CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES
DIVERSITY AND EQUITY
TECHNICAL ADVISORY COMMITTEE MEETING

****

Via Videoconference
November 2, 2022
Commencing at 1:05 p.m.

Shana W. Spencer, RPR, CRR
Court Reporter

APPEARANCES

BOARD MEMBERS:

Wanda Figueroa Peralta (not present)

Julia Richerson

Jordan Burke

Catrena Bowman-Thomas

Patricia Bautista-Cervera

Marcus Ray (not present)

Kiesha Curry (not present)

Jeanine Lubuya (not present)

Elaine Wilson

Roger Cleveland

MS. BICKERS: Okay. It's almost five after. We might want to get started, so that way, we can respect everybody's time. The committee members that I have logged in, I have Julie, Jordan, Patricia, and Roger. If I missed anybody, can you please let me know?

DR. RICHERSON: My name is actually Julia with an "a," not an "e."

MS. BICKERS: Oh, my -- I'm sorry about that. I wrote it down wrong. Sorry about that.

Okay. If no other board members are here, we currently do not have a quorum, so we won't be able to vote for our chair or co-chair. If anyone else logs in a few minutes late, we can circle back to that.

Leslie, I'll hand it over to you.

MS. HOFFMANN: Thank you. I'm very excited to be here. So good afternoon. My name is Leslie Hoffmann, and I'm the deputy commissioner for the Department of Medicaid Services. And I proudly serve as a Medicaid champion for racial and health equity.

This is our second newly established

meeting of the Health Disparity and Equity TAC. In the last couple of months, we have received lots of feedback and positive comments and interest regarding this TAC and upcoming initiatives on both federal and state levels. So folks are asking what we've got going on in Kentucky, so be proud.

What a wonderful opportunity for all of us in Kentucky to practice culture humility and to empower positive change. Very proud of us. So on behalf of the Cabinet of Health and Family Services, we would like to welcome each and every one of you participating on this call today and in this meeting. A very, very warm welcome.

Erin.

MS. BICKERS: We cannot approve minutes either since we do not have a quorum.

MS. HOFFMANN: So we're going --

MS. BICKERS: We're two short for a quorum. So if they join after the fact, I'll let you know, Leslie, and we can circle back around.

MS. HOFFMANN: Okay. Okay. And then the approving of the minutes, the same?

MS. BICKERS: Yes, ma'am.

MS. HOFFMANN: Okay. So, then, we'll go to old business, which this was some -- a few requests that the committee had of Medicaid from our last meeting.

So I'm going to turn it over to Jodi Allen who is also a champion in Medicaid for racial and health equity.

MS. ALLEN: Good afternoon, everyone. So good to be here with you this afternoon. I'm excited to share this health equity infographic that we've created. I think that the visual representation will help you all to really see a lot more clearly all the things that we're doing in Kentucky right now towards health equity.

I'm going to share my screen. Actually, if someone could enable screen sharing, that would be great.

MS. BICKERS: You should now be a cohost.

MS. ALLEN: Thank you. Okay. I'm not able to -- here we go. Sorry about that. Can you see now? Okay. Great.

This is our health equity infographic.

Thanks to Beth Fisher for helping us put this together. I thought she did a really great job.

But as you can see, you can see the CHFS vision, a commonwealth where every Kentuckian reaches their full human potential and all communities thrive. You can see the CHFS pillars of equity, economic support, resilience, and -- I'm having a hard time reading that one. I'm so sorry.

MS. HOFFMANN: Health.

MS. ALLEN: Thank you. I'm so sorry. As far as our DMS vision, to be a diverse and inclusive organization that promotes equity in the delivery of healthcare services to improve the health and well-being of all individuals served by the Department.

So you can also see here our equity goals of integrating equity in policies, programs, and practices; creating a diverse and inclusive workforce; hiring equity-focused vendors; and fostering understanding of equity.

So as we mentioned briefly during the last meeting, these are our overall

enterprise goals for the racial equity action plan across DMS. And just to show you a little bit of progress that we've made towards those goals, all DMS divisions are training on the Government Alliance on Racial Equity tool, which we mentioned last time is an accountability tool that we can use in our decision-making process to enhance racial equity and health equity across the board.

Creating new programs to expand postpartum coverage, integrating care, enhancing mobile crisis, and expanding services for the severely mentally ill, those are all initiatives that are ongoing right now.

And create Equity and Determinants of Health Branch. So we now have a branch that will be focused on these initiatives across Medicaid as well.

And a little bit more about how we have made progress towards our goals. Full implementation of the GARE tool across all divisions will take place by the end of this year, and we are on track to accomplish that goal. Divisions can track progress and input

data now into a web-based technology platform. So we are gathering information, and as we reach our goals in our action plan, we are able to record those and keep track of them for best practice.

In June 2022, Kentucky announced expansion of postpartum coverage through Medicaid and CHIP, and an estimated 10,000 women will be impacted.

Through a demonstration, four Certified Community Behavioral Health Clinics are operating around Kentucky. Clinics provide an array of behavioral health services and integrated primary care which does increase health equity for all in Kentucky.

Equity and Determinants of Health Branch will have several important areas of focus such as assisting with the implementation of the Racial and Health Equity Action Plan, among many, many other things.

Also, you're getting ready to hear today from a group, the Medicaid Innovation Collaborative, that we are going to be a state in this next state cohort focused on social determinants of health and equity.

We're really excited about this opportunity, and I think it will get off the ground and running in January. We've already had some preliminary meetings and just getting organized and structured. But they're here actually today to speak a little bit more with you.

This cohort will be Kentucky, New York, Nevada, Iowa -- so that's a new one that we need to add here -- and possibly North Carolina. But I'm not sure if we have official word on that yet. Maybe they can share that with us today.

But we're going to be learning so much from this group, and we're really excited about all of the things that we are going to be able to accomplish for Kentucky and for health equity through being a part of this state cohort and learning so much more.

DMS and sister agencies are committed to enhancing their behavioral health mobile crisis intervention system to ensure comprehensive, coordinated, easily accessible, culturally informed, and integrated services are available for all

Kentuckians experiencing a behavioral health crisis regardless of ability to pay.

So we are -- we have finished the planning grant for the mobile crisis, and we are now working towards implementation of that program and initiative. So we're really proud of that and excited for that and how we will be able to reach Kentuckians that way as well.

And then here you all are. Welcome to the Health Disparity and Equity TAC members. As your partners in public service, we're excited to welcome you to Team Medicaid and to work together to make health care more equitable for all.

So this is just, again, an infographic that we put together to help you all and just all of our members see the kinds of things that we're doing right now in the area of health equity. So we're really excited to share that with you.

I also wanted to touch base a little bit on the next old business item, which is a follow-up from the Medicaid Innovation Collaborative showcase summaries that we sent

out. So after the initial meeting, we were able to share with you from the Medicaid Innovation Collaborative. Again, they're here, and they'll be able to speak a little bit more with you here in just a few minutes.

But those -- both of those showcase summaries were focused on maternal behavioral health and adolescent behavioral health innovations. And so I just wanted to mention again, if you haven't had time to take a look at those, it's really just fascinating what some of these states -- which, again, these are states that were in the first cohort, and now we're going to be in the next cohort.

But you can see all the great work that was done and just the sharing of some of just the most innovative practices and strategies in behavioral health and just working towards health equity. It's just really amazing to see. So if you haven't had a chance to review those, I would encourage you to do so. But I also wanted to just see if there were any questions, comments, or concerns about that material if you were able to review it.

DR. RICHERSON: No questions here.

MS. ALLEN: Okay. Thank you.

MS. HOFFMANN: And if anybody does have questions, feel free to reach out to Jodi or myself or to send it to Erin, and she'll ensure that we get the information back.

So we'll go on to the next piece, which I'm proud that we were able to get our Medicaid Innovation Collaborative group here today to speak to us for a few minutes. So I feel like this is a really good opportunity for you on this committee and those of you that are listening in today to hear what some of our goals are working in this collaborative going in to this cohort that will last a -- you know, a significant amount of time where we want to go with our goals.

So I will turn it over to -- Karissa, are you on?

MS. GODZIK: I am.

MS. BICKERS: Do you need to screen share?

MS. GODZIK: I will, yes.

MS. BICKERS: You should be able to screen share now.

MS. GODZIK: Wonderful. Thank you. I want to, first and foremost, say thank you to the folks at DMS, especially Leslie and Jodi, who have been amazing partners thus far in this process and very much appreciative of the opportunity to be with you all today.

So want to take this opportunity to share a little bit more about the program. I know DMS has mentioned it before, and so if some of this is repetitive, I apologize. But this is kind of our standard of review and then a little bit of an ask towards the end of the presentation today.

But, of course, this is -- I don't want to talk at you for the amount of time that we've been allotted. So if you have questions, I encourage you to please jump in and ask them as I run through the slides.

So just for context, the first thing I want to talk about today is what we mean when we say "tech-enabled innovation." Because I think this is important context to provide as we talk through what this program is really about.

So first and foremost, when we talk

about innovation, the purpose is really to address the needs or wants of a customer, or, in this case, it could be a client, a patient, or a Medicaid member. This is something that's really driven by a desire to make something better.

So in the case of MIC, as we call it, it's really about enhancing care, and this could be access to care, the quality of care, the coordination of care, all with the intention of producing better health outcomes. And so this could be within or outside of traditional systems of care.

