timeline for the budget. They are presently in the middle of budgeting and will be submitting the DHHS budget in September. Prior to that it will be presented to the HHS internal Executive Team in mid-August when different divisions come forward with decision packages. They have been talking with providers/vendors for the last six months about needs. Once the Executive Team formulates it into one budget, it then goes to the Governor's office who looks across all agencies to develop the budget presented to legislators in December. Department heads will not know what is included until it is publicly announced in December. If it does not align with what was submitted there will be a need for re-budgeting. The budget will be categorized in, allowing for the ability to see more specific line items. The department is looking to re-establish a letter system of communication sent to vendors about the budget. Pamela also shared several initiatives that are going on related to systems change. Please feel free to reach out to her to share ideas. Issues such as full geriatric facilities impacting people getting into the right facilities for their needs, paroled people not being able to get into skilled nursing due to their backgrounds, FTR/Community Connect not able to meet demands of requests for service and issues around residential facilities for kids. A conversation around what minimum expectations for service in a best practice world would be expected per region as it relates to behavioral health would be helpful to have with the BHPC. CCBHC funds will now be freed up for another location due to no RFP responses for Dickinson 10 bed facility.

State Hospital Building and Operations Update, Aaron Olson/Superintendent of State Hospital. They are now in the last phase of design development with the state hospital staff and community providing lots of valuable input. They currently have 680,000 sq ft across six buildings and in the new design will have 280,000 sq ft. Having one environmental group vs six will be very helpful to staffing efficiencies and a new hospital may also have an impact on people wanting to work there. They have been zeroing in on three things: culture, people, and financials (having a more

transparent budget). When asked where current funding levels are for the building, he shared there is $12.5M appropriated for pre-design work provided last session. This money will run out in September. They have a proposal to not pause, but to request the Emergency Commission review their proposal to continue moving forward as it will be more cost effective. It is hoped to begin construction in summer 2025. Current licensing of the state hospital is 125 beds plus sex offenders. The new number is proposed to be the same. They are currently staffed with 81 beds and are not proposing to increase the licensed number of beds. Immediate access is not as accessible as people want to see, with waiting lists at times. When asked if patients were talked to about what is needed, it was shared that staff have asked for patient input and there has been much focus on therapeutic environment. The advocacy of the team at the hospital has been heard clearly in the process as well as through a community meeting.

Adjourned for lunch at 12:05 PM

Vice Chair Matthew McCleary reconvened the meeting at 1:00 PM.

School Based Medicaid & Behavioral Health Services, (PPT slides provided) Mandy Dendy/Medical Services Division, DHHS. Ms. Dendy provided an overview of the public entitlement program, Medicaid, which is jointly funded by federal and state governments. Historically Medicaid was only available for children on IEPs. In 2014 CMS allowed state Medicaid agencies to expand to those not on IEPs. In 2021 ND expanded school-based services beyond medically necessary IEP services to include non-IEP services. When this occurred, ND did not have to do a state plan amendment – just a policy change. Medicaid covers all Medicaid services covered under our state plan in a school-based environment. This includes things like speech therapy, OT, PT, school nursing, ABA, TCM, etc. Most of the times these providers work for the schools but community providers who come into the school would also be considered school-based services. These billed services can include behavioral interventions, counseling services, skills training, and the like. ND is seeing an increase in community providers billing Medicaid for services offered in the school settings, but youth are still getting more services in their community vs school-based settings. ND is fee for service based. The state pays the state share of Medicaid up to 50% in any given year, so ND schools currently pay the state match share for IEP services. IN FY24 the federal share is 53.82% so if a school does not bill Medicaid, they 100% fund things out of their budgets. When a school bills non-IEP services there are no state match requirements, so the school keeps 100% which is a huge incentive for schools to bill for behavioral health services. If a private provider comes into the school to provide services but it is not the school that bills Medicaid, then none of the match comes out of the school's budget. When asked about billing for counseling outside of an IEP when the student has private insurance and the unique intricacies of those situations as to whether Medicaid is a payer of first resort or last resort is covered in federal law, but Mandy will need to seek out that specific information to be certain. DHHS has a behavioral health grant funding program. These grants allow units or districts who are billing Medicaid to apply for a grant up to the amount of their Medicaid Match. See the ppt slides for service requirements related to student eligibility, provider qualifications and covered service array. North Dakota has submitted a state plan amendment to CMS to add school psychologist effective 7/1 and are working on processes around this change. Mental health technicians, primarily through the human services centers, are looking at work that can be brought into schools. A request to CMS to add Behavioral Analysts will also occur in 2024. Ms. Dendy asked members to go back to their home communities and be champions for getting increased behavioral health services in schools, by finding out what the needs are of students in the district, what if any behavioral health services are being offered in the school; knowing if the district is billing to ND Medicaid and what the barriers may be. There is help and technical assistance provided by ND Medicaid. See school-based-medicaid.pdf (nd.gov) for more information

