MEDICAL BOARD OF CALIFORNIA
Licensing Operations

Midwifery Advisory Council
Lake Tahoe Room
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

December 9, 2010

MINUTES

Agenda Item 1 Call to Order/Roll Call
The Midwifery Advisory Council (MAC) of the Medical Board of California was called to order by Chair Karen Ehrlich at 1:02 p.m. A quorum was present and notice had been mailed to all interested parties.

Members Present:
Karen Ehrlich, L.M., Chair
Ruth Haskins, M.D., Vice Chair
William Frumovitz, M.D.
Faith Gibson, L.M.
Carrie Sparrevohn, L.M.
Barbara Yaroslavsky

Staff Present:
Breanne Humphreys, Licensing Manager
Diane Ingram, Manager, Information Services Branch
Ryan Lam, Information Services Branch
Letitia Robinson, Manager, Licensing Operations
Jennifer Simoes, Chief of Legislation
Anita Scuri, Supervising Senior Counsel, Department of Consumer Affairs (DCA)
Cheryl Thompson, Analyst, Licensing Operations
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:
Bruce Ackerman, Midwives Alliance of North America (MANA)
Claudia Breglia, L.M., California Association of Midwives (CAM)
Mason Cornelius, Licensed Midwife
Frank Cuny, California Citizens for Health Freedom (CCHF)
Suchada Eickemeyer, Member of the Public
Megan Goldstein, Member of the Public
Jennifer Heystek, Licensed Midwife
Veronica Ramirez, California Medical Association
Jeff Toney, Division of Legislation and Policy Review, Department of Consumer Affairs

Agenda Item 2 Public Comments on Items Not on the Agenda

No public comments were offered.

Agenda Item 3 Approval of Minutes from the August 11, 2010, Meeting
Ms. Yaroslavsky made a motion to approve the minutes from the April 8, 2010 meeting; s/Sparrevohn; motion carried.

Agenda Item 4 Licensed Midwife Annual Report

A. Update on OSHPD / MBC Interagency Agreement
Diane Ingram, Manager, Information Services Branch, reported the Office of Statewide Health Planning Department (OSHPD) and the Board had been meeting to develop a multi-year Inter-Agency Agreement (IAA). The IAA has been transitioned to a Memorandum of Understanding (MOU) with no charges to be assessed to MBC by OSHPD for hosting the Licensed Midwife Annual Report (LMAR) on its website. The agreement is currently being reviewed by legal counsel.

B. Update on Online 2010 Annual Report Survey
Ms. Ingram reported the delivery of the 2010 LMAR to OSHPD has been delayed due to the testing of the extensive enhancements that were made to prevent reporting errors. It is anticipated that the report will be delivered on December 24, 2010 (a delay of approximately 5 weeks). The licensing file of midwives required to submit a report will also be delivered at that time. Once OSHPD has received the LMAR, they will begin their testing. It is anticipated the report will be available online to midwives sometime in February 2011.

Ms. Ingram introduced Ryan Lam, Associate Programmer Analyst, who has been making the requested enhancements to the LMAR. He provided a brief overview of these enhancements. It was requested that a safeguard be added that will not allow the user to save data into Section P unless she has previously reported a death in Section E. Although the LMAR has a definitions page and the definitions are incorporated in the directions for each section, it was requested that a pop up definition for "infant death" and "fetal demise" be added to the LMAR so the definition appears each time the user runs their mouse over that word.

Ms. Thompson reported a link to the LMAR will be placed on the midwife home page on the Board's website and a letter will be send to all licensed midwives reminding them of the necessity of reporting and indicating the report is now available online with the due date. A paper version of the report will be available to those who request one, though this number has historically been small (8-10 midwives).

D. Consideration of Prospective Versus Retrospective Reporting of Data
Bruce Ackerman, Midwives Alliance of North America (MANA), reported they have a voluntary research oriented data collection system, called the MANA Statistics Project, that is capable of collecting and providing statistics on midwifery outcomes. It is burdensome for a midwife to report their data to both MANA and the relevant state data collection system (LMAR in California), so, currently, midwives may choose not to submit data to MANA. MANA has been in discussions with the state of Oregon to develop a simple model for reporting. Oregon licensed midwives will be asked to participate in the MANA Statistics Project and will satisfy their mandated reporting requirement by printing out a statistics page report and submitting it to their licensing authority. MANA will support this effort by revising their online data form to make it shorter and less daunting to complete and developing a report that will satisfy Oregon's reporting

requirements; this will be available online to Oregon midwives by July 2011. Mr. Ackerman would like to propose that a similar arrangement be developed for California. He stated this could be done at a minimal cost since the data is already being collected by MANA. Further, it would greatly aid in MANA's research efforts by providing a full representative sample of US midwives. Other states are also looking into the possibility of using MANA's Statistics Project for their mandated reporting, as well.