And, of course, it implies that there's something new or novel about a product or service. It's really important that the product or service can sustain over time, that it has the ability to scale, and that it has longevity, both in its business model and in what it -- the impact that it delivers. It's also really important that it delivers value to that intended customer and, ideally, to the broader ecosystem as well.

And when we say "tech-enabled," it simply means that it harnesses an existing

technology to deliver that product or service. So a perfect example is a smartphone app, and this -- in our case, we've seen tech-enabled innovation that looks very low-tech/high-touch and -- all the way to something that's very high-tech with low-touch.

So you can see a couple of, like, the traditional buzzwords that are probably more familiar for folks around the edges of the screen so often considered to be called, like, digital health or health tech. And we're seeing a number of virtual or hybrid-care delivery models entering the market as well.

So there's a good number of tech-enabled solutions or innovations that are on the market today. For us, it's really about assessing the landscape to understand how tech-enabled innovation can tackle the biggest challenges around health equity today.

So how might tech-enabled solutions address social determinants of health? How might it meaningfully engage Medicaid

members? How might it enhance maternity care for black birthing people in the U.S.?

So there are a ton of organizations that are doing this really wonderful work. This is just a very small snippet of a couple of those kinds of organizations, but the market is large and growing on a daily basis.

But I think what we find is there is still a challenge around who these solutions are typically built for, so it's probably not surprising for folks here that they are usually targeted towards a more commercial market, so employer-based plans or even occasionally some Medicare Advantage.

But, really, it's kind of this battle of what we call -- sometimes called Wealth TAC instead of Health TAC. It's that if you have the money to invest in these kinds of solutions to improve outcomes for your member population, it typically skews towards that commercial population.

But we actually find that there is immense value for these kinds of solutions in Medicaid. In particular, we see that when they're built appropriately, they have the

power to fill gaps within traditional systems of care where those systems fall short or are underresourced and, in doing so, can actually enhance that care access, that care delivery, and that care quality over time.

We find it can address disparities, typically, in providing a new approach that addresses the needs and preferences of the target population they're aiming to serve. These solutions can be more responsive to patient or client needs because of -- they're typically built to be very iterative or adaptive. And so we find that they, in their adaptation, can be very proactive to the needs of the populations they serve.

These are great tools often to connect disparate resources that exist across the ecosystem. And so it's often that health services and social services may not have the opportunity to connect, but these are all organizations serving the same Medicaid population.

And then, finally, these solutions we find, because they do have more frequent touch points with members, can actually be

great point -- a point of interaction to collect data from folks, both on physical and mental health needs over time.

But, of course, there are still some challenges that exist. These are innovations that are underutilized in Medicaid. We do see, as a comparison, that commercial populations typically have a higher uptake than Medicaid, and some of that is due to other systemic barriers. For instance, access to -- consistent access to broadband or to a smartphone. But we still see there is some use but not to the scale of -- that there is with other kinds of populations.

And then, of course, the ecosystem is broad and often fragmented. Of course, we have one central federal regulator in CMS, but there's 56 state Medicaid offices. Across those Medicaid offices, they serve about 75 million different beneficiaries, all with very unique needs.

And then across all the states and within each of those departments, there are thousands of different kinds of Medicaid policies and requirements that the

organizations need to consider if they're aiming to get into this market.

And then you drill down even further, and there's hundreds of different Managed Care Organizations that are actually providing the coverage and benefits for these individuals and then, of course, we have that private market that has innovations emerging on a regular basis.

So as the old adage goes, if you've seen one Medicaid program, you've seen one Medicaid program. So lots of diversity across the country.

But we sought to really figure out if there was a way that we could gather a partnership of individuals and organizations that could work together towards this vision of changing the way that the Medicaid system addresses health inequities. And so from that, the Medicaid Innovation Collaborative was born with an aim to improve the health and well-being of individuals on Medicaid by connecting the ecosystem to tech-enabled innovations, similar to the ones that I showed you earlier.

And so we do this by addressing a couple of key pillars within our model. So one is coordinating across the ecosystem. We think it's really important to bring all of the appropriate stakeholders to the table to make sure that everybody has an equal voice in this process. It's really about aligning our cohort members around a common goal and then, of course, having that opportunity to learn and share best practices, not only across states but across managed care plans and communities.

We really want to center on the consumer voice. In this case, we actually work directly with beneficiaries and community representatives to understand how disparities are manifesting in their geographies and then integrate community members into the process to provide feedback through key phases of the program, which I'll share with you in just a moment. And then we really want to make sure that, through actually sourcing these kinds of solutions, that we are doing so in a way that makes the most sense for what the community actually wants or needs.

And then, finally, we believe we can enable action. So we -- both through state technical assistance and working with the Managed Care Organizations, we believe we have the power to evolve the way that the ecosystem views innovation and its potential to address equity concerns.

We provide guidance on policy and payment at the state level but also connect the Managed Care Organizations back to those solutions that can hopefully drive change in the populations they serve. And, of course, all of this really -- the goal is to create that environment that is ripe for the adoption of these kinds of innovative solutions.

And so our program is built with three key phases. First and foremost, we have our define and discover phase, which is where, again, our cohort aligns on a problem -- in this case, social determinants of health for our 2023 cohort -- and really set goals and expectations for the program moving forward.

Then we move into our discovery phase which, again, is where we actually engage

directly with beneficiaries to understand their needs. What are the biggest gaps, challenges, and barriers that exist to actually accessing social services or health services within their communities, and what are the things that would enhance or improve that access over time?

Next, we move into our sourcing and selection phase. We actually go out with a national request for information and source a number of different kinds of solutions that can hopefully address the needs that we've identified through discovery. And then we actually bring all of our cohort members together -- so our state, our managed care, and our community representatives -- to vet, evaluate, and lift up the top solutions that we feel can best address those needs that we've identified.

We move into connection and catalyzation. So we set up an event to actually connect all of our cohort participants to those solutions identified through the selection process. And then, of course, we support both the state and the

managed care plans in the adoption of innovations or policy that can move the needle on health equity in their target populations.

Throughout all of that, we provide a couple of other support mechanisms. We do a number of different, kind of, shared collaborative sessions where there's learning opportunities across the cohort members. We also provide technical assistance to our state agency partners and a number of other, kind of, deliverables that provide value to our participants.

And so we just wrapped up our first cohort which included Arizona, Hawaii, and West Virginia. That cohort opted to focus on behavioral health and, in particular, both adolescent and maternal behavioral health as their focuses. We were successful in recruiting 100 percent of their managed care plans which totaled 15 plans across the three states.

We engaged about -- over 100 stakeholders through that discovery process, so all of that primary research that yielded

the insights which informed our request for information. We got 81 applicants across two different applications, one specific to adolescent and another to maternal, and then selected five solutions to present to our adolescent focuses -- focus area and then six solutions for our maternal focus area.

What's really exciting is that we're seeing some movement towards adoption of these solutions. There are a number of the presenting companies that are now being considered for contracting, and we're also seeing states adopting new policies or procedures in order to encourage their plans to adopt these tech-enabled innovations.

A great example is our partners in West Virginia. They are actually now including a requirement in their managed care contracts to use a tech-enabled solution for their adolescent population. And so it's now a requirement for them to include some kind of tech solution as part of their offerings. They're also implementing a quality withhold associated with adolescent behavioral health. And so we're really excited to see what comes

out of that in the next coming months and years.

And so I want to share with you a quick example. This is actually from a prior engagement where AHCCCS, or the Arizona Medicaid's program and their managed care plans, were looking to address both social determinants of health and digital member engagement. And so a very similar process. It was called innovation challenge back then, but they really honed in on Pyx Health, which is tech-enabled, but it is a human-centered intervention for social isolation.

And so the success here was that all seven of the managed care plans within Arizona actually contracted and implemented Pyx. And within the first six months, they actually saw a savings of over $5,000 per member and about 60 percent of users that showed a reduction in their loneliness. So a great example of exactly how some of these solutions can not only enhance care but improve costs for the managed care plans as well as the state.

And so a little bit more about MIC and

who we are. So this is a program of Acumen America, which is a nonprofit impact investment firm. Acumen America really is focused on systemic change, and so they see the Medicaid Innovation Collaborative as a means of furthering that goal.

And we receive technical assistance partnership through the Center For Health Care Strategies, which is a Medicaid-focused leader in policy and technical assistance.

And, of course, we couldn't do this work without the generous support of our funders. It's important to note here that we actually provide the program to states and managed care plans and community representatives at no cost, and so this is a means of providing what we believe is a really valuable service and adding bandwidth to state agencies that may not otherwise have the opportunity to do this kind of work.

So, like I mentioned, the focus of our 2023 cohort is around the social determinants of health. We recognize that there's been considerable progress in the adoption of tools to identify needs and make referrals,

but we're really interested in that, kind of, SDoH 2.0, or what we call the last-mile challenge. And so how do we actually make sure that gaps are closed and that those social needs are met within the population?

And so in this case, we're really interested in, of course, sourcing those tech-enabled solutions but also new care delivery models that can address the opportunity to really close those gaps. And so we're looking to move beyond resource directories and screening tools that have, I think, in many cases, become a little bit more ubiquitous in the environment today and look at other kinds of focuses.

So in this case, there's a couple of examples here at the bottom of the screen for both food, community enablement programs, as well as transportation. And so these are just a couple of examples of the kinds of things that we would potentially be sourcing through this next cohort process.

And as mentioned, we have Iowa, Kentucky, Nevada, and New York confirmed. You can see this is the number of managed

care -- covered managed care lives within each of the states. I think now Kentucky is actually higher, so I need to update this. But we're really excited to have this broad reach through the next cohort.

