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Oregon Nurse Staffing Advisory Board (NSAB)

Wednesday, February 22, 2017

1:00 PM – 5:00 PM

Meeting Minutes

Cochairs	Susan King, MS, RN, CEN, FAAN (Presiding); Carol Bradley, MSN, RN, CENP
Members present	Trece Gurrad, RN, MSN; Carolyn Starnes, ASN, RN; Debbie Robinson, RN, MSN; Jennifer Burrows, RN, BN, BSc, MBA; Rob Campbell, CP, ADN, RN; Virginia Smith, BSN, RN-BC; Zennia Ceniza, RN, MA, CCRN, ACNP-BC, NE-BC (by phone)
PHD staff present	Dana Selover, MD, MPH; Wendy Edwards, RN, BSN; Anna Davis, JD; Lisa Finkle
Guests present	Kathryn Engle; Margie Gutierrez; Leah Emmett (by phone), Barb Merrifield (by phone)

Agenda Item 1	<i>Call to Order – Susan King</i>
Time Stamp: 00:00:01	
The meeting was called to order.	

Time Stamp: 00:00:30	<i>Acknowledgment – Virginia Smith</i>
Virginia Smith acknowledged Anna Davis’s presentation at the ONSC/ONA conference on February 2, 2017. The workshop gave participants a lot of information and allowed hospitals and direct care nurses from around the state to ask a broad range of questions.	

Time Stamp: 00:01:30	<i>Appointments – Susan King</i>
<p>Susan King asked whether there is any news about appointments to fill vacancies on the NSAB.</p> <p>Dana Selover stated that staff continues to remind the governor’s office of the vacancies. The governor’s office has not provided any new information. The governor is occupied with legislative session that began earlier this month.</p> <p>Susan King stated that she heard the next appointments would be included in a series of appointments made by the governor.</p> <p>Dana Selover stated that the governor’s office can continue to receive applications, because there are three vacant positions.</p>	

Time Stamp: 00:03:53	<i>Introductions – Susan King</i>
All individuals present and on the phone identified themselves.	

Agenda Item 2 Time stamp 00:06:17	<i>November 30, 2016 Board Minutes – Susan King</i>
<p>Debbie Robinson noted that the draft minutes state that Trece Gurrad was not present, but Trece was present and participated in the discussions. Also, on page 9 there was a reference to “service” instead of “serve.”</p> <p>Virginia Smith asked about the resignations from NSAB.</p> <p>Susan King confirmed the resignations.</p> <p>The minutes were approved as corrected.</p>	
Action Item	<ul style="list-style-type: none"> • OHA will correct the minutes to reflect Trece Gurrad’s presence and change the word on page 9.

Agenda Item 3 Time stamp 00:08:30	<i>Rulemaking Update – Anna Davis</i>
<p>Anna Davis stated that the overtime rulemaking process is completed and the rule went into effect in January. The new rule language is available on the nurse staffing webpage.</p>	

Agenda Item 4 Time stamp 00:09:37	<i>Waiver Update – Anna Davis</i>
<p>Anna Davis stated that OHA is still receiving waiver requests. The agency had asked for waivers to be submitted by November 17, 2016. Waivers are being submitted now as awareness grows of the need and use for waivers. When waivers are submitted</p>	

OHA contacts the hospital to discuss the change to the waiver review standard and the important elements of a waiver request. Hospitals that previously had waivers may need to provide additional information to establish that a waiver request meets the new standard. For hospitals that have not previously had waivers, the entire process is new. OHA also contacts the hospital to provide additional explanation when a waiver is denied. Waivers that have been denied have been in situations when the request is for something that the agency cannot waive, such as a request to waive the requirement to have a nurse staffing committee, or when the request is for a waiver of the mandatory minimum staffing and the requested alternative would lead to insufficient staffing.

Virginia Smith asked for more information about a waiver of the mandatory minimum staffing that was denied.

Anna Davis stated that the waiver request was for a plan that would staff the unit with a single RN. In that plan a non-nursing staff member would sometimes be present to assist in the unit, but at other times the additional individual would be on duty away from the hospital leaving the RN alone in the unit.

Susan King asked whether the issue was the training of the additional individual or the absence of the additional individual that was determinative.

Anna Davis stated that the absence of the additional staff could not be overcome so the training of the additional staff was not addressed. The training would be analyzed if the alternative staff would be continuously present in the unit.

