Rocky Mountain Health Plans (RMHP) Regional RAE PIAC meeting minutes

Location:	Rocky Mountain Health Plans office in Grand Junction and Microsoft Teams
Date:	Wednesday, June 8th, 2022
Time:	10 am – 1 pm
Attendees – RMHP:	Barb Bishop, Maureen Carney, Krista Cavataio, Jeremiah Fluke, Patrick Gordon^, Sally Henry, Nicole Konkoly, Cris Matoush, Kendra Peters, Meg Taylor^
Attendees - External:	Alison Keesler, Alison Sbrana*, Allie Richmond*, Ann Marie Stein, Alex Barreras, Becca Schickling^, Caitlin DeCrow, Dan Davis, Dave Hayden*, Deb Barnett^, Dorma Eastman, Elizabeth Edgar Lowe, Emily Shupak, Erik Lambert, Ian Engle, Janet Wolfson^, Jen Fanning*, Jolie Beth Boudreaux*, Julie Reskin^, Julissa Soto*, Kayla Ray, Kellie Jackson*^, Kris Hubbell, Linda Sisko^, Lynn Borup*, Melinda Sandgren, Michelle Jonjak^, Reynalda Davis, Rochelle Larson^, Sherri Corey^, Silvia Santana^, Stephanie Brinks, Sue Conry, Terri Hurst, Tom Keller*^, Tracy Klumker^, Victoria Garcia*, Wade Montgomery^ *=Voting member ^= In-person attendee
Organizations represented:	Banner Health, Centura Health, Colorado Criminal Justice Reform Coalition (CCJRC), Colorado Cross-Disability Coalition (CCDC), Community Hospital, Grand County Rural Health Network, Grand River Hospital District, Gunnison Valley Health, Hilltop, Latino Coalition for Community Leadership, Mind Springs Health, Mountain Family Health Centers, Northwest Colorado Center for Independence, PDF Consulting, Primary Care Partners, Quality Health Network (QHN), Southwest Health System, Summit County DHS, Summit County Family & Intercultural Resource Center (FIRC), Tri-County Health Network, Valley View Hospital

Agenda Items

1. **Call to Order**: Nicole Konkoly, RMHP RAE Network Relations Manager, called the meeting to order at approximately 10 am and participants introduced themselves via the chat feature on Microsoft Teams. Technical difficulties in the room caused a delay to the meeting start time by approximately 15 minutes.

2. **Member Advisory Council updates**

- *Larimer County Member Advisory Council*

Alison Sbrana introduced herself as a disabled Medicaid Member who worked as a Care Coordinator during Phase I of the Medicaid Accountable Care Collaborative when the care coordination entities were known as Regional Care Collaborative Organizations, or RCCOs. Alison represents the Larimer County Medicaid Member Advisory Council.

One of the hot topics that the council has been discussing is the Medicaid billing policy that prohibits providers - including providers who don't take Medicaid – from billing Medicaid patients for Medicaid covered services. The only scenario in which a Medicaid Member can pay for services is if the service is not covered by Medicaid.

One of the main things that has come up in the council is that the policy has caused frustration and confusion among Members because they are getting different stories from different providers when they explain the rule. Not all providers understand the specifics of the rule, and this can cause difficulties for Members who need access to specialists that might specialize in their specific medical condition. For example, Alison is on the Medicaid Buy-In Program for Working Adults with Disabilities and has medical conditions that a lot of specialists don't know about. She is not allowed to cash pay for a specialist in immunology that knows her condition because of this rule. There's quite a bit of frustration around the policy and we've been talking about whether there are ways that we can address this or not.

The next big topic of discussion is chronic pain. Alison and many other council members are having difficulties accessing providers, for multiple reasons, but one is clinical policies regarding opioids because of the issues with the opioid crisis. Another challenge that Members are facing is the limitations on opioids. There is not enough coverage of alternative pain management therapies. We need to be given other options if opioids are not going to be available.

For example, Alison pays about $500 a month for body work that's not a Medicaid covered service but many people on Medicaid don't have the ability to self-pay and we would like to see other alternative pain management therapies covered by Medicaid. One of the issues is with physical therapy (PT). Members report that they're getting denied additional therapy units when they need them for maintenance PT to function. For example, someone who has chronic pain might not be making forward progress but just maintaining their current level of functioning is worth doing and worth paying for because without that their health will decline and they will become more costly to Medicaid as they might have repeat emergency department visits or falls due to uncontrolled pain.

