California Medical Leadership Forum for Public Health/Preventive Medicine
41st Meeting (12th using Video)
December, 12th 2023, 8:00-9:30 am PST
MINUTES

This meeting used a Zoom account from the California Academy of Preventive Medicine (CAPM) with phone access provided. "Handouts" (i.e., the agenda, last meeting's minutes, and Bylaws amendment) were attached to the email notice. Any attendees except those participating by phone could enter information in "Chat." Web references for some agenda topics were embedded in the agenda.

Dr. Hattis began the meeting at 8:04 announcing that the meeting will be recorded and posted on the CAPM Website. In his introductory remarks, he expressed special thanks to Karen Mark and Yingjia Huang from DHCS who will present today. Dr. Hattis noted that this Forum was founded 9 years ago and is unique in that it is the most comprehensive place for physicians, staff of medical organizations, and teachers involved in public health and Preventive Medicine in California to come together. There is no full-time staff and is sponsored by the California Academy of Preventive Medicine (CAPM). The Forum provides sense of community and ability to exchange best practices to continually improve emphasis of prevention and public health. The Forum integrates osteopathic and allopathic schools and addresses issues that are not adequately considered by other groups in the state, including encouragement of medical schools and PH organizations to re-prioritize public health issues such as the decline in life expectancy. He noted that medical schools are generally proficient at teaching diagnosis and treatment, prescribing and procedures but we do a much poorer job at teaching prevention, particularly nutrition, although some of the osteopathic schools may be doing a good job on that. Dr. Hattis pointed out that, in general as a nationwide and statewide phenomenon, prevention is not taught at every stage of chronic and gradually developing diseases. Dr. Hattis went on to add that we need to focus on how we are teaching prevention. With the increasing number of schools of public health and joint MD and DO/MPH degree programs, there is a need to determine whether these are teaching subjects relevant to medical students and residents, as well as how the MPH influenced medical practice. Dr. Hattis indicated the Forum could determine specifics that we would like to focus on.

I. Approval of Minutes:

Forum Secretary Traci Stevenson made a motion for approval a minutes from prior meeting. This was second by Dr. Mankar. Participants voted in favor by raising hand via Zoom and/or unmuting themselves. Minutes were approved with no opposition.

II. Special Topic Presentations #1

A. Karen Mark, Medical Director, California Department of Health Care Services (DHCS): ***"Achieving Quality and Health Equity in Medi-Cal: CalAIM"***

i. Dr. Mark provided a brief overview of CalAIM (California Advancing and innovating Medi-Cal) including the long-term commitment to transform and strengthen Medi-Cal, multi-year DHCS initiative to improve quality of life and health outcomes of Medi-Cal beneficiaries, and a more equitable, coordinated, and person-centered approach to maximizing health and life trajectory.

ii. Goals of CalAIM include:

1. Identify and manage comprehensive needs through whole person care and approaches and social drivers of health.
2. Improve quality outcomes, reduce health disparities, and transform the delivery system through value-based initiatives, modernization, and payment reform.
3. Make Medi-Cal a more consistent and seamless system for enrollees to navigate.

iii. A slide demonstrating the Comprehensive Quality Strategy highlighted main goals including engaging members as owners of their own care, keeping families and communities healthy via prevention, providing early interventions for rising risk and patient-centered chronic disease management and providing whole person care for high-risk populations, addressing social drivers of health.
   1. Underlying principles include eliminating health disparities through anti-racism and community-based partnerships, data-driven improvements that address the whole person and transparency, accountability, and member involvement.

iv. Dr. Mark highlighted importance of Population Health Management as levers of transformation with CalAIM's bold Medi-Cal transformation that expands on tradition notion of "the health care system." This means meeting the needs of the whole person, engaging health care providers who are trusted and relatable, expanding community supports and proactive upstream services, promoting community engagement and making best use of partners and resources.

v. Population Health Management is a cohesive plan of action, a whole-system, person-centered strategy that focuses on wellness and prevention, includes assessments of health risks and related social needs, and provides care management and transitions across delivery systems.
   1. Integrates DHCS/other data streams to perform analytics, provide health plans and networks integrated information and provide beneficiaries service to access data and health education/community-based services.