UPDATES: DHHS Behavioral Health Division

1. **NDPMHCA School Consortium Update:(PPT slides provided) Anne Williamson, Program Manager/Central Regional Education Association** Ms. Williamson joined to update on the prior school year happenings and some of the innovations utilized. The grant funds provided support to the consortium network of school partner and additional schools through the B-HERO technical assistance center which was made available due to extra funds received in February. Several years ago, the state legislature required all schools to designate a behavioral health resource coordinator within their school. Those staff became a natural partnership with the B-HERO team. See the slide deck for a snapshot of training and services that were accessed in phase one of the rollout. Experiences like the Cook Center for Family Health offering targeted parent coaching services and the Check and Connect evidenced based dropout prevention intervention were shared as examples of ways they engaged with schools. Their role is to offer statewide supports to schools in implementation and access to trainers. Access to high quality training has been appreciated by schools. Regarding technical assistance, all engaged schools were a part of a school-wide PBIS tiered inventory walk through to assess their current state of behavior systems. Check and Connect is for K-12 grades, working to intervene early before students are credit deficient. When asked where their service area is, B-HERO is statewide and CREA, while having a traditional catchment area that is in south central ND, does try to operate without borders as much as possible. See the slide deck for phase one learnings and upcoming plans for phase 2. As an entity they have many data collection processes in place with the schools they work with, so have a good sense of their current state of programming and interest in things such as 1915i, etc. When asked about what if anything has changed in programming offered since the grant is no longer oversaw by Sanford, Laura Anderson indicated Sara Kapp could provide that information to the Council, but with an indication most high-level tings remained consistent. She will provide an update to the members when the minutes are sent out.

Sara Kapp Program Administrator DHHS provided this additional information in response to question posed during the meeting and is inserted here to address what changes have occurred: *The ND PMHCA program continues its previous efforts that were being implemented within the previous grant cycle from 2018-2023 as well as implementation of new efforts. The current goals for the program include Goal* ***1: Increase the capacity of primary care providers to screen, diagnose and treat children for behavioral health disorders in primary care settings.*** *Objective 1-a: Increase the number of children receiving access to Tele-behavioral health care in primary care settings by 25% by 2026. Objective 1-b: For North Dakota's PMHCA efforts to work towards achieving health equity related to racial, ethnic, and geographical disparities in access to behavioral health services.* ***Goal 2: Develop and create capacity for telehealth programs in community-based settings by expanding partnerships within Emergency Departments and schools.*** *Objective 2-a: Strengthen and expand training and implementation of integrated behavioral health support in schools to increase the number of students receiving tele-behavioral health services. Objective 2-b: Build capacity within the Emergency Departments and provide training and technical assistance to identify risk factors and early warning signs. Some current activities include Consultation line, Care Coordination offered through Family Voices, Behavioral Health specific trainings through: ECHO sessions, grand rounds and BHD/CFS conference, Reaching Teens, and Reach Institute. Our current efforts within CREA are expanding through statewide schools as presented at the council meeting. Other engagement strategies include increased communication with primary care*

providers, new partnership with Critical Access clinics, UND Pediatric Residency Program and expansion beyond just primary providers within clinics but touch points of Nurses, PA's, NP's etc.