Dana Selover noted that the staffing in this situation would not meet the definition in the law or the rule.

Trece Gurrad asked whether this waiver request came from a rural hospital.

Anna Davis confirmed that this was a small hospital.

Rob Campbell asked how many waivers have been received.

Anna Davis stated that there have been about 10 requests.

Trece Gurrad asked whether any of the requests have been approved.

Anna Davis stated that none of the requests have been approved. Some of the requests have been denied and others are still in the review process.

Virginia Smith asked who is reviewing the waiver requests.

Dana Selover stated that she reviews waivers after Anna Davis while Annabelle Henry is on leave. In addition, Anna and Dana may consult with surveyors. The hospital surveyors are sometimes asked to comment on the request from a nursing perspective.

Trece Gurrad asked whether the agency would ask Susan King or Carol Bradley for input.

Dana Selover stated that OHA may or may not seek guidance from the NSAB. The agency is less likely to ask for advice on specific waiver requests. Some advisory

boards have a statutory mandate to review waiver requests. This board review may slow the waiver request process. NSAB has no specific mandate to review waiver requests.

Anna Davis stated that the agency may need to consult with the Department of Justice about whether the NSAB could provide input about specific requests because that is not contemplated in statute.

Rob Campbell asked if there's a pattern in the requests that have been received thus far.

Anna Davis stated that some of the waiver requests have been requested in the past by the same hospitals and other requests are hospitals that have not previously requested waivers.

Rob Campbell asked whether the requests are about minimum staffing numbers.

Anna Davis stated that many requests are related to minimum staffing.

Carol Bradley agreed that the requests are related to minimum staffing because the definition of nursing staff member does not include techs. She has been contacted by hospitals considering waiver because of this issue. She asserted that most hospitals will need one or two waivers in order to be in compliance with the nurse staffing law.

Rob Campbell expressed concern that the waivers will allow staff without appropriate qualifications to count as staff members for minimum staffing purposes.

Carol Bradley asserted that the majority of waivers will likely come from procedural areas during their on-call hours.

Rob Campbell agreed that most of the techs exceed the standard of care.

Carol Bradley stated that the techs may be more skilled than CNAs in the procedural areas.

Rob Campbell suggested that waiver requests state how the techs are better qualified to meet the patients' needs.

Virginia Smith stated that in procedural areas and behavioral health the units rely on techs who are more skilled than CNAs. She cautioned that in some highly skilled areas like ICUs the hospital may not request a waiver because there are technically two RNs present, but if one of those RNs is a supervisor covering for someone on break, then there may not be adequate patient care even though the minimum staffing numbers are met.

Carolyn Starnes asked whether there are pending waiver requests from surgical services. In her experience those units put techs on call with RNs at night.

Anna Davis stated that there are surgical service waiver requests pending from a few hospital systems and the agency expects to see more of that type.

Debbie Robinson stated that the language about minimum staffing is not new, but hospitals are really just becoming aware of the implications. She asked whether Carol Bradley is encouraging the nurse leaders who contact her to request waivers.

Carol Bradley stated that she is encouraging nurse leaders to request waivers. She stated that there is a difference of interpretation in determining which service areas need nurse staffing plans. The hospitals need to make that determination for themselves.

Susan King stated that there are a number of issues that the NSAB will want to continue to track. One is the issue of the minimum of two required nursing staff members on duty. There was conscious discussion about trying to prevent the team from being an RN and a housekeeper or an RN and a secretary, which was not uncommon in the past. The question is whether the language is too narrow and would prevent the use of techs, which all the hospitals use in some units, and whether there is elasticity for techs in the statute and rules. This topic should be on the agenda in the future, particularly after the next wave of waiver requests comes in. At that point the NSAB can take a broad look at the questions coming in and what type of solution we might be able to offer.

Debbie Robinson stated that when the NSAB discussed this issue in November 2016 Dana Selover stated that if the agency is receiving the same waiver request from all hospitals, that would likely indicate a need for a change to the statutory language.

Dana Selover agreed that if all of the entities governed by a regulation request a specific type of waiver that would be an indicator that the language should be reconsidered. Dana added that she does not anticipate many waiver requests on issues other than minimum staffing because the only nurse staffing regulations subject to waiver are the plan requirements and it is unlikely that a hospital would request waiver of plan requirements like acuity measures or basing the plan on total diagnoses for each unit.