vi. Enhanced Care Management (ECM) is a new benefit in effect from January 1, 2022, that is a whole-person approach that addresses clinical and non-clinical needs of high-need beneficiaries building on Health Homes and Whole Person Care pilots.
   1. Target populations include high utilizers with frequent hospital or ED visits, individuals at risk for institutionalization, nursing facility residents wanting to transition to the community, children and youth with complex needs, individuals transitioning from incarceration and those experiencing or at risk of becoming homeless.

vii. MCP's (Medi-Cal Managed Care Plan) are required to include broad range of programs and services to meet needs of individuals in all 3 areas:
   1. ECM (Enhanced Care Management) highest needs members, includes intensive coordination of health and health-related services.
   2. CCM (Complex Care Management) higher and medium risk, provides ongoing chronic care coordination and disease-specific interventions.
   3. BPHM (Basic Population Health Management): array of services for all MCP members.

a. Transitional care services are also available for all MCP members transferring from one level of care to another.

viii. Community Supports (also known as ‘in lieu of services”)
1. MCP’s integrate community supports into the population health strategy, often in combination with the ECM benefit.
2. Focus on addressing combined medical and social determinant of health needs and avoiding higher levels of care.
3. Provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays and ED use.
4. Community supports include housing transition services, housing deposits, housing tenancy services, short-term post-hospitalization housing, respite care and serviced, day habilitation programs, nursing facility transitions, personal care and homemaker services, environmental accessibility adaptations, medically tailored meals, sobering centers, and asthma remediation.

ix. Dr. Hattis inquired what practicing providers need to know about accessing these services and if there is anything in particular, we should be teaching medical students and residents about these services.
1. Dr. Mark indicated that it is important for providers to be aware of these services for their patients.
2. We are moving toward population care management that includes various health care workers that help refer patients to the necessary services.

x. ECM is designed to address the data that:
1. Over half of Medi-Cal spending is attributable to 5% of enrollees with the highest needs.
2. Medi-Cal enrollees typically have several complex health conditions.
3. Enrollees with complex needs must often engage in several deliver systems to access care.

xi. PATH: Providing Access and Transforming Health Initiative
1. 5-year, 1.85 billion investments to build capacity and infrastructure to address ECM, Community Supports and Justice-involved services.
2. Funds additional staff, billing, and data exchange to allow community organizations to contract with MCP’s, funds collaboration with correctional agencies and county social services and implement pre-release Medi-Cal enrollment.

xii. Additional areas of CalAIM include Medi-Cal matching plan, Global Payment Program, Contingency Management and Justice Involved Initiative.

xiii. Management and Evaluation of CalAIM will include a Dashboard to launch in 2024, individual evaluations including the PATH, GPP, Medi-Cal Matching Program, Drug Medi-Cal Organized Delivery System and Community Supports programs.
1. Monitor and evaluation is ongoing on assessment and improvement of care with reports ongoing and results upcoming in 22026.

xiv. Dr. Mark provided her email address: Karen.Mark@dhcs.ca.gov for further questions

A. Question and Answer Period:

i. Jessica Nunez de Ybarra asked if there were any challenges to be aware of and if there were any connections with local health departments of DPH in terms of how the data will coordinate so public health departments can respond.
    1. Dr. Mark replied that health data management systems that will be pulling data from many streams and have been working with public health on vaccinations, as an example. They are also working with public health on memoranda of understanding between the MCP's and local departments of public health to help ensure that members can get care.

ii. Dr. Hattis asked how this would influence the 'average office visit' such as need for documentation or referral services.
    1. Dr. Mark replied that there are many diagnostic codes that providers can utilize that will enable care plans to see the data and who needs the supports. The whole care team including community health workers or care managers will be involved, to refer patients to necessary supports.