2. **Overview of SUPTRS Prevention and MHBG Prevention Requirements: (PPT slides provided) Laura Anderson, Policy Director, DHHS.** Ms. Anderson presented an overview of North Dakota's substance use prevention initiatives, covering a range of topics including prevention strategies, federal grant administration, training and technical assistance, communication approaches, and early intervention efforts. She highlighted

   the Behavioral Health Continuum of Care and the Strategic Prevention Framework (SPF) model; and emphasized the importance of addressing risk and protective factors that influence the likelihood of developing substance use or behavioral health problems. Effective prevention, Anderson noted, focuses on reducing risk factors while strengthening protective factors. The BHD's role in prevention involves administering federal grants, specifically the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant and the Partnership for Success (PFS) Grant. These grants fund primary prevention strategies aimed at individuals not identified as needing treatment. The SUPTRS Block Grant requires at least 20% of the funds to be allocated to primary prevention, focusing on underage drinking, adult binge drinking, and opioid misuse. Local prevention providers, including local public health units (LPHUs) and tribes, play a key role in these efforts. Anderson highlighted examples of community implementation, such as Responsible Beverage Service Training in Cavalier County and sober rides during the county fair in Wells County. To support these prevention initiatives, the BHD provides extensive training and technical assistance, to strengthen the capacity of individuals, groups, and organizations to implement and sustain effective strategies. This support includes in-person training, consultations, online events, collaboration, resource sharing, and information dissemination. A free resource center is available to assist with these efforts. When asked if there is a way to look at how we can prevent based upon the child's mental health needs, she stated although mostly the funds are targeted to substance use prevention, they are able to implement universal or environmental strategies rather than more individual risk level circumstances efforts which has the potential to impact all on some level. Statewide messaging is another crucial component of the prevention strategy. Based on research, the key messages to parents and caregivers focus on love, looking (being present), and listening to children. These messages aim to promote positive behavioral health through parental engagement and monitoring. The target audience for these messages includes parents, caregivers, professionals in contact with high-risk parents, and communities sharing these tools locally. Early intervention was highlighted as a critical aspect of the prevention strategy. Early intervention involves recognizing the warning signs of mental health or substance use disorders and providing timely intervention to prevent further development and consequences. Laura shared data as an example high school alcohol use by one indicator in the YRBS data has dropped more than half since 1995 from 60.7% to 19.5%. Another data indicator they look at is the age of initiation of using alcohol. It has gone from in 1995 more than a third of high school students reported having their first drink before the age of 13, to now 11% had their first drink by age 13. The purpose of the MHBG is to provide community mental health services for adults with serious mental illness and children with serious emotional disturbances. A significant portion of these funds must support evidence-based programs addressing early serious mental illness, including psychotic

disorders, regardless of the individual's age at onset. When asked about legislative priority ideas, it was noted that since the federal dollars don't provide funding for MH prevention promotion, funds could be used for MI prevention strategies. It was pointed out that there is now less effort for family level programming on the treatment side, which is really a target rich prevention opportunity. It was recommended the state consider offering technical assistance training for providers in this area around good prevention materials to families. Concerns about the high level of vaping were raised, with Ms. Anderson pointing out vaping is addressed via funding that comes from the DC and therefore is run through the health department side and public health partner. See slides for other specific data points and programming highlights addressing prevention efforts. This year a PFS discretionary grant of $1.25M/year for up to five years was also awarded. It targets military, college students and children living with adults with SUD. The BHD is currently selecting five communities to target. This link was provided to order free prevention resources. Behavioral Health Free Resources > Catalog (x-shops.com)

3. **Family Network Update with Q&A: (PPT slides provided) Matthew McCleary, Deputy Director/Mental Health America.** Mr. McCleary shared about the CFN contract recent happenings. In June they hosted a conference in Bismarck with 85 in attendance. Sessions focused on indigenous mental health related topics and a variety of other topics, including one on cleanliness of homes and public housing challenges. He shared an example of a client who helped where there was a risk of homelessness that involved systems collaboration. Since his last report they have visited Jamestown, Williston, Bismarck, and Minot human service centers, also visiting recovery centers in those communities. During those visits they hand out promotional materials at community outlets such as libraries, rec centers, etc. Call volumes have increased. Katie Sims joined as a full-time navigator and part-time parent coordinator this month.