And I've reached a point in the conversation where we have a little bit of a request. And I think that, hopefully, this is a great group that may understand, you know, who within Kentucky would fit this bill.

So we, as part of the process, form a Community Advisory Council. In this case, we're looking for about three to five representatives per state. We're looking for folks who are or have been Medicaid beneficiaries or have the lived experiences with challenges meeting social needs and/or are an advocate who has that direct contact with individuals with social determinants of health needs.

Ideally, this is somebody who has a good pulse on the most pressing social service gaps or barriers in their communities and is somebody who is comfortable speaking up and

sharing their perspective in a group setting.

The role is that this group will provide key input throughout the phases of the program and that they would represent the community interests throughout the project.

Really, we're looking for feedback around our research insights but also our research process. Because we're just getting that kicked off here this month, around that innovation sourcing and evaluation. So actually getting folks to review applications and provide their perspective on which of the solutions feel like they would be the best fit in those -- in their communities. And then could also support actually feedback directly back to the managed care plans or to DMS in terms of what they feel are the solutions that are the best fit.

So we anticipate this time commitment would be about an hour and a half per month. That could ebb and flow a little bit depending on the time in the program. It's important to note here that this is a paid position, so we would provide a monthly honorarium to the individuals participating

in the Community Advisory Council up to about $900 over the course of the program.

And so if you know someone who would be a good fit, we would love to talk with them. You can email me at karissa@medicaidcollaborative.org. As soon as I stop my screen share, I'll also put that -- my email in the chat for folks. And then, of course, Leslie and Jodi also know how to get ahold of me. So if you don't capture my contact information today, they know where to find me.

So I will take a moment and pause for questions, and if I missed some in the chat, I apologize. But I'll leave this up on the screen.

MS. BICKERS: Karissa, if I drop my email in the chat, could you please send that to me so I can share the presentation with the TAC members?

MS. GODZIK: Of course. Yeah. Happy to.

MS. BICKERS: Leslie, we also have a quorum.

MS. HOFFMANN: Oh, okay. So just

real quick, for Karissa's comments about working with her in this type of collaborative and really empowering Kentucky to be a part of decisions that are being made; right? We know that you probably need time. But this is something that we could probably utilize the committee, that they can take a look at these local partners that might be good representatives to be on this committee, on this council.

So I don't think -- Karissa, I don't expect anybody to answer today, but I think we can have that as a take-back or a recommendation for the committee to take a look at between maybe now and our next meeting. And if we have any questions, we can reach back out to you. Is that okay?

MS. GODZIK: Yep. That's absolutely fine. If you do have folks in mind and you want to pass my email along directly to them, that's perfectly fine as well. Or if you want to be, kind of, the conduit to making a connection, happy to -- happy to set up a conversation in whatever way people prefer.

MS. HOFFMANN: Sure. Okay. So, Erin, I think we'll go back, if that's okay -- if we're finished, Karissa, we'll go back to establishing the quorum, Erin.

MS. BICKERS: Yes. Let me pull up my screen here so the agenda is ready. So, first, just a friendly reminder, that all of our committee members, when we're establishing our quorum, you've got to have your video on.

So if you're not on the committee, if you could turn your video off. And if you are on the committee, if you could turn your video on, please.

And I'm going to do a quick roll call of the members that I have logged in. I have Julia.

DR. RICHERSON: Yes.

MS. BICKERS: Jordan.

DR. BURKE: Present.

MS. BICKERS: Catrena.

(No response.)

MS. BICKERS: I thought I saw her logged in a minute ago.

MS. BOWMAN-THOMAS: I'm here.

There we go.

MS. BICKERS: Oh, there you are. I see you. Patricia.

DR. BAUTISTA-CERVERA: Here.

MS. BICKERS: Elaine.

MS. WILSON: I am here.

MS. BICKERS: Okay. And Roger.

DR. CLEVELAND: Here.

MS. BICKERS: Okay. Thank you guys. So we have established a quorum. So the first order of business is I had sent out an email and asked if anyone was interested in being the chair or co-chair, and I didn't get a response. I'm going to put you guys on the hot seat now.

So if anyone would like to volunteer for either one of those positions or nominate one of your fellow committee members, just let me know, and we can do a vote. Your chair and co-chair work together to set your agendas and keep everything moving, and they will also run the meetings moving forward.

So if anyone is interested in being the chair, you can nominate yourself or someone else now.

DR. RICHERSON: This is Julia. I nominate anyone but me. But if you -- and so the reason why, I've chaired a TAC before. And the trouble that I had, all of my time was taken up in the admin work, making sure people showed up, making sure we got quorum. I didn't get to do any of the work, like the stuff I wanted to do.

So that's why, I guess, I'm speaking up, to see what role -- is the chair responsible for making sure everybody gets here? You know, there was a lot of admin work when I chaired a TAC before. And so I'm not interested in that because I really want to do the work-work instead of the admin work.

MS. BICKERS: In our other TACs that we run, typically, what the chair does, and the co-chair, is they will send an email out with a draft agenda and ask others to contribute to the agenda.

I will be -- I am technically responsible for, kind of, spearheading the meeting, and I make sure that you guys have a quorum as you guys log in. I kind of take roll, and so I take part of that

responsibility.

So, really, it's just getting your agenda prepped and to me and then I get it uploaded. I get the invites out to everything. I share the agendas with our staff at DMS, and I also share it with the MCOs.

MS. JUDY-CECIL: Yeah. And then it's -- this is Veronica Judy-Cecil with Medicaid. The only other piece to that is, you know, running the meeting, so calling for motions and recommendations.

But we -- I did want to add, for anybody willing to step up, that we -- we will absolutely support you. You know, this -- I understand what you're saying, Dr. Richerson.

And that's, I think -- you all, again, have your day-to-day lives and work. And we appreciate that you're volunteering to be a part of this group, so we don't want to make it burdensome.

So we will -- we will provide as much support as we possibly can to make it successful. But we do have to have a chair.

MS. BOWMAN-THOMAS: Can we

nominate -- I want to nominate Dr. Cleveland. Can I do that? But I don't want to be nominated.

MS. JUDY-CECIL: He's welcome to accept the nomination. And so the other thing we can do is if there is just one nomination and the person is willing to accept the nomination, then we can just call for a vote among the members, you know. We can -- you all can vote by acceptance.

MS. WILSON: I would second the nomination, but Dr. Cleveland would probably kill me.

DR. CLEVELAND: That is true, Elaine and Catrena. I -- this is, like, maybe five advisory groups I'm on right now, not counting the ones I serve on campus. So I would love to, but I probably wouldn't do it any justice because I'm extremely busy, like all of us are. I think Catrena could probably handle it, though.

MS. WILSON: Sounds good to me.

MS. BOWMAN-THOMAS: Don't throw it back. No, I can't. I'm on so many committees. I will fully support the chair

and the vice.

Well, Dr. Julie, she threw it out there. Dr. Julia. They said they would do all the legwork, so I nominate her. I'm just nominating people so --

DR. RICHERSON: Now, how many of us are there? Are there -- how many people are on the committee? Why don't we each take it for two months.

MS. BICKERS: There are ten of you. We have four members missing today.

DR. RICHERSON: So we each take it for two months, and that gets us through two years.

MS. JUDY-CECIL: You know, we'll have to take that proposal back to see how that fits with the executive order in the -- it's a very -- I appreciate the innovative idea.

So if you all -- if we want to table it, which I just really don't want to do, but if there's nobody who's stepping up today, you know, we can take that back and see if that's a potential option.

DR. RICHERSON: Is anyone --

Jordan, would you be willing to do it just, like, for the first three months, or Patricia?

DR. BURKE: I was actually going to ask -- like, I imagine the person would need to be here to be nominated or -- no?

I was looking through the minutes last time, and Dr. -- I don't want to say her name wrong, but I think Figueroa maybe, you know, seemed like she at least had some decent insight and maybe more knowledgeable. And then, obviously, Dr. Richerson as well spoke up and had some questions and things like that.

So I was just trying to, kind of, look through and see who maybe had contributed a lot and may be able to help guide us as the chair. And so those were the two names that I had saw. Dr. Richerson already spoke up and said maybe not ideally wanting to do that. But I didn't know if Dr. Figueroa would, but she's not here to kind of answer that question.

MS. BICKERS: If it helps, I have an agenda template that most of the TACs

follow that's pretty -- I mean, it looks very similar to this one. You know, as your meetings grow, of course, your agenda will likely grow, so just throwing that out there.

DR. RICHERSON: And I already asked Dr. Bautista to do it, and I think she already declined. But now you could jump on.

DR. BAUTISTA-CERVERA: If you go as the chair, I'll support you. I'll do my best.

DR. RICHERSON: Only for purposes of moving forward, I will do it for three months, but that means somebody else has to do it next.

MS. JUDY-CECIL: So let's take that, and I appreciate your willingness to do that. And we will -- excuse me. We will call for a vote, and we can do it by -- gosh. I'm blanking on the word. If the members could just open their mic, and we'll call for a vote of Dr. Richerson as chair. If you would please --

DR. BAUTISTA-CERVERA: I will co-chair with her.

MS. JUDY-CECIL: I'm sorry?

DR. BAUTISTA-CERVERA: I will co-chair with her.

MS. JUDY-CECIL: Oh, thank you. Okay. Excellent.

So Dr. Richerson as chair, Ms. Bautista as co-chair. And if you agree, signify by saying aye.