Virginia Smith suggested that there might be a waiver request for the requirement to consider tasks not related to providing direct care, including meal breaks.

Dana Selover stated that hospitals would be unlikely to request a waiver, but may have unexpected and minor variances from the standards.

Anna Davis stated that hospitals can submit a single waiver request that describes different practices in different units as long as it is clear what is being requested for each unit.

Susan King stated that the NSAB can recommend that hospitals submit one waiver that includes multiple units.

Carol Bradley stated that some hospitals are already using this practice.

Virginia Smith would like to have the NSAB continue to consider waiver issues and be apprised of waiver decisions. This would benefit both the NSAB and the agency.

Dana Selover suggested that waivers should be a standing agenda item at this point.

Trece Gurrad agreed that this would be a good NSAB activity.

Action Item	<ul style="list-style-type: none">• OHA will make waivers a standing item on the NSAB agenda.
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Agenda Item 5 Time stamp 00:28:40	<i>Draft FAQ review – Anna Davis</i>
<p>Debbie Robinson appreciated that the FAQ includes questions for which there is not a yes or no answer. The questions still exist and there is value in providing guidance even when there is no definitive answer.</p> <p>Virginia Smith pointed out that in the Overtime section question numbers two and 13 are the same question.</p> <p>Dana Selover pointed out that on pages nine and 10 questions 15 and 18 are the same. Dana asked whether the groupings of questions made sense.</p> <p>Rob Campbell said the groupings were helpful.</p> <p>Virginia Smith found the diagrams very useful.</p> <p>Susan King asked whether it was necessary to have the names of individual nurses who would be provided by an agency as replacement staff included on the replacement staff list.</p> <p>Jennifer Burrows stated that this might refer to a list of people at the agency who have already been oriented to this hospital.</p> <p>Carol Bradley stated that there is no value in listing the individuals working for an agency, because the hospital cannot contact those individuals directly. She suggested that having the name of the agency is more useful.</p> <p>Wendy Edwards stated that she has seen agency names and has sometimes seen individual names as well, but that may not be consistent.</p> <p>Carol Bradley stated that travelers can be contacted directly.</p> <p>Anna Davis pointed out that the definition of “on call nursing staff” in OAR 333-510-0002(13) refers to nursing staff members or nursing service agencies, so the rule would allow for the list to include staffing agency names rather than the individuals employed by the agency.</p> <p>Trece Gurrad stated that her hospital has always interpreted the requirement to maintain a replacement list as requiring the agency name.</p> <p>Susan King stated that the NSAB recommends that wording of the FAQ answer allow the use of agency names rather than agency employee names on the replacement staffing list. Part of the audit may be determining whether the agency can supply the staff that is needed.</p> <p>Carol Bradley asked whether there is a question in the FAQ about Hospital Nurse Staffing Committee alternate members. She has received that question multiple times.</p>	

Anna Davis stated that there is an answer that references alternate members, but there is no question directly on this point.

Susan King stated that the NSAB recommends that hospitals can use alternate members.

Trece Gurrad specified that the use of alternate members should be included in the committee charter.

Jennifer Burrows suggests that it would be good to encourage the use of alternate members because that allows the committee to get a quorum.

Virginia Smith clarified that a quorum is necessary to hold a meeting.

Susan King summarized the discussion that the NSAB would like to recommend that committees have alternate members.

Anna Davis stated that the agency may not be able to recommend that committees have alternate members, but the NSAB can. The caveat to this is that some committees meet more frequently and the meetings last a full day. It is possible that having alternate members in this situation creates unnecessary difficulty when the hospital does not have enough individuals who want to serve on the committee.

Susan King stated that the agency can advise hospitals that having alternate members is one option.

Debbie Robinson described how alternate members work at her hospital. Alternate members only attend when the primary representative is unable to attend.

Jennifer Burrows stated that this is also how alternate members are used at her hospital.

Wendy Edwards stated that if the practice is included in the charter and if the selection process for alternate members is also documented, then the practice is acceptable. Wendy also suggested that the presence of an alternate member be documented in committee meeting minutes.

Trece Gurrad stated that hospitals often need alternate members for nurse managers as well, because nurse managers may not be available for committee meetings.