MANA has worked with the California Association of Midwives (CAM) to develop adjunct software to help midwives satisfy their reporting requirements in California; however, each time California or MANA's data forms change this software would have to be redone.

Ms. Sparrevohn explained that the California statistics are collected in a retrospective manner where results for the entire year are reported all at one time. In contrast, the MANA Statistics Project allows midwives to enter their data prospectively. When a midwife enrolls in the MANA program, she agrees to enter every client into the system. Each new client is registered and data is then entered for that client's outcomes. A consent form from clients is required since the data will be used for research purposes. This may create a reporting problem if the client refuses to sign the consent form. In such instances, MANA would still be able to report that there was a client who received services, but it would not be able to report the outcome of those services. The vast majority of the clients would, however, be reported in the statistics.

Dr. Haskins noted this consent requirement would have to be revamped for California reporting purposes since midwives must report outcomes for *every* client served. This issue is being worked on in the agreement with Oregon licensing. Mr. Ackerman was unsure if the consent form could be eliminated entirely, but stated it might be possible to use the information from a client who refused to sign the consent form for reporting purposes only, but not for research. This would be a matter for further discussion. Client confidentiality is preserved in that the client's name is never entered in the reporting; the midwife creates a code of her own design to use in assigning a number for each client. Dr. Haskins also noted the MANA Statistics Project includes data for midwives, most (but not all) of whom are licensed. Any reporting would have to exclude outcomes from unlicensed midwives.

The MANA Statistics Project is currently provided by MANA as a service to the profession at no cost to the midwives. Oregon is providing $7,000 for the creation of the shortened reporting form. Mr. Ackerman stated he did not believe there would be any on-going funding from Oregon.

MANA does not actually conduct the research on midwifery outcomes, but maintains the registry as a database that can be used by other entities who are conducting research. Data has been collected since the early 1990s. Mr. Ackerman reported that any deaths reported in the MANA statistics are followed up with an interview.

Ms. Scuri suggested obtaining the elements of MANA's reports so these could be compared with California's reporting requirements to determine if there is value in changing California law to include these elements in place of what is currently being collected. Since the process in Oregon should be completed by July 2011, the MAC could have helpful information to consider at that time. Participation in the MANA program would provide a way to compare California midwifery data with that of other states.

Mr. Ackerman reported that, by the fall of 2011, California midwives who participate in the

MANA Statistics Project should be able to print out a report that will assist them in completing the LMAR report submitted to OSHPD.

Mr. Ackerman stated that OSHPD would likely still be part of the reporting process in California. He suggested that midwives would use the MANA Statistics system on an on-going basis throughout the year. At the end of the year, the midwife would generate a report from the MANA system and submit it to OSHPD. OSHPD would then take these reports and aggregate the data into a summary report for MBC to submit to the Legislature.

Agenda Item 5 Discussion of Changes to the Midwifery Page on the Medical Board's Website

Ms. Thompson reported the Midwife License Application and a customized LiveScan form will soon be added to the website. As soon as it becomes available, a link to the 2010 LMAR and a helpful User Guide to the LMAR will also be added. While it would be desirable to provide the ability for midwives to renew their licenses online, the current system is limited and does not have this capability. The Department of Consumer Affairs (DCA) is undertaking a major IT project called BreEZe that will replace the current ATS Licensing and CAS Enforcement systems. Online renewals, as well as the ability for a midwife to check on the status of her application, will be possible with BreEZe. This new system is expected to roll out in December 2012.

Dr. Haskins asked about the possibility of editing the definition of "midwife" provided on the home page to remove the phrase "under the supervision of a licensed physician and surgeon, in active practice" or provide an asterisk and footnote to indicate the Board is aware that physician supervision is impossible due to liability issues, or anything else that would indicate this definition is not accurate in practice.