III. Roll Call and Reports by School, Organization, or Agency

i. **State Government Agencies**
    1. <u>Department Health Care Services (DHCS)</u>
        a) Karen Mark (provided presentation #1, noted above)
        b) Yingjia Huang (provided presentation #2, noted below)
    2. <u>California Department of Public Health (CDPH)</u>
        a) Jessica Nunez de Ybarra: CDPH Office of Policy and Planning
            a. Jessica noted that California's new surgeon general, Dr. Diana Ramos and staffer Lauren Groves were joining us the meeting today.
            b. Jessica also was happy to see Dr. Johnathon Fielding on the call, noting that several years ago he worked in Los Angeles County overseeing Public Health and it was an honor to see him on this call. Jessica also informed Dr. Fielding that the webinar "Public Health Live" at UCLA in 2000 was made digital and the department is working on incorporating it into department training.
    3. <u>Surgeon General, State of California</u>
        a) Diana Ramos: Surgeon General; Dr. Ramos greeted the group. This was her first visit to the Forum. She said that she and her staff are advisors to the Health and Human Services Agency and its health-related departments in the state. Dr. Ramos said she was appointed by the governor. She is trained in Ob/Gyn but has also been a Public Health leader all of her career, and had the privilege of working under Dr. Fielding in Los Angeles as well as working with Jessica (Nunez de Ybarra) when at the state as Assistant Deputy Director for chronic disease prevention.
            a. Key areas of focus in the Office of the Surgeon General include improving maternal mortality rates, in particular ethnic disparities, along

with addressing adverse childhood experiences and being a partner in the mental health.

b. Dr. Hattis mentioned a project he did in San Bernardino County addressing maternal mortality that he would like to share with her adding that one of the values of this Forum is to collaborate, and for representatives to become aware of public health initiatives they had previously not known about.
c. Dr. Ramos provided her email in the Chat and welcomed partnerships: Diana.Ramos@osg.ca.gov
d. The Office of Surgeon General is based in Sacramento.

b) Lauren Groves: As Special Advisor for the Office of California Surgeon General, she said that her priorities are same as Diana's and they are both excited to collaborate. She suggested we reach out if there is interest in any of their initiatives.
   a. The Office of Surgeon General does partner with all of the departments within Health and Human Services Agency in California.
   b. The office partners especially with the Dept. of Public Health, and Lauren came from the Dept. of Public Health prior to this position.
   c. Lauren has a master's in public health and has been working in chronic disease for about 20 years.
   d. Dr. Hattis mentioned that chronic disease mortality had increased recently, not directly related to COVID but possibly indirectly related to the impacts of the pandemic. The perspective of the Surgeon General would be valuable for this Forum, to determine priorities to address to help the state to be able to get back to the traditional trajectory of increased life expectancy over time.
   e. Lauren provided her email contact in the Chat: Lauren.Groves@osg.ca.gov

ii. **Medical Schools**

1. UCSF/Berkeley Joint Program: Ali Barclay represented the Joint Medical Program today. Ron noted that each organization can have 2 regular representatives plus guests and recommended that Ali become a second representative with Dr. Marbin.
   a) Ali provided her email in the Chat: abarclay@berkeley.edu
2. Touro University California: Traci Stevenson represented Touro, and is also the Forum Secretary.
3. Stanford
   a) Sandra Tsai: Preventive Cardiology Clinic
      a. Dr. Hattis recalled that Dr. Tsai and Levin provided a presentation for the Forum on preventive cardiology.

b) Eleanor Levin: Dr. Levin wanted to emphasize that Sandra also has a master's in public health and does an outstanding program on diabetes prevention, and is also very modest.

4. UCLA Geffen School of Medicine
   a) Priyanka Fernandes: Director of Preventive Medicine Residency/Fellowship Program
5. Loma Linda University: Karen Studer: Residency Director and Vice Chair, Preventive Medicine Department
   a) Also representing the School of Public Health today
   b) Karen is on the American Board of Preventive Medicine and will be serving on the board of CAPM this upcoming year.
6. California Health Sciences University (CHSU): Dr. Goldgraben, Assistant Professor of Specialty Medicine.
   a) First graduating class will be this year.
   b) Full accreditation is in process.
7. University of Southern California (USC)
   Howard Hu: Chair, Department of Population and Public Health Sciences at the University of Southern California.
   a) Dr. Hu is a physician epidemiologist and said that USC has a big department with a 124 faculty members and bunch of institutes and research centers. He is from the East Coast having been at Harvard, University of Michigan, and the Dean of the School of Public Health at the University of Toronto, before he was recruited to USC.
   b) Dr. Hattis mentioned Dr. Hu's impressive CV and considers him an honored member of the Forum.