(Aye.)

MS. JUDY-CECIL: Any nays?

(No response.)

MS. JUDY-CECIL: Okay. Well, then, we will --

DR. RICHERSON: For three months. For three months. We're all going to take turns.

MS. JUDY-CECIL: We will move forward with that approach. And, again, we'll work on the logistics of that. We'll take that off -- a one-off from the meeting today.

And, Dr. Richerson, would you mind calling for a motion to approve the minutes from the previous meeting?

DR. RICHERSON: Is there a motion for approval of the minutes?

DR. CLEVELAND: So moved.

MS. BOWMAN-THOMAS: This is --

DR. RICHERSON: Roger moved. Catrena --

MS. BOWMAN-THOMAS: Second.

DR. RICHERSON: Is it Catrena? Did I say that right?

MS. BOWMAN-THOMAS: Uh-huh. Second.

DR. RICHERSON: Seconded. Any further discussion on the minutes?

(No response.)

DR. RICHERSON: All those in agreement, say aye.

(Aye.)

DR. RICHERSON: Any opposed?

(No response.)

DR. RICHERSON: Great.

MS. JUDY-CECIL: All right. Thank you. Thank you, Dr. Richerson.

Let's see. I think --

MS. HOFFMANN: I was -- yeah. I'll go ahead and take back over. So under new business, No. 6, our second item on the agenda is committee goals. And we have

Vivian Lasley-Bibbs from the Department of Public Health on.

MS. LASLEY-BIBBS: Good afternoon, everyone. So I think the objective today was to try to think of what you heard and how we can maybe establish some high-level goals that we wanted to kind of address as we move forward.

So we know that there's some data gap -- we saw the data. We know -- well, at least you saw the health department's data as it relates to some disparity gaps. I'm not sure if Medicaid has done their own data mining in looking at where those gaps are from the data perspective.

And then we know that there's some -- also some social determinants of health issues with access to transportation and being able to connect folks to resources and how might we connect those. And I think that's what the collaborative is working on, with what I've heard, as to recommendations moving forward.

And then one of the questions might be, do we want this work to match the work that's

going on with the collaborative so that we're all on the same page and that they're working in tandem.

So I think there's a couple of questions that we have there, and maybe I want to hear from you guys. As to what you've seen presented today, what might be some of those goals are that we set, at those high-level goals, and then maybe get into some objectives and then strategies to -- and activities to achieve those.

So if we can -- do I have any comments or feedback from what you've heard today as to what you might want to put as maybe one or two goals that we'd start with? I don't want to take over the conversation. This is the TAC, our committee, so I want to give people a chance to chime in. So I'm just facilitating the discussion.

(No response.)

MS. LASLEY-BIBBS: Please don't give me silence.

MS. HOFFMANN: I was going to --

MS. LASLEY-BIBBS: Please don't.

DR. RICHERSON: We would love a

menu, Vivian, like what you think, from your expertise, that we might look at and then prioritize. So, you know, we know there are data gaps, but are there areas that we should prioritize, you know, maybe so -- you know, just to give us some more concrete guidance maybe.

MS. LASLEY-BIBBS: So I'm going to defer to Leslie and Veronica for that as to where they've identified the gaps and then I can tell you where I see some of the gaps are.

MS. HOFFMANN: So, Vivian, we've talked about DMS versus -- or Medicaid versus DBH and your -- public health a lot, and we seem very similar. When we hear your report-outs to our report-outs, Jodi and I have noticed that we sound very similar in what we're trying to go forward with; right? The social determinants of health, racial and health equity.

And, of course, I think we're at almost 1.7 -- I think it's 1.69 million now in our population. Our data looks very much like yours probably. We know we have some gaps

that need to be identified, and we need a community presence.

And we need folks working together from boots on the ground -- from boots on the ground to this committee and all of our sister agencies working together, which the collaborative is one of our main goals for Medicaid to reach. But we want everybody to be able to utilize and be involved in the collaborative if they decide to do so.

Veronica, do you have anything else to mention right now as far as where we are? Put her on the spot.

MS. LASLEY-BIBBS: Well, while she's thinking, we can go back to some of the things that rise to our data in DPH, and one is truly the infant mortality, infant -- mom and baby mortality and morbidity rates. And that's one of the things that DPH is really focusing on, is closing that disparity gap between our black and white moms.

The other thing that I was hearing was the utilizations of services, whether -- and that be access to transportation and availability of those services and folks

being able to -- to not only find them -- okay? -- and become aware of them but actually be a part and be able to get there to be a part -- take part in those services.

So those are things that we look at, too. And we're also looking at those other priorities that these communities have that take precedence in their daily lives: Housing, employment --

MS. HOFFMANN: Yes.

MS. LASLEY-BIBBS: -- all the other things that we know impact health and health outcome.

So I think we need to decide: Are we working on some of those upstream things that impact health, or are we stuck in the middle looking at social determinants, where we've been awhile? Or are we just looking at how to improve and close data gaps? And I think they're all linked, but I think we need to decide --

MS. HOFFMANN: Yes.

MS. LASLEY-BIBBS: -- where we need to focus.

MS. HOFFMANN: I think we're at the

same spot as you are. And, also, we are trying to start -- so we've got a lot of things that are running simultaneously of what you just said. Social determinants, projects, policies, using the GARE tool to look through the lens to ensure that we're, you know, meeting all the expectations that we need to. And, you know, even our date is December 31st for all of our divisions to ensure that they've had some work related to the GARE tool and some practice with it.

So -- and just some basic language. Jodi and I have talked about this before, just knowledge about basic language. And, of course, the need for the data is there, but what can we do right now until we get there with the data; right?

So Jodi and I have been working on lots of social determinants of health here lately, working with CMS. And that spurred some of the conversations of how proud we've been that, in the state and federal levels, they've -- like, this is wonderful. You know, you now have a TAC, and they're making decisions with you. What a wonderful

opportunity and the collaborative that will get us down to a community level; right? We want everybody involved that we can.

So if nobody has, Vivian, anything for you today --

MS. LASLEY-BIBBS: Well, there's --

MS. HOFFMANN: Sorry.

MS. LASLEY-BIBBS: There are two more things I wanted to say, two more things.

MS. HOFFMANN: Oh, yes. I'm sorry.

MS. LASLEY-BIBBS: Okay. And the two more things I wanted to just add. One of them was I hope we don't do the downstream approach with this group. I hope we do -- at least do some of those social determinants of health and then the root --

MS. HOFFMANN: Sure.

MS. LASLEY-BIBBS: Some of those root causes. I think -- I guess my question is, to this group: Have we done an environmental scan to our Medicaid recipients and expanded Medicaid recipients, for them to identify what their needs are currently?

Looking through a different lens maybe than we have before, using that racial equity

lens and the GARE tool, some of the questions that that tool asks us. I'm not sure we have that information. I think we're making assumptions based on what we have looked at versus what our clients and stakeholders need to tell us.

So I pose that as well as looking at maybe what policies currently might be impacting some of this work or not -- that's impacting us to not be able to do it or to not do it in the way it needs to be done so...

Catrena, I'm sorry. Did you have something to say? I saw you kind of blink in and then I -- you went away. Did you want to contribute?

MS. BOWMAN-THOMAS: Yes. One thing that we are hearing a lot about is just access to mental health services, especially, you know, as we are talking about from an equitable standpoint. You know, really just being able to access them, just parents with young children and just the stresses that -- you know, that are brought on by what we've already talked about. The social

determinants of health has really just exacerbated the need for mental health services, and people just aren't able to get it.

And so how can we, one, you know, let people know how to access it; and, two, if there are policies and procedures that are preventing it from being streamlined, how can we begin to look at that and address that so people can get those services?

MS. LASLEY-BIBBS: Okay. I think we can formulate that into a goal. I think you just did. Not even knowing you did, but I think you just did, is to really look at our mental health services and the access. And what are those barriers and challenges currently that are preventing folks from access -- accessing those resources?

Asking them, not us assuming, so asking them: What are some of those barriers and challenges? How do people feel about that? I thought that was great.

MS. BOWMAN-THOMAS: Some of the data that we've seen here in northern Kentucky, I think it was less than two

percent of people of color that have had -- that have had a diagnosed disability are actually receiving any -- not disability but a diagnosed -- I'm not sure. I'm not a doctor. I forgot the right word but --

MS. LASLEY-BIBBS: (Inaudible).

MS. BOWMAN-THOMAS: -- a diagnoses.

MS. LASLEY-BIBBS: Yes.

MS. BOWMAN-THOMAS: Yes -- are not -- only -- less than two percent are receiving any type of treatment. And so, you know, it's just very concerning to know that people have been identified, and they are not able to access the treatment that they need.

MS. LASLEY-BIBBS: So is this just your -- is this just northern Kentucky data, Catrena, or is this statewide data you just did?

MS. BOWMAN-THOMAS: It was northern Kentucky data.

MS. LASLEY-BIBBS: Do we have a statewide number for black and brown communities receiving mental health services in the state?

MS. HOFFMANN: Jodi, do you know if

Angela has that information where we have just recently been working on it?

MS. LASLEY-BIBBS: If we can make that a SMARTIE goal.

MS. ALLEN: Yes. I think that that would be -- it would be great to definitely look into that further. I know that it's been challenging to acquire specific data.

MS. LASLEY-BIBBS: Yeah, it is.

MS. ALLEN: For sure, yeah.

MS. LASLEY-BIBBS: It has been, yeah.