Ms. Scuri suggested it might be best to completely remove the second sentence outlining the scope of practice from the definition posted on the website. Ms. Whitney indicated this would have to be reviewed.

Agenda Item 6 Program Update

Ms. Thompson directed members to page 15 of their packets for the midwifery licensing statistics for the first quarter of FY 2010/2011. During this period, 9 new midwife licenses were issued and 30 licenses were renewed. Since the end of October 2010, 12 additional midwife licenses have been issued, bringing the total number of new midwives up to 21. This number already surpasses the totals for all of FY 2009/2010 when 19 licenses were issued.

On Wednesday, February 16, 2011, approximately 15 midwifery candidates will sit for the NARM exam at the Medical Board's offices. This exam, which is offered twice per year, satisfies the Board's written examination requirement for licensure.

Agenda Item 7 Discussion on Title 16 California Code of Regulations Section 1379.30 and Effect of Sunset of Former Business and Professions Code Section 2514

Ms. Scuri reported that Ms. Ehrlich had voiced concern with the sunset of B&P Code Section 2514 which outlined the educational requirements for midwifery education programs. When this section of law was allowed to sunset, it was transferred verbatim into regulation as Title 16 of the CCR Section 1379.30. This section includes the practices an education program must prepare a midwife

to perform, including the administration of intravenous fluids, analgesics, postpartum oxytocics and RhoGAM, administration of local anesthesia, paracervical blocks, pudendal blocks, local filtration, episiotomy and episiotomy repair, Vitamin K and eye prophylaxis, among others.

Ms. Scuri noted for other professions, these regulations might reflect scope of practice; however, she suggested it might be preferable if there were a regulation that specifically listed those duties a midwife may perform, even though they are within a midwife's scope of practice under the midwifery law and this was the intent of the regulation. B&P Section 2507 states that a license to practice midwifery authorizes the holder under the supervision of a licensed physician and surgeon to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning for the mother and immediate care for the newborn. The items listed in the regulation are essential components of a midwife being able to carry out the duties authorized in law. Ms. Scuri stated the midwifery law authorizes midwives to perform those actions and carry out those procedures.

Ms. Sparrevohn stated that the way the regulation was written, it does not provide any authority for midwives to obtain analgesics, oxytocics, etc. This creates a barrier for midwives in obtaining these needed items.

Dr. Haskins noted that Section 1379.30(e) which requires approved midwifery education programs to prepare midwives to provide management of family planning and routine gynecological care including barrier methods of contraception such as diaphragms and cervical caps, is an issue for the obstetrician and gynecologist communities. They believe midwives who perform such functions are overstepping their bounds and, were this to become more widely recognized and practiced, is likely to be vehemently challenged by the American Congress of Obstetricians and Gynecologists and the California Medical Association. Dr. Haskins clarified that "routine gynecological care" in her mind, would include the annual health maintenance exam including pap smear, breast check and thyroid check.

Ms. Sparrevohn stated the midwife scope of practice is identical to that for licensed certified nurse midwives (CNM); no one would contest that CNM may conduct health maintenance exams as part of routine gynecological care. She reported she works in exactly the same manner as a CNM, with the only difference being her inability to call in a prescription under her own name.

Dr. Frumovitz stated years ago, when gynecologists were confronted by family practitioners and internists doing routine gynecological care, they fought this fiercely. He reported there is a need to educate the obstetrician/gynecological community as to the capabilities and services midwives provide, rather than arguing about a sentence in the law.

Ms. Ehrlich asked, in Dr. Haskin's opinion, if the midwives were to leave routine gynecological care as taking place under the supervision of a physician or surgeon (rather than under independent midwifery practice), would licensed midwives be able to be hired in clinics and other such facilities to perform annual, routine health maintenance exams for women and would this be acceptable to physicians.

Dr. Haskins stated she thought this would be true. Most physicians believe there cannot be independent practice of midwifery and that it must be under physician supervision.