Jennifer Burrows stated that one of the challenges of the HNSC is creating understanding of the fact that committee members need not be an expert on the unit or the plan, the HNSC is responsible for making sure that the plan that comes before them has had input and consideration. It's an oversight function rather than knowing whether the plan is actually good for that unit. The HNSC needs to be able to trust that the group presenting the plan has done its job.

Carolyn Starnes stated that alternate members come to all HNSC meetings at her hospital so that the alternate members can keep abreast of issues and be ready to step in if the member is unavailable.

Susan King asked whether there were other topics that should be added to the FAQ.

Jennifer Burrows suggested that the phrase “overflow unit” might be more familiar statewide than the reference in the draft to a “pop-up, temporary unit.” She is also concerned that it will be difficult to have a staffing plan to address that unit when it is unclear who will be in that unit.

Carol Bradley stated that at her hospital the two units that utilize the overflow space have that possible expansion built into those two units’ staffing plans.

Virginia Smith stated that at her hospital the med/surg unit and labor & delivery unit both have staffing plans that contemplate using overflow space. The staffing plan also reflects how the unit operates when it expands into that space. For example, the labor & delivery unit adds a security guard when using the overflow space because the overflow space is not a locked unit.

Carol Bradley suggested a wording change in the 10-hour break section to clarify when the break can be claimed. She asked whether the hospital is obligated to restore the work hours to the nurse who claims the break. If the nurse must work a certain number of hours each week and the nurse claims the break, thereby reducing her weekly total, does the hospital have to find a way to allow the nurse to work those hours at some other point during the week? When asked about this before Carol has said the hospital is not obligated to restore hours, but generally nurses do get to make up that time based on scheduling logistics. The 10-hour break is not paid time and there’s confusion about that.

Virginia Smith clarified that the question is if the 10-hour break overlaps with four hours of scheduled work time is the hospital obligated to give the nurse another four hours of work.

Dana Selover stated that one of the question at the February ONA/OAHHS conference was whether the nurses must take sick leave for the 10-hour break.

Virginia Smith stated that at some hospitals if you are scheduled to work and you do not come to work at that time then you must use paid time off (PTO).

Rob Campbell asserted that the practice of requiring the 10-hour break time to be PTO sets a dangerous precedent.

Carol Bradley stated that the ability to provide make-up hours depends on when the 10-hour break occurs during the week. The nurses who claim the break have already worked at least 12 hours and will likely work enough hours during the week.

Carolyn Starnes asked whether nurses’ 10-hour breaks are automatically being treated as PTO.

Carol Bradley said that Legacy hospitals doesn’t do that.

Trece Gurrad stated that the 10-hour break rarely overlaps with the entire shift, but her hospital has a policy that nurses have to meet their status minimum. So far the breaks have not been a problem, but it’s an important question.

Carolyn Starnes asked which has more weight, the policy or the law.

Trece Gurrad stated that the policy meets the law, but there are other laws about benefit hours

Jennifer Burrows stated that the 10-hour rest is at the nursing staff member's discretion.

Virginia Smith stated that different hospitals have different policies regarding the use of leave.

Trece Gurrad stated that the collective bargaining agreement might cover the 10-hour break topic.

Guest Margie Gutierrez asserted the issue will be resolved by interpretation of the bargaining agreement.

Susan King stated that this question may be outside the scope of the NSAB's work.

Virginia Smith asked how this should be addressed in the FAQ.

Trece Gurrad suggested that the FAQ refer nursing staff members to their bargaining agreements.

Anna Davis suggested that the FAQ state that the statute is silent on the issue of PTO for 10-hour breaks.

Virginia Smith acknowledged that each organization will likely address this question in its own way.

Susan King stated that questions about divert status come up a lot and there may not be enough questions about this. Some hospitals have a policy of never going on divert. This might be a topic for in-depth discussion later.

Anna Davis stated that the question she receives most frequently on this topic is whether a hospital can have a policy that says an administrator makes the decision. The policies in question have a process by which nursing staff members request divert status, but the nursing staff members do not make the final decision. The statute does not say how the decision must be made, instead the statute says there has to be a process for making the decision.

Carol Bradley stated that hospitals go on divert for a variety of reasons. The policy often has a different decision-making process depending on the reasons for going on divert.

Virginia Smith stated that there may also be county regulations that govern the decision-making.