MS. HOFFMANN: And we've just recently been looking at the homeless population as well and trying to match up some of that data for the first time ever, so that's been wonderful. And this just came up this morning, about how we might be able to get some statistical data broken out related to racial and health equity so...

MS. ALLEN: But, Catrena, I would definitely -- I mean, I am a clinician by practice, and I would say -- I'm in a rural area of Kentucky, but I would definitely agree that the access to services right now

is a huge issue. And we're seeing that across the state, but we're seeing that nationally. We're just really in a crisis honestly with mental health provision.

MS. LASLEY-BIBBS: That sounds like a goal that we can turn -- that we can make SMARTIE by getting some additional information. And not to --

MS. HOFFMANN: Sure.

MS. LASLEY-BIBBS: -- conflict with what Catrena has shared, but I think that's one that we can put down.

DR. BAUTISTA-CERVERA: And if I may add to the goals for the committee, JCPS has, you know, shared with the Immunization Advocacy Committee for the board of health in Louisville that the gap between -- you know, schools according to the place where they are located, not only with immunization but with so many root -- it just went out of my head. But, you know, it's not only working with the causes for all these disparities.

But, also, we need to, I think, address vaccination not only for kids but also for adults. At the same committee, adult

medicine doctors shared even those that have received or are receiving Medicare Part B coverage, the access for them to some of the preventative vaccines, it's almost impossible. Because one shingles vaccine is $160, and it's not covered by their insurance.

So there are so many things. And I'm just speaking about vaccination upstream, but root causes of disease are so many. So I would just add vaccination not only for pediatric but also for adults.

MS. LASLEY-BIBBS: Okay. So you want to increase access or increase those immunization rates? Which one? Both?

DR. BAUTISTA-CERVERA: Both. You know, for JCPS, out of all the kids that have Medicaid coverage, I think the medical director for JCPS said that it was only -- I don't remember. It's thousands of kids, and it's the providers that give vaccination -- I'm going to check -- double-check that number, and I'll give it to you because it's hard to believe that that is happening in the city. And I can imagine what's happening in

rural areas where, you know, being a vaccine provider, it's even harder.

MS. LASLEY-BIBBS: Okay. That sounds like a second goal, and we can have more than one. And we can have multiple ones and then we prioritize, based on the information that we have, where we think we can make definitely tangible short lens and improvements that would be -- versus a long-term lens. So we can definitely add that -- thank you, Patricia -- as a second goal.

These are great. Does anybody have a third area maybe that we can add?

DR. RICHERSON: I don't know that this would rise to the level of a goal but something around: How do we as a group learn how to process information more effectively? So when people and communities are telling us their problems, that there are problems, that we have a mechanism to hear them, to process that information, and to act more effectively.

So I think -- I think Medicaid staff and the program knows about problems.

Community -- people -- those of us working in the community try to reach out, say, to one MCO or another MCO. Like, it's hard to -- it's hard to -- the communication flow to effectively address problems is fragmented.

MS. LASLEY-BIBBS: Okay. So I hear what you're saying about the communication piece. I guess my question is: How is this information relayed in some type of an electronic system? So if we know that people are having these issues and we hear them both from the provider side and then from the MCO side and then Medicaid, how are we documenting that conversation that is taking place or that knowledge gain? How is that being captured currently?

Because if we aren't, that sounds like we need to be, and it needs to be -- needs to have a process of getting that communicated up to the necessary folks to make the difference -- right? -- to address the issue.

So if I'm not hearing anything -- Leslie, I'm looking at you. Because if I'm not hearing anything --

MS. HOFFMANN: Yeah. I was going

to say, of course, we have multiple TACs -- right? -- that we work with on a regular basis. And they make recommendations and bring problems to us, and some may be connected to this TAC as well; right?

And so then we have several mailboxes that we receive, depending on what area of Medicaid they need to go to. But we've got several areas that -- CHFS Listens and different mailboxes that we'll send requests or problems that folks might be having and then we can, you know, roll out an answer and log those.

On the behavioral health side, we receive -- we have one called the DMS issues box that we receive any questions related to behavioral health questions.

Maybe that's something, too, Vivian, that we want to look at. Like, how -- if folks do we have a problem, what's the email address, the email box, the contact person, like something basic just to get started; right?

So if Dr. Richerson identifies something in the community and she wants to know who to

contact, that we've got maybe some basic contact information set up. Even at the MCOs, we could help with that as well, get some -- I see one or two of the MCOs today. We could -- on with us today. We could probably come up with some basic contact information that's connected.

MS. BICKERS: Leslie, I was going to throw in that a lot of TACs will add those issues to their agenda. The MCOs are always here, and they can be prepared to help answer some of those things and help guide you guys to the appropriate place to where, if you have questions or issues with the MCOs, you also, as the TAC, have the right to ask them to present data if you have questions, concerns about some of their members, trends that they're seeing.

And so as a TAC, you can also request that the MCOs -- usually, with six of them, we try to break them up over a couple of months to give them a little time to speak. But that's also something that -- as a TAC, that you guys can bring those issues to these meetings, where we're all here as a whole,

and can help get those answers for you.

Of course, if there's an urgent matter, you're always welcome to reach out. You can email me, and I can send those to the appropriate place and help point you in the right direction of who the best person to contact would be.

DR. RICHERSON: Great. And I'm thinking more of people that don't even know that there is a hierarchy in Medicaid. I'm talking about, you know, a new pediatrician just started practice. Like, they don't even know anything, but they've identified a really important health equity issue.

For example, nutritional anemia. There's an epidemic right now; right? We know food security is horrible. These kids, their hemoglobins are horrible. Fer-In-Sol, which is what's covered by Medicaid, is unpalatable. None of us would take it because it tastes so bad. But the Novaferrum, which is a few dollars more, we can't get. So we've seen where we've got kids with chronic nutritional anemia, with -- even with a PA, we can't get Novaferrum.

So that's the type of an example -- and I was going to bring that up later, but that's, like, a specific example of there's a problem. Kids are suffering, and it's -- you're not getting that information. Medicaid isn't.

You know, I'm advocating -- like, I've done -- I've called ten different people. Like, I know who to call, and I can't even get the change made.

So thinking about from a -- sort of rethinking the way that communication happens for people working directly with families and adults and children in the community so that if they identify something, they have a place they know that they can reach out.

And it may be too big of a question, but I think -- I think we have mechanisms in place that aren't capturing some of this really valuable input.

MS. LASLEY-BIBBS: Yeah.

MS. BICKERS: Angie, do you have your hand raised?

MS. LASLEY-BIBBS: Yeah. And I saw Dr. Cleveland and Justin as well, so we'll

have to -- we've got a lot of folks to catch with. Go ahead, Angie.

MS. PARKER: Hi. This is Angie Parker. I'm the Director of Quality and Population Health with Medicaid, and this TAC began a little bit after the fact that we just completed our Quality Strategy for Medicaid. And it does address social determinants and health disparities within that.

And so I plan on giving this to Erin to provide a copy of this because this is getting ready to go to CMS for your review. We did have other TACs that contributed to this Quality Strategy, so I think it'll be good for you all to see this as well. And it could potentially help with developing committee goals.

I'd also like to say, with the managed care companies, that -- and through our quality group or division within Medicaid, that we've done -- we've worked -- we've done what we called a focus study on social determinants of health that can be shared with this group as well.

We have a lot of -- you know, as Deputy Commissioner Hoffmann -- a lot of reports out there, and, you know, we tried not to boil the ocean and tried to get down to where we need to focus. But we do know that there's a lot to be focused on, and how do we get there.

As -- in the presentation that Jodi gave earlier, we did hire an Equity and Determinants of Health branch manager who started today. So I'm not going to put her on the spot and introduce her today. So she is -- but she is listening in on this meeting, and I am happy to say, you know, that she's very excited to work with you all and us and how we can best work through this, the health and racial equity of the -- of this TAC.

So any questions?

MS. LASLEY-BIBBS: So, Angie, if we do -- I want to come back if they do because I want to make sure that Justin gets an opportunity and Dr. Cleveland, if he has something to say. So either one of those two gentlemen can chime in.

MS. PARKER: Sure.

MR. DEARINGER: Yeah. Hi. This is Justin Dearinger. I'm with the Division of Healthcare Policy here at the Department for Medicaid Services. And I just wanted to let you all know that the CHFS Listens is a very good springboard to be able to get individuals in the field that may not -- like you said, they may not know somebody in Medicaid. They may not know exactly who to talk to or who to listen to.

But that's a good platform to be able to send any questions or issues or suggestions to a varied group of individuals. That suggestion box and question email is actually regulated by a group of individuals that ensures that those questions are answered by individuals in the right expert fields. They make sure that they're answered within a certain time frame, and they're -- yeah. I see it in the chat. Those answers are logged and -- so that you can look back on them.

I know we have an individual in our division -- we get a lot of those every day. We have an individual in our division, and

that's part of their primary responsibility, is to, you know, administer those, get those to the proper individuals who can answer those questions, make sure they're answered in a timely fashion, log those to see -- so that we have a record of what they were about and then how they got answered and if they got answered correctly.

And then we also have an employee who just started. Part of their new job responsibilities are taking all of those issues that may have an equity portion of it, logging those and sending those on to Angie's division and the other individuals in the department.

And so those are -- that's a very good option, like you said, for people that are just out in the field, normal, everyday individuals. They may be providers, or they may just be individuals who are receiving services that are having issues, whatever the case may be.