Agenda Item 8 Terms and Conditions of Probation

Ms. Whitney stated that at the previous MAC meeting she had reported that there had not been an

opportunity to look at the terms and conditions of probation as they might apply to midwives. She directed members to pages 16 of their packets for the Manual of Model Disciplinary Guidelines that were established for physicians. The Guidelines are currently being revised by the Board; a hearing on the revised Guidelines will take place at the January 2011 Board meeting. Rather than discussing terms and conditions of probation as they relate to midwifery at this meeting, Ms. Whitney asked to postpone this discussion until the revised Guidelines have been adopted. She requested that the Council appoint a member to work with Ms. Robinson, Ms. Thompson, and legal counsel to pull out and discuss the appropriate sections of the Disciplinary Guidelines that could apply to midwives and then present at a future meeting for discussion. Ms. Gibson volunteered to serve in this capacity.

Agenda Item 9 Update on Barriers to Care

Ms. Simoes reported she was charged with meeting with the various state agencies to determine if there were any changes that could be implemented without statutory or regulatory authority to address identified barriers to care. Ms. Simoes, Mr.Worden, and Ms. Thompson met with the California Department of Public Health (CDPH) on several issues noted under barriers to care. Issues surrounding birth certificates include each county creating its own rules and worksheets, midwives' being unable to submit birth information electronically, register births within 10 days, and obtain social security numbers automatically.

Lynette Scott, the State Registrar, met with Medical Board staff and provided information on constraints the state and counties are facing. Per CDPH, out of hospital births have issues related to security concerns. Since the 9/11 terrorism acts and the increase in identity theft, there has been increased attention to birth certificates at both the state and federal level. Birth certificates are considered potential "breeder documents" opening the door to many other potential abuses. Birth certificate security is, therefore, considered a critical first line defense. Counties take on considerable liability when they register a birth to ensure that the birth really did occur. Heightened security extends to the paper being used for the certificates, the way the information is recorded by the counties, etc. This is of particular concern in jurisdictions along the Mexican border since the birth certificate is the key document used to establish citizenship. This is why some counties may have tighter requirements and rules than others.

A guide on how to register an out of hospital birth is located on CDPH's website; this lists the state requirements. Each county tries to meet the state requirements in a different way, hence the variation from county to county. The State Registrar does not dictate exactly how the requirements are to be met.

The Automatic Vital Statistics System (AVSS) is used to electronically register births. The Registrar reviewed the requirements for using the system with staff; these requirements are spelled out at www.avss.ucsb.edu. As the local registrar is accountable for the information they record, independent use of AVSS for registering out of hospital births has additional requirements. These include purchasing a license from UCSB, performing training on the system, purchasing the required hardware including a special printer, maintaining numbered birth certificate paper in a locked environment, and receiving approval from the State Registrar's Office. These requirements pose a significant expense for an independent midwife interested in registering births electronically. Further, the Social Security Administration has issued a federal guideline that specifies that if the AVSS system is used to establish a social security number, the birth must have occurred in a hospital.

Ms. Yaroslavsky suggested that at some point in the future it might be feasible for the licensing of midwives, registration and reporting of individual birth data by MANA and OSHPD, and the registration of births with counties to be integrated.

Ms. Simoes noted any such requirements would also have to be matched against not only state but federal requirements.

With regard to the law requiring that births be registered within 10 days, Ms. Simoes noted, while this is in law, there is no way for the State Registrar to enforce this. She stated that having uniform practices for registering out of hospital births across all California counties would require a change in law, as counties are currently permitted to establish their own procedures as long as they meet the state requirements.

The next barrier to care addressed dealt with the difficulty midwives face in obtaining lab accounts with diagnostic laboratories due to the CDPH's Laboratory Field Service's determination. Staff spoke with the Beatrice O'Keefe, Division Chief, Laboratory Field Services (LFS). Ms. O'Keefe stated that any healing art licensee has the authority to open and maintain lab accounts, including licensed midwives. She stated the difficulty licensed midwives are facing are primarily due to lack of education among diagnostic laboratory staff. LFS is willing to work with MAC to get the information out to the labs. Staff was invited to the upcoming Clinical Laboratory Technology Advisory Committee (CLTAC) meeting on January 14, 2011 in Richmond to address this issue.

Ms. Ehrlich asked that a letter be requested from Ms. O'Keefe that can be sent to every licensed midwife to be presented if they are denied a lab account.

Ms. Simoes suggested that a collaborative approach might be more effective, where labs are given the opportunity to respond once they have received education from LFS.