iii. **American College of Preventive Medicine:**

1. Eric Oyan: Director of Marketing and Membership for ACPM (the only non-California entity included in our Forum). Eric stated they have had a lot of great projects this year including launching military environmental exposures Part 2 course.
   a) This course is free and done in conjunction with Dept. of Veterans Affairs.
   b) They are gearing up for Preventive Medicine 2024 which will be in the District of Columbia.
      a. Dr. Hattis stated CAPM supports the initiative of ACPM to obtain federal funding for Preventive Medicine residencies; and for the first time this Forum has members from all of California Preventive Medicine Residency Programs.
      b. The budget climate has not been stable. Dr. Hattis added that it has been a rough year for funding noting Congress only passed 22 bills

over the year so there is a need to get more legislation through and more Congressional awareness of health needs and public health.

iv. **California Academy of Preventive Medicine (CAPM)**

1. Sumedh Mankar: Vice-Chair of this Forum; served on the California Academy of Preventive Medicine Board for several years, and is a former President. He frequently attended this Forum prior to being appointed by Dr. Hattis. He currently works for Promise Health Care, part of Blue Cross Blue Shield, serving Medi-Cal members in San Diego and Los Angeles Counties.
2. Don Lyman: works with legislative affairs for CAPM and with CMA on resolutions during the year.
   a) Ron mentioned an attached handout with bills that CAPM followed and Alecia Sanchez has been our number one CMA public health person.
3. Susan Bradshaw: Another former President of CAPM, she has for several years as well as with Don Lyman on legislation and CMA matters.
4. Jillian Martin: Incoming President CAPM. Jillian is senior medical group director within the clinical safety department at Genentech.

v. **Osteopathic Physicians and Surgeons California (OPSC)**

1. Holly Macriss, OPSC
   a) Dr. Hattis noted this Forum includes the 3 Osteopathic Medical Schools in the state, that fulfill an important role.

vi. **California Medical Association (CMA)**

1. Alecia Sanchez: Chief Strategy Officer
   a) Ron inquired if she could identify legislative priorities that CMA had this year. Alecia stated she would provide information later in the meeting.

vii. **Schools of Public Health**

1. UC Berkeley School of Public Health

a) Jarred Mazzanti: Director of Strategic Initiatives in Dean's Office.

b) Ron mentioned UCB has connections with the medical program at UCSF and alliance of programs in graduate of public health education. UCB was the first school of Public Health in the State of California

2. UCSD School of Public Health

a) Jackie Peretti: Preventive Medicine Resident at UCSD Health SD State Residency. Program director is Jill Waalen.
   a. Jackie is also active-duty Navy and will be in California for at least the next 4 years. Jackie will be added to the guest list and included her email in the Chat: jperetti@heath.ucsd.edu

b) Dr. Margaret Ryan: Clinical Professor and residency program support.

a. Dr. Ryan works for the military with the Defense Health Agency Immunization Group and at the Naval Medical Center in San Diego.

3. UCLA Fielding School of Public Health

a) Jonathan Fielding, already mentioned in II.a.2 above, stated that he is interested and anxious to help.

    a. His current contact is mainly thru Center for Healthier Climate Solutions.

viii. **Guests**

1. Ashley McClure: Organizer of Climate Health Now and CMA Climate Champion.

a) Co-founded non-profit, Climate Health Now, that's organizing people in the health community to advocate around state level climate legislation in the interest of health and equity. Has also worked with CMA as alternate delegate.

b) She offered this Website for information: www.climatehealthnow.org

c) Dr. Hattis wondered if she had been in contact with Dr. Fielding. Ashley indicated she would love a further introduction.

IV. Special Topics Presentation #II: Medi-Cal Adult Expansion

i. **Yingjia Huang, Assistant Deputy Director, California Dept. Health Care Services (DHCS)**, which manages Medi-Cal, California's state Medicaid program.

1. DHCS is responsible for policies on medical eligibility, coverage, and benefits for individuals to enroll in medical (Medi-Cal).
2. Since 2016, California has been in a 'journey' to expand Medi-Cal to individuals without a satisfactory immigration status, whom we refer to as undocumented individuals.
3. Beginning in 2016, California began taking incremental steps by age group to expand coverage.
4. Coverage for this population started in 2016 with children under 19 years old, and as of today, about 121,000 children in the state are benefitting from this policy which provides a full breadth of medical services, regardless of immigration status, if under the income thresholds for Medi-Cal.
5. In 2020, coverage was extended to ages 19 to 26.
6. Last year (2022), full coverage was expanded to all adults above ages 50 and above.
7. Finally, preparing to complete coverage of all age groups in January 2024 by including 26–49-year-olds, regardless of immigration status.
    a) About 700,000 individuals will become eligible.
8. With Medicaid, the federal government defines 2 types of services:
    1. Full Scope: full breadth of services with in-patient, out-patient, pharmacy, dental, vision.
    2. Restricted Services: only includes emergency services and labor and delivery as defined by CMS.

a) Historically, undocumented individuals were only eligible for the restricted services of emergency services and labor and delivery.

b) This is only category of services that the state receives federal participation funding and is a very limited package.