That's a good tool for them to be able to get their voices heard, make sure they get an answer from a qualified professional. And

that information is getting logged so that we can keep up with that and coordinate that and make changes accordingly.

MS. LASLEY-BIBBS: Thanks, Justin. Roger is still on. Did you have something, Roger, you wanted to add?

DR. CLEVELAND: No. I was just going to just echo what Julia was talking about earlier about communication. I thought that's really important. I don't know how we turn that into a goal. But vertical and our horizontal communication is critical to access, and so it's something to consider. And then if we do get that in place, how do we measure it? So I just wanted to kind of echo what she was saying earlier.

MS. LASLEY-BIBBS: Thanks. So I do think there's a way to turn it into a goal. Maybe we put that on a Post-It on our sidebar and work -- and think about how we can turn that into a goal. Because I think a number of issues have been raised. One of those is the communication between providers, communication -- and state government and all of those other folks that are playing a role

in this and how all of those dots are connected.

Even though I heard them all and they're all great things, I still think there's a disconnect into how they all play and relate to each other and when and how you do each of those. I think we have things in place. I just don't think we all know how to put a -- put that matrix together as to -- or organizational chart, so to speak. Because you all know I'm a boxes and square numbers person, how to make all that flow.

So I think we can think about that, as to what that might look like and maybe present that at the next meeting, since that's such a critical issue, and I do believe it is. Because if you don't know about something, then you don't know how to address your particular issue; right? You don't know how to handle that, if it's known, but you don't know what resource to go to or how to connect the dot for that individual. So I think we do need to list that one. I think there's been a lot of good discussion around it.

So we have potentially three committee goals to start with. Is there something else we think is equally important?

MS. BOWMAN-THOMAS: One thing to add to the communication is just being conscious about creating a friendly environment. You know, I think we hear a lot of times, you know, the environments that people go into are not friendly, or they don't feel welcome. So, you know, how does that tie -- maybe tying that into that communication piece. Because if you don't feel welcomed, you're not going to go back.

And, you know, I think we see that, and we've heard that, in particular, from people of color, that they've gone and just didn't feel welcomed, particularly here. And I can only speak about where I am in this region, but I think -- I'm sure, you know, if we solved that, it probably would reflect that same thing. So I think maybe that's included in the communication.

MS. LASLEY-BIBBS: I agree. I do think there's some opportunity for training there, too, Catrena. I think, you know,

there's ways to interact with -- if you're a frontline person, there's a way to act as a customer service representative and how you're supposed to, you know, be engaging and inviting and make people feel comfortable.

I think it's a low-hanging fruit in the short-term limb that we put down as a goal as well, something that I think we all need to do. We all -- in all of our respective organizations and the representation in this TAC, I think that's something that we all need to be mindful of. And I agree, Catrena. Sometimes we can -- our agencies can not be very welcoming, so I think that was a good point.

Anything else?

DR. BURKE: In the last meeting, one of the slides mentioned, like, a biannual, on odd years, the Minority Status Health Report. And I was trying to look back. I seen the one from 2017. I couldn't find, like, a more recent one. I'm sure it's somewhere. I just --

MS. LASLEY-BIBBS: It is. It's in the secretary's office for final review.

DR. BURKE: Because I was just trying to, you know, look at some data and see if there's -- can we look back over, you know, the past few years -- because health outcomes aren't immediate. You know, they lag -- and see if there's any -- are there areas that we are seeing changes that were made that did result in equity improvement, you know, or better equity outcomes and try to figure out what those policies were that were implemented to see how they could potentially be applied to other areas that we don't see those types of changes. Or we see, you know, a widening of the gap and how to kind of address those things. But, you know, because I couldn't find a more recent report, I wasn't, kind of, able to look at trends as much.

MS. LASLEY-BIBBS: So even -- Jordan, I will say even in our most recent report, there hasn't been much policy movement toward closing -- to addressing health inequity. Recommendations are made, but some of those are policy recommendations. Some are other things.

And we haven't seen a lot of traction. We're hoping that we're going to see more traction. We -- since the pandemic, we've been getting -- we've been invited to sit at the table of some folks that we haven't been invited to sit at their table before.

So we're hoping to get some movement and traction in the policy realm around addressing equity, so stay tuned for that. I wish I had a better answer for you --

DR. BURKE: No. That's fine. Thank you.

MS. LASLEY-BIBBS: -- but I don't.

DR. BURKE: Another question I had, though. I know, like, these Certified Community Behavioral Health Clinics -- and it was mentioned earlier as well -- that there's four locations now. Is there -- like, will there be, like, a central hub? I anticipate that it's going to expand to more locations and things. Is there, like, a way that -- like, as providers, that there would be a way for them to know where those locations are that are close that people could access them?

Because I was just trying to find

locations, and I think maybe Pathways in Ashland is a -- at least it says it's a CCHBC, or BHC. But I just didn't know if there was -- if the end goal was to have them somehow tied together, so people will actually know where those locations are to -- to hopefully, you know, improve access for other people in different areas. But they have to know where they are first.

MS. HOFFMANN: Yeah. And we can provide -- I've spoken about the CCBHC initiative in several meetings just recently, and I can provide probably some visuals that'll probably help, too, about understanding that particular demonstration. It's eight quarters. It started in January. And then after the demonstration period, we could look to expand.

But the original application was applied for through the Department of Behavioral Health in 2016, I believe, and we did not get awarded until 2020. After they reconciled money, had leftover, Kentucky and Michigan were the next two in line, and we had the opportunity to move forward. They told us

that we had to use the existing application, which was four -- just so happened to be four CMCHs who also are going to now be a Provider Type 16-CCBHC.

But this is the first real initiative that I saw that was totally integrated health care, you know, kind of a one-stop shop, wants you comfortable, serves everybody no matter -- regardless of payor source, and had some very distinct populations. Like, we -- to look at the elderly, LGBTQ, the veterans. The veterans was one of the first ones I really noticed that this had a specific component.

Now, remember, this was written -- in 2014, I think, is when the opportunity first came out, so it's a little bit behind times. But after we get through the demonstration, of course, then we can -- we can go forward with an expansion.

So, again, there's eight demo quarters, and it started in January. So we'll go to December of 2023, I believe, and then we'll, somewhere along the line, decide how we're going to initiate and go further with that,

whether it be a state plan or however we decide to move forward.

So yeah, it's really just got -- got off the ground and moving, and it's a very good initiative.

MS. LASLEY-BIBBS: Jordan, anything else? Any other questions?

(No response.)

MS. LASLEY-BIBBS: Thank you for those. Anybody else have any comments or questions before we move on? I'm glad we have some goals. It's been a good discussion. I think we're still learning about what resources are out there and what all of us are doing in our respective role and how we all connect. So I think that's a good -- that's a good start.

I'm sure we'll be tweaking these and be refining these and maybe eliminating something and adding something else. So it's for us to kind of chew on and think about what we want to do moving forward.

And I think we need to keep policy on the radar, as Jordan has raised our antennas to that. You know, what policies do we have

in place currently, and have we looked at those?

I know we're looking at them through the health equity work that we're doing within the Cabinet. But maybe that's something, Leslie, we can share at the next meeting, is what some of those action items are in the Community of Practice 14, the racial equity work that CHFS does. I think that might be helpful. Just a suggestion.

MS. HOFFMANN: Yeah. And we're doing the same thing, Vivian. We're -- just recently added required language into contracts. If there's an RFP, we've been adding language there, SOWs, policies, CMS programs that we're held accountable to, and maybe those are brand-new ones that we're just bringing on board.

So each division within Medicaid is looking at their own policies, too, and that's part of their own goals. Where can I make that change, and when can I make that change, if it needs to be an amendment or a modification and if it -- you know, those kind of things.

So I think so far -- because we've been involved with a lot of initiatives that are going on -- Jodi and I have been -- we've been plugging those in. As Angie Parker mentioned earlier, I was part of that strategic plan, so we got the racial and health equity requirements and goals going forward put into that strategic plan. So that was a really good thing.

One good comment that I received via text here is that the MCOs all do something very similar related to social determinants of health, and a lot of them do this in their value-added. It's not necessarily a requirement. They do that as an MCO in their value-added.

But in the future, we might want to have -- again, I'm just thinking of things that we can do for this TAC. We might want to have some MCOs to come and present based on their initiatives as individual MCOs. They won't be exact, but they're very similar, in what I found when I was working with the social determinants of health.

DR. RICHERSON: Vivian, I had one

other -- should we have a placeholder goal just around data? Like, I think we just need a data goal. Like, know our data, or what is our data.

MS. LASLEY-BIBBS: Yeah. I do think we need to have a real good look at where those data gaps are, again, and just kind of see what we have and what we don't have and what we would like to capture maybe in the future that we don't capture and how we report that out.

We don't really look -- we don't really capture, to me -- and this is just my personal opinion, from our side of the house -- anything related to the social determinants of health as to -- to really capture information on an individual. So I think that's something we need to think about as well. I would put a place -- I'd put a pin in it for sure.

Anything else?

(No response.)

MS. LASLEY-BIBBS: If not, I'm going to turn it over to Julia, Dr. Richerson, for general discussion now, if

that's okay, Leslie.

MS. HOFFMANN: Yes. That's next. Thank you.

MS. LASLEY-BIBBS: Okay. All right.

DR. RICHERSON: Great. So I had sent in just, you know, a list of things that were on my mind, but I don't have to go first. If we want to go around and if anybody else wants to bring up any things that they have had on their mind that they might want -- might have wanted to bring up today. Does anybody have anything?