Finally, one of the other big topics that we've talked about quite a bit up here is behavioral health access. We've had multiple discussions with the director of the new behavioral health facility that's being built and the unmet needs in our populations. One specific concern that we have is the need for behavioral health services for people with intellectual developmental disabilities. We want to make sure that the new facility will be able to serve this population and are also looking at other ways we can serve this population. We're also having general discussion about the challenges of behavioral health access for Medicaid clients in Larimer County.

- *(new) Spanish Speaking Member Advisory Council*

Julissa Soto introduced herself as an independent health equity consultant. Julissa explained that RMHP is developing a Medicaid Member Advisory Council in Spanish/ en español. She is working with many local agencies to see if their members would like to join. The council meetings will be in Spanish and culturally relevant. Members will be able to express how they feel, and the challenges they face, in their native language. We will report to this committee about what's coming up in the council. A recruitment flyer will be shared as part of the meeting material packet.

- *Western Slope Member Advisory Council*

Tom Keller introduced himself as a representative of the Western Slope Member Advisory Council. Tom explained that the group had their most recent quarterly meeting on Monday. Representatives from the Division of Vocational Rehabilitation (DVR) came to the meeting, including the state director and Western Slope regional director as well as several staff members from the local offices. They got an earful from a lot of the folks who have tried to use their services and the takeaway was that DVR will be working closely with organizations like the Colorado Cross-Disability Coalition (CCDC) and Centers for Independence to make sure that clients are getting their needs met.

The statewide member experience advisory council – which Tom also participates in – has been talking about updates to the Colorado Benefits Management System (CBMS) which a 30+ year old system that needs to be completely rebuilt. There is a need for better integration at the county level, because the information that people at the county and state level see are not syncing up for members. The CBMS is used for both Medicaid and the Supplemental Nutrition Assistance Program (SNAP).

Tom explained that he has gone through an administrative appeal process on the Medicaid side and has talked with people who have gone through it on the SNAP side and it doesn't come out the way that it should. Tom thinks it's because the information that's being shared at the county, state and federal levels are not being shared properly. The state data exchange information is not coming through as well as it should. Part of the challenge is that there's a general lack of communication and understanding between the users and the administrators.

Tom think things will start to improve once we can bridge that gap. He acknowledged that the Department of Health Care Policy and Financing (HCPF) has been working hard on it and really wants to improve it, but there's still a long way to go. That's one of the reasons why the administrative process is so difficult for people. Hopefully we'll see some changes with that over the next year or two.

3. Hospital Transformation Program (HTP)

Barb Bishop, Clinical Program Manager with RMHP, shared an overview of the Hospital Transformation Program (HTP). HTP is a 5-year program initiated by the Department of Health Care Policy and Financing (HCPF) to engage hospitals in better supporting Health First Colorado Members.

Key activities and quality measures for the program are designed to be consistent across the state yet flexible enough to allow for local variation. The primary goals are to improve patient outcomes, advance delivery system reform, lower costs and increase collaboration across the medical and community neighborhood. Community engagement is a cornerstone of the program and an ongoing requirement for program participants. As part of the program, hospitals are collaborating with organizations that serve and represent broad interests to identify community needs and resources. As the RAE, we are working in collaboration with hospitals to help them succeed in the HTP program. Through regularly scheduled meetings, hosting educational opportunities, connecting hospitals with local community resources, improving alignment and care management, our shared goal is the improvement of care coordination and care transitions for our vulnerable populations.

Today we will be hearing from representatives of Banner, Centura and UC Health hospitals about their progress on the HTP program to-date. Barb introduced the following guest speakers:

- Kellee Beckworth, Senior Project Manager with UC Health

- Stephanie Brinks, Quality Outcomes Program Coordinator with Centura
- Reynalda Davis, Senior Manager, Government Programs with Banner Health

Stephanie Brinks shared that Centura operates two hospitals in RAE Region 1: St. Anthony Hospital in Summit County and Mercy Hospital in Durango. At the heart of HTP is making sure that we are improving the outcomes for Medicaid members. When someone comes into our hospital, we want to connect them with the resources in the community that can help them stay healthy and meet their needs so they don't have to come back to the hospital.

Our primary goals for today are to explain what HTP is and share our community engagement requirements and social determinants of health interventions. In terms of the timeline, we're about 75% of the way through Program Year 1. Each year in January, the hospitals have to submit their data, which is our performance on the quality measures. Are we reducing readmissions, lowering your length of stay, and screening patients for social determinants of health – those kinds of things? Each hospital has an implementation plan that maps out our strategy for the next 5 years.