IMD Waiver Interim Activities Update: (PPT slides provided) Carlotta McCleary, Executive Director, ND Federation of Families for Children's Mental Health. McCleary of Mental Health America of North Dakota presented on the IMD Exclusion, a critical component of the Social Security Act affecting Medicaid payments for mental health services by providing an overview to help us understand what is involved. The IMD Exclusion prohibits Medicaid payments for services provided to individuals under 65 residing in institutions for mental diseases (IMDs), defined as facilities with more than 16 beds primarily engaged in mental health care. This exclusion is rooted in the historical shift from institutionalization to community-based services, promoting state responsibility and encouraging the development of community services. The IMD Exclusion does not apply to individuals 65 and older or children under 21 in certain psychiatric settings. Managed care enrollees can receive IMD services for up to 15 days per month, and states can apply for waivers to receive federal funds for specific services within IMDs. Before applying for an IMD waiver, states must develop strategies for budget neutrality, infrastructure, and service integration. She shared evidence suggests that increasing psychiatric beds can drain resources from community-based services, leading to higher costs without improving access to psychiatric care or reducing emergency room visits. The presentation emphasized the importance of balancing institutional care with community integration, aligning with Congress's intent as reflected in laws such as the Americans with Disabilities Act and the Olmstead decision. As a group, the BHPC did take a stand against the waiver during this past session for those reasons. During the April 2024 Interim Human Services Committee meeting, the issue has arisen again. Various organizations, including Prairie St. Johns as well as her testimony on behalf of the Mental Health Advocacy Network (MHAN) were offered. Prairie St. Johns supported the pursuit of an IMD Exclusion Waiver, while MHAN, represented by McCleary, opposed it, highlighting concerns about

budget neutrality and advocating for the expansion of community-based services instead. Sara Aker from the ND Department of Health and Human Services also noted the need for a comprehensive behavioral health care continuum before pursuing an IMD Exclusion Waiver. There was no time allotted for public comment. McCleary indicated concern of some misleading issues coming up related to uncompensated care, which in her estimation was not taking into consideration SUD vouchers and payments coming from human service centers. A member shared an example of the types of barriers that occur related to uncompensated care for things the SUD voucher does not cover, such as when someone in care needs to leave the facility to seek medical care for an injury. It was stated DHHS needs to be aware of this barrier. There was discussion of the request by providers of the immediate pursuit of ND's "in lieu of" authority to provide Medicaid Expansion reimbursement for up to 15 days, which would be a policy change. This could provide an opportunity for getting people the care they have needed and not been tending to and to stabilize medically. At the end of the 15 days, you could move them into an outpatient service or continue to keep them in care using the SUD voucher. It was also discussed that providers can certainly offer more than 16 beds; you just need to follow the rules to do it. As an example, having beds spread across communities in settings of no more than 16 beds. Members indicated a desire to know what Medicaid's position on this may be. The question was raised as to whether, if the waiver were put in place, if jails and the State Hospital would be impacted. It was noted it would not. It was also noted that there is not a single report in published record related to North Dakota's behavioral health service needs where there is a recommendation to expand institutional facilities. Regimbal reminded members of the educational materials still available from December 2022 and January of 2023 provided via out of state presenters who assisted us in understanding the issues around the waiver so that we could decide if we should take a position and if so, what it would be. It was requested the material be provided again to refresh understanding and the BHPC would like to further consider gathering more information on the "in lieu of" option to form an opinion before the next legislative session.

Public Comments. Vice Chairperson McCleary called for public comments. None were provided.

Lightening Round Sharing by Members- Besides the hiring of Katie Simms as reported earlier, the Federation of Families also hired two new parent coordinators, Katie McNamara in Bismarck region and Penny Nygaard in Devils Lake. Kurt Snyder shared about Heartview's training consortium, and the grant recently received grant from the opioid settlement that will allow tuition assistance for those pursuing addiction counseling degrees. NDTAAP addresses the pipeline for licensed addiction counselor trainees. Tami Conrad reminded of the BHD conference set for September 16-19. Free attendance option is available for members. She provided a code via email earlier this summer. Denise Harvey shared about training this fall related to employment that will bring in national experts. See their website for more information.

Next Meeting- October 16, 2024, via videoconference or in person at Bismarck Job Service at 1601 East Century. This will be our annual meeting.

Adjournment. Having completed all agenda items and hearing no further comments from BHPC members, Vice Chair McCleary called for a motion to adjourn the meeting at 4:00 PM CT, with CARLOTTA MCCLEARY MAKING AND DENISE HARVEY SECONDED A MOTION TO ADJOURN.

Respectfully submitted,

Janell Regimbal/Facilitator

Insight to Solutions