(No response.)

DR. RICHERSON: Well, I'll kick it off and then just interrupt, or we can take turns.

So the first thing I wanted to bring up -- and I think these are all questions maybe that we'll just ask for a discussion or response for the next meeting. So mentioning, sort of, what Dr. Bautista had mentioned around vaccines. We know there are many barriers. One of the barriers is the fee schedule for providers that don't use the

Vaccines For Children program.

The fee schedule hasn't been updated for many years, and so pediatricians and family medicine and other offices will not administer a vaccine and lose money.

So this is a request to have a review of the vaccine fee schedule and plans to update it. I know the intention several years ago was to maintain it with up-to-date costs, so I think that's probably just an oversight that's gotten lost in the last couple of years.

Another thing I wanted to mention is community health workers. We know how vital their work is in working on equity, and I just would like to have us play a role in those conversations that are going on right now since the legislation has passed. And just -- maybe just have that on a regular agenda or let us know how we can have a contribution into those conversations.

Along the same line is doulas. So another evidence-based practice that we know many states have taken on as Medicaid programs, per se, and paying -- I think most

states are using state plan amendments for that but having that as a more thorough discussion.

I mentioned last time around caries, specifically in children. I know it's a problem in adults as well. But I work with children, so that's what I speak about. We reached out to some local dentists here around taking children to the operating room to take care of rampant caries, and there were month delays. You know, two years ago, there might be a two-month delay, and there were five- to six-month delays in getting children to the OR.

When I reached out and spoke with a pediatric dentist, they said we will take them. It's not a payment issue on our side. The ORs, the community-based ORs, so the surgical centers, the payment rates for both the time for the building as well as anesthesia, they say it's too low for them to block off enough spots for the dentist to have enough spots to see all the children.

So, for example, they may only give a pediatric dentist six spots for the month

because the faster surgeries that they can turn over more quickly, they provide more surgical appointments for those.

So the CPT codes are 41899 and 00170. That's the -- what I understand to be the center code and then the anesthesia code. So I am hearing directly from dentists who would take kids and treat them, but they can't because the ORs will not give them time, the outpatient surgical centers. So we definitely want some information on opportunities to look at those fees.

Two more things. One is going to the MCOs. I can only speak to my experience in working with the families I work with. So I work with all Medicaid -- all of my patients have Medicaid unless they're uninsured. So I work with all five MCOs, and I'd like to talk more at some point about the incentive programs that they offer, the member benefits.

The families I work with cannot access those. They are -- most of the families don't speak English, or if they speak English, they don't read English. Navigating

apps is extremely complicated. And so there's money left on the table, and these families need cash.

And so I think that is a really -- I think integrity is the word that comes to mind. We have all these programs that look great on paper, but I know the families that I work with are not accessing them because of the significant barriers. So I'd love to brainstorm and have conversations about that.

And then the last thing are the gaps we know that are out there. Like Catrena mentioned, we know there are people that want mental health services, behavioral health services, and aren't getting them. We know that there are children with anemia that can't get the iron medicine that they need.

And so how do we process that information? Just in this group, how can we really bring some of that up? It's not big policy issues, usually. It's not, you know, ten-year-plan type things. These are things that, some of them, we could fix in a month, so I'd love to have an opportunity to have some of that bubble up and address more

quickly.

So those are just some things that have been on my mind. Oh, the -- I'm sorry. The very last thing is for us to understand as a TAC what tools we have. So I mentioned, for example, PIPs. Is this -- can we talk about recommending PIPs to the MCOs? Things like that. Like, what are our tools for action? I'd be really interested in understanding that better.

MS. LASLEY-BIBBS: I just want to answer one of the questions. I think Leslie and Angela know most of the -- we have a CHW group. Two of us are funding, within DPH, our CHWs across the state, and we're expanding that network. And we're also working with Commissioner Lee on the sustainability model for funding those community health workers after our grants go away.

So I do think it would be nice to have a report to this group about that work, learn about what's being discussed as it relates to House Bill 25 and where we are with that. So I do think that's a great suggestion.

You also mentioned something, Julia, that I meant to mention when we were talking about committee goals, and that's looking at our literacy, looking at health literacy and also looking at literacy in general for our -- we have a sixth-grade reading level in this state, fifth- and sixth-grade reading level. And none of the information that I see is at that reading level.

So I think we need to be thinking about, you know, the literacy level of our communities and also universal design in how we present information. So I'm just saying I think that's a great speaking note as well.

And then you said something about TAC tools, if you can explain what you mean about that, Julia. Maybe I'm not as familiar.

DR. RICHERSON: No. I'm just wondering -- I know that TACs make recommendations to the MAC and then -- you know. But what other tools do we have or techniques that we have to move ideas along?

You know, for example, requiring a PIP. So, say, for example, we wanted to talk more about doulas. Could there be an opportunity

to, you know, encourage a PIP for maternal -- for doulas or something?

So I'd love to know: How do we -- how do we package what we -- what our suggestions and ideas are as a TAC so that they have movement?

MS. JUDY-CECIL: This is Veronica Judy-Cecil with Medicaid. You -- so you would put it into a recommendation. You know, this body does serve as an advisory, and so that would come up to Medicaid for us to take a look at.

The -- as we explained in the first meeting, this isn't -- this isn't technically part of the MAC and TAC, and so the recommendations don't have to go through the MAC. You all can -- those get submitted directly to us, and we'll consider those.

I do want to request that -- you know, this really is about us listening to you all out in the community who have a lot more experience and expertise in diversity inequity and in addressing inequities, that, you know, we can present to you all.

But we really want to hear, you know,

what is it specifically can we do. You know, what -- what kind of policies could we enact to improve the Medicaid program in addressing those disparities/inequities? We can't do everything, and I think we do need to make sure that we're moving forward in a way that is, I guess, realistic or manageable.

So -- but it is -- it is very important to us and Medicaid to understand more about, what are the barriers that you all see out there and potential recommendations around what can we do as a program to try to address those.

And -- so, you know, just trying to -- I want to make sure you all understand we're here to listen to you all. We don't want to be -- we don't want to just present to you. We really want that engagement and recommendations that are actionable, you know, that we can take to try to improve the program.

DR. RICHERSON: Great. So, for example, the list that I just gave, are those the type of suggestions you want, or do you want more big-picture policy, you know? I

guess -- I know you don't want to limit it, but can you give us even some more guidance on that?

MS. JUDY-CECIL: Yeah. Sure. So, you know, I think -- I think what would be helpful to us is to break those out, break those down and actually have conversations about -- you know, for instance, the doula recommendation.

And by the way, I mean, some of these are things that we are hearing in other TACs which is good; right? So there's some -- there's some alignment. There's some common themes and recommendations that are coming out. And those -- you know, that matters, obviously, when there's such a demand for something.

But, you know -- so I think it's -- there are some states -- there's a handful of states that are covering doulas. Let's just -- you know, I think let's take these a couple at a time as opposed to, like, putting them all on the next agenda. So we can have -- I think what we want to have is in-depth conversations so that we can --

that'll help us. You know, if it's, like, recommending doulas, it'll help us understand, well, is -- if that's not something we can immediately do, is there some other barrier or, you know, some other way to address that.

I will tell you that we are monitoring -- some of the MCOs do cover that as part of their value-added benefit. And if we haven't sent that to you, we probably should, is the grid about what those extra benefits are that come from the Managed Care Organizations.

But what we're kind of doing is monitoring those to see their outcomes. So -- because that gives us -- that gives us the ability -- it's kind of being piloted. And we can see, you know, is there really an overall benefit to that for Kentucky, understanding that some of the states are covering it, you know, in their state plan.

But those are some of the things. You know, I think what's -- that you might want to prioritize some of the things you're interested in and then let's have those deep

conversations about them and then -- you know, then you can kind of maybe work from that as an actual recommendation around it, if that makes sense.

DR. CLEVELAND: You all may have mentioned this already, but I was wondering: Do you all have a racial equity policy currently?

MS. HOFFMANN: We have a racial and health equity plan for Medicaid that aligns with our other sister agencies that aligns with the Cabinet's pillars. Does that make sense? So we could share that with you.

DR. CLEVELAND: Okay. But that's a plan but not a policy. It's not a --

MS. HOFFMANN: It's actually -- it's a plan, and we just -- like, we just started. I think the language for us to really get -- or the drive for us to really get started on this was in 2020 from the secretary's office. So we've all kind of developed our own individual plans from each department and then reported those out to ensure that they align with the Cabinet. We want to be on the same page; right?

So we've been doing the report-outs, and that's why I said I had heard Ms. Bibbs give her report-out, and they seemed very similar to us in nature, public health and Medicaid serving the huge population. They sound very similar to us.

DR. CLEVELAND: Okay. Thank you.

MS. LASLEY-BIBBS: So, Roger, we do have a health equity policy within DPH, but it's for the Department for Public Health only. So we are part of this bigger picture and work within the Cabinet. The secretary, it's an initiative he's moving forward with: Racial and health equity.

So what we're looking at is, now, looking at our health equity policy and how we can use that racially in -- on our policy within DPH, so I hope that --

DR. CLEVELAND: Okay. Thanks.

MS. HOFFMANN: Mr. Cleveland, our first task delivery date is December the 31st, and we want -- we've got a tool that we're trying to utilize, that we want every division within our department, and even smaller groups, like the behavioral health

initiatives within the commissioner's office -- so we've got two groups there. We're all going to practice using that tool and get familiar with it so that we can start utilizing it every time a new program, new policy, anything like that.