   1) Full Scope: full breadth of services with in-patient, out-patient, pharmacy, dental, vision.
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   3) Historically, undocumented individuals were only eligible for the restricted services of emergency services and labor and delivery.
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   5) Full Scope: full breadth of services with in-patient, out-patient, pharmacy, dental, vision.

c) Full Scope: full breadth of services with in-patient, out-patient, pharmacy, dental, vision.

3. Uncompensated Care: Since implementation of the Affordable Care Act uninsured rate has decreased in California. The California Healthcare Foundation recently published an annual report:

   a) Looking at the non-elderly adults, uninsured rate, which was around 10% at that time of eve of Affordable Care Act, has gone down significantly to about 4%.

   b) The pool of uninsured continues to shrink partially due to:

      1. The Affordable Care Act offered a kind of coverage to single adults, which was not previously included prior to the concept and the construct of health care reform.
      2. California, (one of the first states, besides, Oregon) has implemented this kind of coverage for all policies.
      3. Hospital presumptive eligibility: Simple kind of application to get individuals who are coming into the hospital for care and may not be insured at that time.
      4. Hospital staff are trained to assist these individuals to sign up for Medi-Cal. It's a very simple form, unlike the regular Medi-Cal application.
      5. Allows determination of eligibility status in 'real time'.
      6. Flexibilities including 'presumptive eligibility,' allows up to 2 months of full scope benefits which will cover inpatient costs at the hospitals as well as full range of mental health services.
      7. To continue on to Medi-Cal, the patient can submit the whole account application online.

c) With the section 1115 waiver, we have a program called Global Payment Programs, which funds our public health care system, and there are about 15 designated state hospitals that are participants in this.
d) DHCS is looking at the methodology of value-based care to finance the pool of uninsured individuals.
e) There is an ongoing 'redetermination' campaign of Medi-Cal eligibility since COVID-19, so the influx of people coming into the program will be partly balanced by many people losing Medi-Cal.

b. **Questions and Answers:**

i. Dr. Hattis asked if there is an estimation of cost and if the legislature is committed to ongoing funding.

1. Dr. Huang stated for age 26-49 approximately for first 6 months approximately 1.2 billion in the state general funds. The expansion is funded thru state dollars and the federal match is only for emergency services which is about 2 billion of the total funds. For a full year of 26-49 y/o will be about 3.1 billion in the State of California funding the state.
2. The other age groups will cost a little bit less but it is still a large investment from the administration as these are individuals without a satisfactory immigration and the federal govt. will only fund very specific types of services.

ii. Dr. Hattis also asked what hospitals are required to provide uncompensated care and will they be getting a windfall since the uncompensated will now be compensated.

1. Dr. Huang replied that dollar amounts for the public care entities such as county hospitals that are participating in the expansion have not been modified at this time. This is in early stages with financing portion at nexus between eligibility policies. Medi-Cal is in a state of flux primarily due to the fact that we're in the post-COVID-19 era and they will not be making conclusions about financing immediately.
   a) With Medi-Cal redeterminations resuming it is expected 2-3 million will be expected to drop off from that account. This is not including individuals that don't have satisfactory immigration papers.
   b) At this time, there has not been change in projections as it related to the global payment programs or the pools of dollars that are being used to fund the uncompensated.

iii. Dr. Hattis asked who the 2-3 million people dropping off are from the medical expansion were.

1. Dr. Huang explained that when COVID-19 hit in March 2020 a federal requirement was placed on all state Medicaid agencies across the nation that no agency shall redetermine Medicaid eligibility.
2. Previously, redetermination was a requirement at least annually. This requirement was paused for 3 years which means we kept people in that account the last 3 years that may not necessarily need the coverage.