Kellee Beckworth with UC Health shared that while reducing readmissions and length of stay are a big emphasis of the program, the hospitals are also focusing on understanding patients' social needs and providing good discharge plans for patients with behavioral health concerns.

A few examples of local measure selection:

- Centura is focusing on screening for prenatal and postpartum depression and anxiety
- Centura and Banner are focusing on high frequency readmissions for chronic conditions
- Banner is focusing on Medication Assisted Treatment (MAT) in the emergency department

Reynalda Davis with Banner shared that when we're talking about social need screening, it's really the social determinants of health work. At least once year, when a patient comes in and is admitted to the hospital, we need to know do they have utility, food security and/or transportation needs? Once we screen for that, we are required to let Rocky know so they can help us with coordinating resources to meet those needs.

On the back end, we're trying to build relationships with community-based organizations (CBOs) and make sure that when we ask the questions of our patients, it's not a distraction to the ultimate purpose for why they're here, which is for healing. We also want to make sure that we're tracking the trends that we're seeing so, for example, are we seeing more patients come through that have transportation needs, and can we build solutions that help address that?

Again, this is a 5-year program and because we're currently in performance year 1, we're really trying to set our infrastructure and we need your input to build that together. That's our hope for this. This is going to be a process that's adaptive, iterative, but more importantly definitely a journey.

Q&A:

- Ian Engle with the Northwest Colorado Center for Independence commented that he would like to see a measure on patients discharged from the hospital to a nursing facility versus discharged to their home with the appropriate services in place to support their long-term care. The hospital representatives noted that this was not one of the choices available in the suite of measures they had to choose from; however, they agreed that it is important to focus on and explore.
- Patrick Gordon with RMHP thanked the hospital system partners for their hard work on HTP and shared that in the current climate, with respect to nursing availability and workforce, even the best transition plans and processes are under a lot of pressure right now. We see

people discharged to their home and then readmitted to the hospital simply because there aren't adequate services and supports available to them at home. Readmissions are absolutely the right place to look, and transitions are the right focus. But collectively we have to find a way to stabilize the workforce situation because the shortage and wage and price spiral that the system is experiencing is out of control. Patrick has talked to many providers, navigators and case managers in the community who are dealing with that challenge, and believes that we must get over that first step before we can get to better performance because it's creating a lot of havoc right now.

- Ian commented that the length of stay measure concerns him a bit because too much focus on reducing length of stay could contribute to a readmission down the road if it affects the treatment received during the stay/causes a premature discharge.
- A participant asked if stakeholders gave feedback to the hospitals when they were in the process of selecting their measures. The hospital representatives shared that they each pursued different avenues to collect stakeholder feedback, including focus groups and surveys.
- Ian expressed that he appreciates what Reynalda discussed with regard to partnering with community-based organizations and the opportunity there. If we're talking about this whole project being around successful transition from hospital back home and back into the community, to kind of harken a little bit on what Patrick was saying, choice without options is not really choice. Ian is looking forward to partnering with the hospitals to advocate for people to live healthy and safe in their own homes.
- Reynalda responded that one of the HTP requirements is that as part of year 5, we must come up with a sustainability plan that outlines how the hospitals and our partners are going to continue the work. From a grading standpoint, the plan accounts for 30 percent of our score in the last year so it's a critical component. We would like to touch base with you, Ian, to talk about our shared successes and how can we increase capacity for our CBOs and what investment looks like from that standpoint.
- Dan Davis with Pagosa Springs Medical Center commented that as we work together on identifying referrals for social determinants of health needs, it would be advantageous to find a way to share information on CBOs identified for each region. A participant responded that we have Rural Health Connectors that help identify those organizations and they're always willing to share information.
- A participant commented in the chat that one of the challenges has to do with information being shared in a timely manner with the RAEs so that they can get the patients what they need. Reynalda responded that coordination is key – between all of us, the hospitals, the RAEs and wherever the discharge location will be; so we're looking at what good coordination looks like, and making sure that one, privacy and HIPAA compliance are maintained, and two, that it's accessible to different groups. We all have different medical records systems/electronic health records, which can present a challenge with data sharing. Banner is working with the health information exchanges and trying to catalog resources in the community that will give us all an idea of capacity. In other words, if we refer a member to housing, we want that resource to be available right then and there, so that's a work in progress.
- Sherri Corey with Quality Health Network (QHN) shared that QHN is working closely with our hospitals and offering a platform for what you were talking about, called the Community Resource Network (CRN) that allows participants to screen for social needs and to close that loop with electronic referrals that go to those community organizations for the needs of the patient prior to discharge. While sharing resource lists can be helpful, the CRN is an actual database that's connected to the statewide 211 directory, so it's nice to have those real-time

updates about what's available in the community. To Patrick's point, we can identify the needs but if the resources aren't there, then it's very difficult. So CRN serves as the platform, but where the rubber meets the road is whether the resource exists in the community.