Ms. Whitney stated, with MAC's permission, that the Board will send a written request to LFS asking for a written response that could be distributed to licensed midwives. In addition, the Board will send a representative to the CLTAC meeting in January.

Claudia Breglia, CAM, thanked Ms. Simoes for her efforts. Previous correspondence from LFS to the labs indicated just the opposite, that licensed midwives required a supervising physician's signature on file in order to open an account. She requested that any letter from LFS reference this prior direction as being inaccurate, since labs cite this correspondence in denying accounts. Dr. Haskins warned that by opening lab accounts, licensed midwives will be subject to certification requirements for performing certain tests. In addition CLIA waived tests may require completing voluminous paperwork and paying a fee to the state and federal government for the ability to perform them.

Ms. Simoes reported the other previously reported barriers to care would require regulatory changes. In her discussion with CDPH, she was told that any changes to the Comprehensive Perinatal Services Program (CPSP) (such as adding midwives to the approved provider list) would require a change in regulations. CDPH indicated they were very behind in their regulations; further, they have a different regulatory approval process that would require approval from "higher up" before they could move forward. Ms. Simoes was told it would take at least 2 years for any regulatory change to become possible. It is possible that Federal Health Care Reform may resolve this issue.

Ms. Scuri reported there is a provision in the rulemaking law that allows a member of the public to petition any state agency to change a regulation. DCA's website contains a rulemaking manual that outlines the requirements for petitioning for a change in regulations. The statutory response time, to either deny or set the matter for hearing, is set in law. Such rules do not exist for one state department to petition another state department. Ms. Scuri suggested the best route would be for one of the midwifery organizations or groups to petition CDPH for the regulatory change.

Ms. Simoes noted a petition from midwifery organizations to CDPH could be used to address both the Alternative Birth Center regulations and the CPSP; a petition to the Managed Risk Medical Insurance Board could be made to address changes to the Access for Infants and Mother's Program.

Agenda Item 10 Discussion on Membership of Midwifery Advisory Council

Ms. Ehrlich requested that, in the future, should there be a public member opening on the MAC, consideration be given to filling the vacancy with a member of the public who has been a recipient of midwifery services.

Ms. Scuri noted the number of members on the Council is not set in law; this was set by the Medical Board when the MAC was first implemented and could be changed. The statute specifies that half of the members shall be California licensed midwives. Increasing the size of the Council would be allowable under current law.

As the Council currently consists of 6 members, three of which are midwives, this would entail adding two more members to the MAC (one public and one licensed midwife). Given budget constraints, Ms. Ehrlich indicated she did not think this would be approved, even though the Council operates at a relatively minimal cost to the Board.

Dr. Haskins noted that, over the years, she has seen consensus among the public members and midwives, rather than split votes. She takes this as evidence that the composition is not critical. Further, she stated that the MAC generally has excellent audience participation such that issues of concern to midwives or the public (including parents who are recipients of midwifery care) are voiced and those opinions entered into the public record. In the issues that have been addressed by the MAC over the years, Dr. Haskins stated she cannot recall a single instance where she wished there were a member who had used a midwife sitting on the MAC to provide their input.
Ms. Ehrlich was concerned that opportunities for parents to participate and have a voice in the workings of the Council were very limited. She stated the public member slot filled by one of the physicians was often empty, the physician choosing not to stay and commit to the Council. She stated she has no issues with the current public members, but, should one of them choose to step down that consideration be given to filling their slot with a parent.

Ms. Gibson stated she felt all the Council members did a good job of representing what is most important and beneficial to midwives; she thought the perspective of someone who actually uses midwifery services may be different and is missing from the current Council.

Agenda Item 11 Discussion on VBAC (Title 16 California Code of Regulations Section 1379.19(b)

Ms. Scuri reported there have been extensive discussions about vaginal birth after cesarean section

(VBAC) when the Midwifery Standards of Care were being created. Title 16 CCR Section 1379.19 places the Standards of Care into regulation and has an entire section on VBAC and when a midwife can provide services to a client who has previously had a C-section. If the client meets the criteria set forth in the Standards of Care, then the midwife must provide the client with informed consent and document this in the client's midwifery record.

Dr. Frumovitz stated VBACs are a controversial and sensitive issue, particularly with the cesarean section rate now at 33% and growing and some hospitals refusing to perform VBACs. He noted that physicians are being held to one standard and midwives practicing at home are held to a different standard, which does not seem appropriate.