3. This redetermination requirement will resume March 31st of this year and that process does not end until May 2026.
4. With the 'unwinding' of the COVID-19 continuous coverage requirements it is estimated that 2-3 million will be dropping off as they are no longer eligible due to higher income or other reasons. Some of these may get coverage through the Affordable Care Act but others may become another pool of uninsured individuals.

iv. Dr. Hattis noted that for Medicaid recipients, during COVID, the State was getting a federal match, but this will not be true for the millions receiving the new expansion and (presumably) more expenditure. Dr. Huang indicated this is a potential but impacts are very uncertain at this time.

v. Dr. Hattis asked if the 2 months of initial coverage was when a person was hospitalized and Dr. Huang explained that yes, when a person is hospitalized this is another pathway to full coverage and that the federal government does match this.

vi. Dr. Hattis noted, for undocumented people, in particular, hospitals were absorbing the costs and inquired if there was a rollover in attempt to recoup costs by increasing rate insured were charged. He added he is trying to zero in on if hospitals are getting a potential windfall that they don't have to pass on to the insured patients. He was concerned that hospitals might just hire more administrators and bloat the health care budget.
   1. Dr. Huang noted that is a great question but outside of her expertise and she is probably unable to answer that. She confirmed that no special arrangement was made that would require hospitals to lower rates.

vii. Jessica Nunez de Ybrarra noted that there might be other important questions that participants were refraining from asking due to limited time and remaining items to address.

V. Public Health Legislation

i. Alicia Sanchez, CMA, noted the bulk of this meeting focused on Medi-Cal and the CMA will continue to be focused on Medi-Cal and funding issues.
   1. The presentations were a testament to California's commitment to Medi-Cal and expanding access through coverage and ensuring a very rich benefit package.
      a) Ensuring that there is adequate access has been something that CMA has been concerned about over many years.
      b) The Medi-Cal model has been likened to a 3-legged stool, the legs being eligibility, benefit coverage, and access.
   2. Rates of Medi-Cal reimbursement have not been increased across the board for over 25 years and that makes it a difficult system for a provider to work in.
      a) They were very focused on that in the last year and worked with the budget process to re-establish the Managed Care Organization (MCO) tax.
      b) This tax, for next year is going to allow for increases in preventive care, non-specialty mental health services, and obstetric services
      c) In 2025 it is intended to expand beyond that.

d) CMA and other partners have filed an initiative that would protect services and ensure that the MCO tax is maintained and ensure the funding remains in the system.
e) It is important to acknowledge that the funding can't be supplanting funds but needs to be in addition to other funds.
f) There isn't time to go into detail regarding forms of funding today, but it is worth pointing out that the MCO tax funds do allow for an annual 75 million dollar allocation to GME to fund programs and there is a nexus to this group's interest as it related to GME. While this is not necessarily primary prevention, there is an interest in making sure that the Medi-Cal program is able to really meet its charge in the most effective way.

3. Dr. Hattis asked if CMA would be sponsoring any Climate Change Initiatives. Alicia stated at this time they are not sponsoring or co-sponsoring any bills on climate relief, but that one of the major issue reports at the House of Delegates will be focused on climate change.
   a) That report has not yet been adopted because they had to postpone the October House of Delegates meeting.
   b) The conversation will now convene on February 10th. For physicians who are delegates or organizations that have delegates, this is an opportunity to engage in that conversation and there will be additional discussion.

ii. Don Lyman discussed CAPM priority bills of the year, which were listed in a "handout." He discussed this summary and also resolutions that went through the CMA.
   1. Dr. Hattis indicated there were several CMA resolutions of interest including prohibiting increase or denial in malpractice insurance because of providing reproductive services like abortion or gender affirming care. That was signed into law. Another resolution was restricting 3D printing of firearms. These were for 2023 and we will see what happens in the 2024 legislative session.

VI. New Business: There were no new business items raised.

VII. Plans for Next Meeting and Adjournment:

i. Prior to adjourning, Dr. Hattis mentioned that copies of the meeting video including closed captioning can be obtained, if interested.
ii. He also asked for suggestions for topics at future meetings. Suggestions for meeting topics can be sent to preventive@aol.com
iii. Special thanks to the presenters and welcome and gratitude to Dr. Ramos for joining us was given and the meeting was adjourned at 9:31 am.

Submitted by Tracy Stevenson with editing by Ron Hattis.
These minutes were approved at the March 12, 2024 meeting.