- Patrick commented, that's a very important point. Whichever HIE we're working with in the state, the availability of real-time alerts for care transitions is a critical resource. It's been a game changer for us at the health plan and QHN has been very instrumental in getting us statewide access. We're committed to doing whatever we can do to partner with the systems to make that process more robust and leverage the data that's already there.

4. RMHP Prime Expansion – David Mok-Lamme, RMHP

David shared a map showing that the counties that have been part of the RMHP Prime service area to-date are Garfield, Gunnison, Mesa, Montrose, Pitkin and Rio Blanco. Prime is a limited pilot in the state of Colorado for Medicaid in which RMHP is responsible for all the medical costs for certain Medicaid enrollees in these counties.

Currently, Medicaid-eligible adults in the Prime service area are enrolled in Prime, as well as children living with disabilities. Prime is unique within the Medicaid program because RMHP receives a global budget from the Department of Health Care Policy and Financing (HCPF) to pay for the cost of care for these members. This gives us flexibility in how we pay providers, including payments that are outside of the fee-for-service structure.

Typically the state pays providers based on a certain fee schedule for each service provided. In Prime, we have a different model for primary care where we make a global payment – also known as a capitation payment – to the provider that serves as the member's health home, and the provider can provide services to members that are best for that member.

In general, HCPF and stakeholders have been grateful for and supportive of the Prime program. It tends to have positive member experience ratings, good health outcomes and a favorable financing system for providers. It gives RMHP more opportunity to reinvest in different community programs in the health neighborhood. Because Prime has shown improved health outcomes and lower costs with savings to the state, we are able to expand the program.

There are 3 phases of expansion that RMHP is working on with HCPF:

1) Expansion of Prime to include adults in Delta, Ouray and San Miguel Counties. This has been approved by HCPF and will go into effect on July 1, 2022. Eligible members in these counties will automatically become enrolled in Prime.
2) We're working with HCPF on a plan to expand Prime into Eagle and Summit Counties with a target date of July 2023.
3) The third phase of expansion we're planning is to include all Medicaid-eligible children in Prime, not just Medicaid-eligible children living with disabilities. The target date for this expansion is July 2024.

While Prime is a Medicaid program, the overall goal is to serve all members in our communities and the global payment or capitated payment that we use for Prime is also used in our Medicare products such as Medicare Advantage and the Dual Special Needs Plan (DSNP) as well as Child Health Plan Plus (CHP+). This way, providers can have a seamless experience with us for all the different populations they serve. We're also working on expanding the provider global payment model to our individual and family plans.

The bottom line is that Prime is a community initiative. We can't expand – or continue to operate – the program unless communities want the program. It's designed to build upon the strengths that exist here in Western Colorado and better serve Medicaid members.

Q&A/Discussion:

- *If a member moves from a county that isn't part of the Prime service area to a county in the Prime service area, how does that work?* David explained that a member should become automatically enrolled in Prime when they move to a county where Prime is available, but RMHP can always work with HCPF if the enrollment process doesn't automatically happen.
- *How is a Prime member's experience different than that of a member who is not enrolled in Prime?* David responded that a lot of work happens behind the scenes to make sure the member is connected to appropriate care. For example, each month we send providers a list of Prime members in their community that don't have a Primary Care Provider (PCP) to encourage them to outreach to those members to invite them into their practice. The global payments are risk-adjusted, so a provider will receive a higher payment for a member who has multiple chronic conditions. This creates an incentive for providers to outreach to members with complex conditions. The biggest difference is probably on the provider payment side, because providers can contact RMHP about all their claims, whereas the state pays physical health claims for non-Prime members. Overall, Prime members tend to have a better experience with the healthcare delivery system because providers are better connected. We also have more leverage with specialist providers to help a member get into specialty care. That's not supposed to happen. Everyone is supposed to have equal access to specialty care, but we know from experience that's not reality. Because we pay specialty providers for Prime, we can say, you must see our Medicaid members at the same frequency and timeliness that you take our Medicare and individual plan members.
- *The payment model described sounds good, but we've seen some unintended consequences in the behavioral health world with capitated payment models, where in some instances, it wasn't financially supportive for providers to serve patients with high mental health needs.* David explained that there's a lot of differences between the Prime global payment model and what's happening with community mental health centers across the state. In Prime, providers only receive the global payment if they're actively caring for a member, either by generating claims for services or a patient choice form that's signed by the patient. This means there must be a high level of connection between the member and provider before payment is generated. In most mental health center capitation models in the state of Colorado, capitation flows for all members of a county regardless of care. Risk adjustment is another unique aspect of the Prime global payment model; for example, providers can receive up to ten times higher payment for a member with very complex needs. And we are held to very strict accountability by HCPF and the legislature. Every year a report is produced that judges Prime's performance before the program can be renewed. We're in year 7 or 8 of the program, so there's a lot of accountability and history. There's certainly lessons we can use on the behavioral health side, and Prime is not perfect. It has its own unintended consequences, but we're focused on a positive experience for members and providers and the accountability piece is very important.
- *Moving forward we should look at, who could potentially be left out? If it gets too targeted, we will need to make sure we aren't further marginalizing people who aren't targeted – i.e. the oppression of marginalization. We should continue to evaluate who's* ***not*** *getting access to quality primary care and behavioral health services, and make sure we're not leaving people behind. Like they say, the squeaky wheel gets the grease, but who's not getting the*

grease? Meg Taylor responded that this came up at our Member Advisory Council meeting the other day and that's absolutely right, that if people know who to contact or are the "squeaky wheel" they can get help, but what about all the other people who are being left out and not receiving the services and support they need? David added that every financial mechanism or way we pay or incentivize different organizations to do different work is going lead to different perverse incentives. For example, more funding goes to providers that are able to have larger panels with more members in active care. It can be difficult to strike the right balance. We're always open to feedback if people think that a certain segment of the population is not being prioritized as they should be / getting the care they need.

5. Quality Measure Performance Updates – David Mok-Lamme, RMHP

Based on committee member feedback, we're going to be providing a much higher-level summary of how we're performing on the quality measures. For more detailed data, and plain language definitions of each measure, the KPI dashboard is a good resource. That will be included in the meeting material packet.

Key Performance Indicators (KPIs) are set by HCPF and used to measure quality performance across the RAE regions and distribute revenue to the RAEs. We're doing very well on preventive services. All the following areas – behavioral health, dental, and well visits – had a steep decline in access during COVID so the increase we're seeing is indicative of members getting back to these care patterns that we want them to have and that's why we're meeting most of the targets here. It's important that we continue to see these numbers grow.

Behavioral Health Incentive Program (BHIP) measures follow a similar format to the KPIs in that there is some type of event associated – for example, a member could be diagnosed with or screened for a substance use disorder (SUD) for the first time, be leaving an inpatient hospital or have a positive depression screening. We're performing well on some of these measures and currently on track to meet our targets for the SUD emergency department follow-up measure as well as follow-up from positive depression screenings that occur in primary care. We're not doing as well on some of the other measures and have room to grow.

We will be diversifying and being smarter about the way we distribute incentive funding related to these measures. Our current payment policy is to share some of the incentive revenue that we receive with the four community mental health centers (CMHCs) in RAE Region 1, based on membership instead of their specific contribution to the measure.

Starting in July, we are completely changing the way we share incentive dollars. We will invite key providers from our independent provider network as well as Tier 1 primary care practices, which includes most of the Federally Qualified Health Centers (FQHCs), to share in the incentive dollars that we earn, and each provider's payment will be proportionate to their contribution to the performance measures.

The CMHCs continue to be an important partner in this work. We're at the point now where we want to work with a broader set of providers that have been doing this work for a long time and we've overdue in needing to update the way we share incentive dollars. We're excited to bring in more providers to be able to share the financial outcomes of these measures as well as create a larger group of providers to whom we can refer members. It's not just about performing better; it is about getting members timely access to care and making sure we use the resources we have – in this case incentive dollars – to make sure that there are providers that are available to provide timely care to members.

Q&A/Discussion:

- *What measures do the RAEs have around hospital utilization?* David explained that there are three domains of work that we're held accountable for in that area. The first is emergency department (ED) visits which is measured in terms of per thousand members per year (PKPY) which means how many ED visits would one thousand members have if you followed them continuously for 12 months. Our target from HCPF is to have less than 550 PKPY. We're currently at about 450 PKPY so we're meeting our target. However, that's partly due to COVID, because people have changed the way they use EDs during COVID and that's contributed to lower utilization.