Jennifer Burrows stated that even when the decision is made to go on divert, that may not change what actually happens in the unit. If the whole city is on divert then really no one is on divert.

Debbie Robinson stated that when there is only one hospital in town there may not be a realistic divert option.

Trece Gurrad stated that weather, mudslides, and other factors may make it impossible for hospitals to be on divert status if patients can't actually get to another hospital.

Susan King stated that this may be a topic that the NSAB can discuss when there have been some surveys and there is more information about what is happening in the field.

Trece Gurrad asked whether questions have come up surrounding EMTALA. Hospitals have to do a medical screen and once a laboring patient arrives the hospital cannot send the patient away, but the department may already be at capacity.

Wendy Edwards stated EMTALA is a federal complaint-driven process. Staffing comes up in EMTALA investigations, but the scenario that described is separate from nurse staffing.

Trece Gurrad stated that the hospital cannot turn those patients away, but in those situations the staffing may not be according to the staffing plan.

Wendy Edwards stated that from a nurse staffing perspective the surveyors would evaluate the situation as they would any other complaint.

Anna Davis added that OAHHS has a compliance group looking at EMTALA and will be doing some education around EMTALA. The group also looked at the rise in the EMTALA complaints over the last few years.

Carol Bradley suggested that some of the EMTALA complaints are the result of financial screening at hospitals.

Jennifer Burrows suggested that the increase in complaints may be the result of a patient's need for specialty treatment only available at one location. She asked how the hospital will be evaluated if it was functioning in accordance with the staffing plan and the hospital attempts to bring in more staff or transfer patients in response to a surge, but the hospital is unable to do so.

Trece Gurrad stated that in her experience surveyors still find the hospital practice deficient despite the extenuating circumstances.

Wendy Edwards stated that surveyors generally confer to evaluate these situations. If there were an increase in the number of situations of this type across the state, the surveyors would talk about it as a larger issue. The fact that a surge occurred does not mean that the hospital did not make efforts to fill the vacancies.

Margie Gutierrez stated that the ED at her hospital is updating its surge policy and asked whether this type of situation would be considered a disaster

Wendy Edwards stated that the hospital would need to see information to determine whether this was a disaster within the definition.

Susan King asked whether the surveyors would look at whether this was an isolated incident or a continuing pattern.

Wendy Edwards stated that surveyors would be looking at how often this is occurring.

Carolyn Starnes asked Wendy Edwards what the surveyors are seeing on complaints and whether a complaint investigation impacts the likelihood of a full survey in the same year.

Anna Davis stated that full surveys are random, so a complaint investigation will not impact the list of hospitals undergoing a full survey in any given year.

Wendy Edwards stated that she has not participated in a complaint investigation under the new rules and the full surveys have not started. The hospital survey team works together closely. One of the trends surveyors saw under the prior rules was a lack of a clear system to determine acuity. The other trend was a matrix or grid that sets staffing ratios and was separate and distinct from the nurse staffing plan. The matrix or grid needs to be based on the required elements and part of the staffing plan that is approved by the HNSC.

Carol Bradley stated that one challenge is that there is no single tool to measure acuity. Each acuity system has its own strengths and weaknesses. The question for hospitals is how the system is being used.

Rob Campbell asked how the acuity measurement fits with the requirement to consider national standards in formulating a plan.

Anna Davis stated that acuity and consideration of national standards are separate requirements.

Susan King asserted that specialty standards drive the plan.

Trece Gurrad stated that there are departments for which there are no national standards or systems.

Jennifer Burrows stated that at her hospital the acuity system is used to assign patients.

Debbie Robinson stated that the system can also determine the number of nursing hours a unit needs.

Susan King stated that the law does not require a formal, validated acuity system. The HNSC needs to be able to explain how the decisions were made when the staffing in a unit differs from nationally accepted standards.

Wendy Edwards stated that each hospital is different and it is difficult to answer these questions as hypotheticals.

Virginia Smith asked that the FAQ include a question about acuity and how to incorporate acuity in to the staffing plan. There is also confusion about how to use the matrix and make the determinations in a particular shift. Reflecting these issues in the staffing plan can be difficult.

Trece Gurrad stressed the importance of have the skills and tools to use in a surge.

Susan King stated that there is consensus that acuity should be addressed in the FAQ.

Carolyn Starnes confirmed that this issue also requires consideration of ADTs.