Ms. Ehrlich noted that the practice of midwifery is not the practice of medicine. There are distinctions in the standards and philosophies that differ. She stated she sees this as a denial of care issue and it is far preferable for a mother to have a VBAC with a midwife present than have an unassisted home birth. Ms. Ehrlich reported the ACOG guidelines state there shall be no forced surgery and that women have the option of informed choice.

Dr. Haskins noted the Standard of Care incorporating VBACs was established before the existence of the MAC; it was decided by the Midwifery Committee of the Medical Board, with vocal input from ACOG representatives. The final determination that the Medical Board agreed with rested on the client's right to self-determination. The Administrative Law judge who reviewed the scope as presented in the regulations agreed. Very specific criteria must be met, including advising the client that ACOG recommends a hospital birth, informing her how many VBACs the midwife has performed and the level of her training and competence. If the client acknowledges all of this in writing and still wants to deliver at home, then she has that option.

Ms. Breglia distributed a copy of the Midwifery Standard of Care and the ACOG Practice Bulletin No. 54 from July 2004. This document has been superseded by ACOG Practice Bulletin No. 115 from August 2010, which states that:

> "In addition to fulfilling a patient's preference for vaginal delivery, at an individual level VBAC is associated with decreased maternal morbidity and a decreased risk of complications in future pregnancies. At a population level, VBAC also is associated with a decrease in the overall cesarean delivery rate. Although TOLAC is appropriate for many women with a history of cesarean delivery, several factors increase the likelihood of a failed trial of labor, which compared with VBAC, is associated with increased maternal and perinatal morbidity. Assessment of individual risks and the likelihood of VBAC is, therefore, important in determining who are appropriate candidates for TOLAC."

Ms. Breglia noted midwives take this evaluation very seriously; many midwives will not take on a client with multiple cesareans, or a primary VBAC with twins (even though Practice Bulletin No. 115 states there is not an increased risk with twins or after two previous cesareans).

A copy of the Annals of Family Medicine 4:228-234 (2006) "*Vaginal Birth After Cesarean in California: Before and After a Change in Guidelines"* was also distributed by Ms. Breglia. This report showed the number of attempted VBACs decreased sharply in 1999 after ACOG adopted more restrictive guidelines for VBACs, but the neonatal and maternal mortality rates did not change during this period. The conclusion was that neonatal and maternal mortality rates did not improve despite increasing rates of cesarean delivery.

Dr. Haskins noted the importance of the 9 months of communication and the establishment of a relationship between the midwife and the client in making decisions on care. If a midwife transfers a patient to the hospital, the physician does not have the benefit of that prior communication and relationship and must follow hospital protocol. She noted it is often the hospital's decision, not the individual physician's, on whether to allow TOLAC and accept the liability for a ruptured uterus.

Agenda Item 12 Agenda Items for Next MAC Meeting

Suchada Eickemeyer, member of the public, reported she had both her children with the help of midwives. She stated the process of obtaining a birth certificate and social security number was onerous and took almost 6 months.

Ms. Gibson stated she has been told by her local Social Security Office that they will not accept a birth certificate that indicates a home birth as documentation. This can create great difficulty for a low income mother trying to get a social security number in order to enroll her child in federal assistance services. Correcting this would require congressional intervention, not state intervention.

Dr. Haskins asked that an agenda item be added on the implementation of the Obama Health Care Reform from a CMA and ACOG perspective to help update the Council and interested individuals on movement toward collaboration.

Ms. Sparrevohn requested an update on the lab accounts and the CLTAC meeting.

A member of the audience requested that the difficulty some midwives face in securing a back up physician for women choosing out of hospital births be placed on the agenda. Dr. Haskins stated ACOG was moving in a positive direction toward collaboration between licensed gynecologists backing midwives in a way that is acceptable to both and she will provide information at the next Council meeting.

Ms. Ehrlich requested discussion on strategies to resolve the physician supervision issue, including possibly defining of the appropriate level of supervision. This discussion item may be tabled depending upon the content of Dr. Haskin's report.

Ms. Yaroslavsky requested that future MAC meetings start at an earlier time to accommodate flight schedules while still allowing sufficient time for driving time.

Agenda Item 13 Adjournment

Meeting adjourned at 3:12 p.m.