  There's also a total cost of care measure that holds RAEs accountable for the total medical costs for Medicaid members, which is primarily driven by inpatient and hospital utilization so there are a lot of efforts to reduce inappropriate or unnecessary hospitalization. The third, more qualitative, point of accountability is that the RAEs are responsible for helping members access the lowest appropriate level of care and avoid high-cost visits that are unnecessary or inappropriate. The key is following up after someone is discharged or transferred from the hospital and making sure we're investing in and partnering with local organizations that serve members, both primary care and social services, public health, and human services.

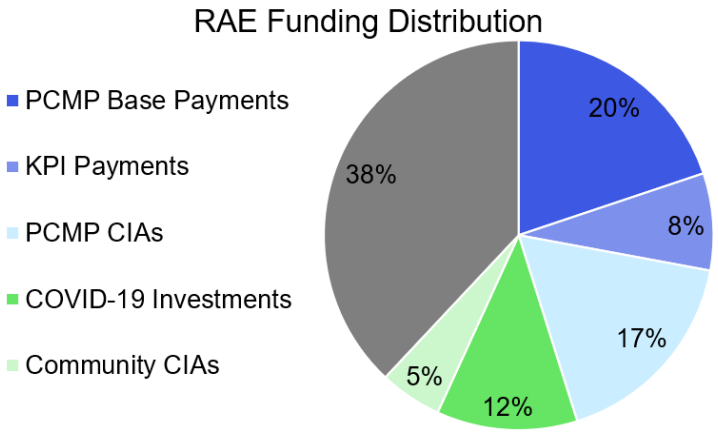
6. **RMHP Leadership Updates** – Meg Taylor, RMHP

- *Behavioral Health Provider Network Expansion*: We're trying to expand the number of providers in our network. We did a really good job of this at the outset of the RAE contract (July 2018), however it has shrunk over time.

- *Provider Training on Providing Mental Health Treatment to Person with Intellectual Development Disabilities (IDD)*: Thanks to the partnership of Julie Reiskin and the Colorado Cross-Disability Coalition (CCDC), we have a training that we're launching soon to help behavioral health providers become skilled and knowledgeable about serving people with intellectual and development disabilities. We're offering $3,000 reimbursement for the first 50 registrants. Providers who successfully complete the curriculum will be eligible for enhanced rates in their contracts for outpatient services, and will receive a Certificate of Completion. There are two course options with different frequencies: a monthly course offered a 6-month time span beginning in June, and an intensive course offered over the course of 1 week in October. A flyer containing details will be shared in the meeting materials packet.

- *Community Reinvestment Program*: We pass through dollars based on our performance. Program operations accounts for 38% of the budget. This includes everything we must do from an operational perspective. Primary Care Medical Provider (PCMP) payments account for 20%. Community Integration Agreements (CIAs) with Tier 1 PCMPs accounts for 17%. Tier 1 practices are the highest-level practices that are open to new Medicaid patients, and they have contracts with us to support behavioral health integration. KPI payments account for 8%. (Pie chart below).

Community Investment



Last year we had about 12% of the budget allocated to COVID-19 investments. Community CIAs accounted for 5% of the budget. These are community integration agreements or community investment with all kinds of organizations – a few examples represented here today are CCDC, PDF Consulting, and the Northwest Colorado Center for Independence. These organizations are working with and investing in the communities around social determinants of health, behavioral health, just basic needs.

Going forward, we would like this group to help guide some of the decision making as to how we invest in the communities. The plan is that we'll bring it to the entire PIAC for discussion, but voting members are the ones who get to say this is where we want the dollars to go. It will be a piece of the pie of the 5 percent that's allocated to Community CIAs because some of that money is already dedicated for the next calendar year. We're going to bring basically a menu of options for everyone to know about and then the voting members are going to be voting on where that funding will be going for the next calendar year.

Meg is excited that it's not just Rocky making the decisions. We have tried to be responsive to the community when a community-based organization said we need this amount of money to do this because we're lacking in our area. This provides an opportunity for this committee to have a say in what we're doing. We'll be bringing ideas to the September meeting for the group to discuss.

Action items:

- Meg requested that if people know of anyone who might be interested in joining RMHP's behavioral health provider network, to connect them with Meg and/or Nicole so we can discuss further and address any questions or hesitations they may have.

Next meeting: **Wednesday, September 14th, 2022, from 10 am - 1 pm via a hybrid format**