Trece Gurrad stated that individual departments need to account for acuity and not just rely on a matrix. Staff needs to know how to understand and apply the system so that decisions about staffing numbers are clear.

Wendy Edwrds stated that surveyors need to be able to see how the nurse staffing plan works.

Carol Bradley stated that there is a lot of confusion about which departments need a staffing plan. There is also disagreement when there is a provider-based service on campus and a nursing staff member functions as an adjunct to that service. There may be questions about direct patient care itself. The question comes up in procedural areas where the person providing the care is a nurse.

Anna Davis stated that this question has come up already. The answer OHA has given is that hospitals should consider several factors and document the decision in the HNSC about whether the unit needs a nurse staffing plan.

Carol Bradley stated that this is an area that will be coming up more often as there are more creative settings of care.

Zennia Ceniza stated that this question was posed by Salem and they still couldn't come to a resolution. Zennia Ceniza provided the example of a provider-based clinic and the nursing staff member is providing a discrete service.

Carol Bradley brought up the example of a nurse navigator or care coordinator who is not providing physical care, but is working with specific patients.

Susan King stated that the first question is whether the service is under the hospital license.

Wendy Edwards confirmed that these standards will not apply at Rural Health Clinics or other locations not covered by the hospital license.

Susan King suggested that NSAB members forward other questions they receive to Anna Davis.

Action Item	<ul style="list-style-type: none"> • OHA will make suggested changes to the FAQ.
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Time stamp 01:35:00	<i>Upcoming issues – Susan King</i>
<p>Susan King summarized the issues the will likely need to be discussed by the NSAB in the coming months. The issues are:</p> <ul style="list-style-type: none"> • outpatient services; • divert status; • trends and concerns discovered in full surveys; and • waivers. 	

Agenda Item 6 Time stamp 01:36:00	<i>Public Comments</i>
<p>Susan King welcomed the members of the public at the meeting.</p> <p>Margie Gutierrez thanked the group for allowing her to speak up during the meeting. She asked for clarification of the relationship between complaint investigations and full surveys.</p> <p>Wendy Edwards stated that the surveys are random and the complaint investigations do not impact the routine survey schedule.</p> <p>Debbie Robinson stated that complaint investigations do not make a full survey occur sooner or later.</p> <p>Susan suggested that this information be included in the FAQ.</p> <p>Carolyn Starnes stated that some hospitals do not have a process for documenting additional voluntary hours.</p> <p>Wendy Edwards stated that lack of documentation is a problem during complaint investigations.</p> <p>Jennifer Burrows stated that if a nursing staff member agrees to stay after a shift ends and continue working then there may not be adequate documentation. Her hospital is going to require a nursing staff member to sign a document stating that they are working additional mandatory hours when the nursing staff member states that the hours are not voluntary. The hospital's assumption is that if the nursing staff member did not request that the hours be documented as mandatory then the hours are voluntary.</p> <p>Carol Bradley stated that the hospital is instituting a system that requires nurses to state whether they will claim the 10-hour break when they are clocking out.</p> <p>Rob Campbell asked whether this would also be an opportunity to ask whether overtime hours were voluntary or mandatory.</p> <p>Virginia Smith stated that there are hospitals that make the determination that overtime is voluntary or mandatory. There may be disagreement between the nursing staff member and the manager about what is mandatory.</p> <p>Jennifer Burrows stated that this issue recently arose in her hospital and it was regarding hours during a call shift.</p> <p>Rob Campbell suggested that this may occur when a case continues beyond the end of the shift.</p> <p>Susan King stated that this topic will likely return in a discussion of overtime.</p> <p>Carol Bradley asked whether the NSAB has received a response from Lynne Saxton regarding the subsection in the overtime rule that is specific to the Oregon State Hospital.</p> <p>Dana Selover stated that OHA staff have not received a response.</p>	

Susan King asked whether there is an expectation of a response.

Carol Bradley stated that Lynne Saxton committed to responding during a telephone call. During the call Carol Bradley told Lynne Saxton that the NSAB took exception to the addition of the language. Lynne Saxton indicated during the call that she did not know the source of the additional language. Carol Bradley suggested that there be a letter sent to Lynne Saxton on behalf of the NSAB.

Susan King agreed with this proposal and asked NSAB members to indicate whether they agree with this idea.

NSAB members voiced approval.

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