So we're just, kind of, at beginning levels. That's really after our plan -- Jodi, if I've missed something, let me know. But after our plan was established and approved, that's really our first delivery; right? We've been working on training and knowledge about the tool, and Rashad from Department of Behavioral Health has been working on that with us as well.

MS. ALLEN: And policy is being created and then implemented/integrated across the board. As we go along, that's part of the process with this racial equity plan as well.

DR. CLEVELAND: Okay.

MS. ALLEN: Yeah.

DR. CLEVELAND: One reason I ask is because we're a few years behind you in public education, so we want to steal, beg,

and borrow whatever y'all have right now. Public health is ahead of us, so that's one of the reasons. I'm being selfish. That's the only reason why I asked.

MS. HOFFMANN: Yeah. We've all been sharing resources that are good and that are approved up at a Cabinet level. I've often reached out and gotten other language for policies and things like that that we know has been approved up to a Cabinet level, and it's driving towards the same goal. So yeah, we've been sharing a little bit back and forth, especially with our sister agencies that we work on a lot of initiatives with so...

MS. ALLEN: Mr. Cleveland, if I come across anything that I think might be helpful to you as I'm doing research, I'd be happy to share.

DR. CLEVELAND: I appreciate it. Thank you.

DR. RICHERSON: So should I jump in now as chair and move on to recommendations?

MS. HOFFMANN: Yes. Thank you.

DR. RICHERSON: Okay. So I think

we have internal recommendations. I don't think we have any recommendations for the MAC right now but -- so it seems like we have some follow-up items.

So the goal-setting discussion with Vivian will get captured, and that will obviously be an ongoing agenda item. We identified community health workers as a possible future agenda item to talk -- to bring them in and learn more about that work.

The -- for the list that I went through as far as prioritizing, I think between now and the next meeting, maybe we could get feedback on the fee schedule update and an update -- or feedback on the dental, those two dental codes -- not dental codes, surgical center codes. Maybe those would be the most low-hanging fruit on that list and then we can talk about others in the future.

On the MIC, I guess, if people have ideas on who might serve on that, we'll get that email sent out with the minutes. And it was in the -- it's in the chat for Karissa.

What else? What else do we need to make sure we get on the agenda for next time?

MS. HOFFMANN: Dr. Richerson, if you're interested in it, Jodi and I thought we might bring forth the GARE tool, a short video, and maybe just do some high level, so you could see, kind of, the lens that we're looking through for baseline, looking at policies and contracts and things like that. We can just do a high level, if you want to, and there's a little video to go along with it.

DR. RICHERSON: Great. Do you want to plan on doing a deep dive into one of the goal questions, like maybe the -- Catrena, on the -- starting that conversation around mental health access?

MS. HOFFMANN: Yes. That's fine. So yeah, and just remember that some of these goals and objectives are going to take longer -- right? -- than others.

DR. RICHERSON: Oh, yeah.

MS. HOFFMANN: We do, on the mental health side, have probably an advantage, that we've been addressing, strongly addressing mental health issues, especially during and after COVID. Of course, that's a hot topic

right now and need. So yes, we can start on a conversation with that.

The data is probably going to take us a tad bit longer. We've got -- I mean, that's, like -- you know, that's one of the things that we want the Medicaid Innovation Collaborative to assist with, is: How do we get there, and what do we do with it? And who -- you know, how we connect with the communities and providers and other partners.

DR. RICHERSON: Great. Any other recommendations or questions for the Medicaid team that we want to talk about next time?

MS. BOWMAN-THOMAS: I think maybe to think about streamlining services. We hear, a lot of times, where people have to -- it's just very hard for people to navigate Medicaid and, you know, where to go and who to go to. And you have to go here, and you've got to understand your plan.

And so just, you know, how to really streamline that entire system to make it more -- I know that's -- yeah, if you could do that, that would be -- you know. But I do know that that's an issue that we hear

consistently from families, is that it's just difficult to navigate.

DR. RICHERSON: Great. Other things on people's minds?

(No response.)

DR. RICHERSON: The next item is the MAC meeting representation which is November 17th. I don't -- as chair, I cannot attend the MACs, so someone else can attend the MACs. So I don't know if Patricia can attend or, if you can't, if somebody else could block that time to get a feel for what the MAC is like.

So that when we present, you'll kind of give us advice on how to best make our recommendations to the MAC and also to hear what they're talking about, what the other TACs are talking about.

DR. BAUTISTA-CERVERA: I think I can attend. If I get the link or the invitation for the meeting, I would appreciate it.

And, you know, thinking about what Dr. Cleveland and Vivian have mentioned and the racial policies and the low literacy that

the whole state is having, something that comes to my mind again is that the lowest -- the lowest percentage of vaccinated schools are the ones that have the lowest scores for reading and math. So -- and those are the schools that have the highest minorities, higher number of minorities that -- with kids that are eligible for reduced or free lunch, at least in Louisville.

And so this -- you know, all the social determinants of health go hand in hand. But I think vaccination can be upstream, and we can do a lot of good things through that.

DR. RICHERSON: Great. Yeah. Vaccination is kind of like the canary in the coal mine, certainly a signal, a red flag when things aren't going well.

MS. JUDY-CECIL: Does the health department in Jefferson County go into the schools and do vaccination events? They don't. Okay.

DR. RICHERSON: We have a great health department with very limited vaccination program.

MS. JUDY-CECIL: Okay.

DR. BAUTISTA-CERVERA: There are two clinics for vaccination. One -- each clinic has one day, and the vaccines are charged per dose of vaccine.

MS. JUDY-CECIL: Gotcha.

DR. BAUTISTA-CERVERA: So even if it's a scaled fee, it's still out of reach for so many families.

MS. JUDY-CECIL: I see. And then what about -- I guess, then, do providers -- are there any providers that are contracted with the schools maybe to come in and perform vaccinations? Has that happened?

DR. BAUTISTA-CERVERA: No. They are home providers, home medical providers. But out of the whole bunch that work for Medicaid -- I cannot remember the number, but it was so low, sixty-seven providers for the thousands of kids that are Medicaid eligible. I'd have to check the numbers. I don't want to make it up.

MS. JUDY-CECIL: Okay.

DR. BAUTISTA-CERVERA: But most of them will do physical exams but will not provide vaccines.

MS. JUDY-CECIL: Okay. That's interesting. That's what this -- conversation is important, is, you know, to help us identify those issues. Thank you.

DR. RICHERSON: JCPS does have a VFC contract, so they can administer themselves. However, you know, the practices that see children but don't administer a vaccine, it's because of the fee schedule. So they do administer vaccines to commercially insured children but not to Medicaid children.

MS. JUDY-CECIL: Okay.

DR. RICHERSON: So -- and it's because of the fee schedule.

MS. LASLEY-BIBBS: So if they're -- so, Julia, if they're a VFC provider and they don't -- they can choose or not choose, depending on whether that client is a Medicaid client versus a private insured, on whether they give the -- whether they give that vaccine or not?

DR. RICHERSON: So they're -- so in the school, they are a VFC provider, so they give to everybody.

MS. LASLEY-BIBBS: Right.

DR. RICHERSON: But in the community, if -- so if there's a pediatric office that doesn't want to do VFC but they still have Medicaid patients, they will send that patient elsewhere to get their vaccine because the vaccine in their refrigerator is too expensive because Medicaid doesn't pay them enough for the vaccine.

MS. JUDY-CECIL: It would be helpful to understand what that -- you know, what's the amount that providers are looking for.

DR. RICHERSON: Sure. It's -- and I don't -- is Stephanie Bates still with Medicaid?

MS. JUDY-CECIL: No, she's not.

DR. RICHERSON: Okay. She was on top of this about, whatever, four years ago. So she -- there are -- there's -- it's whatever it costs, the medication costs, so there's national numbers for that.

So that is an easy thing to drill down. It just needs to be updated up to what it actually costs, and there's lots of resources

to look for that.

MS. LASLEY-BIBBS: Julia, Judy has -- Dr. Judy has her hand up.

DR. RICHERSON: Hello, Judy. Do you have a question?

DR. THERIOT: Hello. Yes. I was just sitting here thinking. Because, in the past, if you were a Medicaid patient and eligible for VFC, the providers that were not VFC providers could not use one of those vaccines in their office. But now everything's changed. Within the last couple of years, it's changed, and so now you can.

And I agree. I looked at the fee schedule earlier today. Some of the fees have been updated -- those vaccination fees have been updated in 2022. Some haven't.

And I personally have no idea how much things actually cost, but I wonder if there is an information gap out there, that the providers just say, oh, I'm not a VFC provider. Therefore, I can't use my private stock. And that's part of the problem.

DR. RICHERSON: I think that's a small part. Because I've worked individually

with the pediatric practices here in town, and I have said, no, no. It's okay. You can give it. And they're like, we're not going to give it because this vaccine costs $230, and you're only going to pay me 150. So they know they can give it, but they're like, I'm not going to do it.

So I think there is some of both, and I think when we update the fee schedule, then we can re-educate practices about -- and it's a handful of practices. We're not talking, you know, a huge number of practices, but it's a lot of kids that are in those practices not getting vaccinated.

So yeah, that's a good point. But back in the day --

DR. THERIOT: It wasn't that long ago.

DR. RICHERSON: Right, right. But yes.

DR. BAUTISTA-CERVERA: Just two comments. JCPS just became recently a VFC provider, and they are working on developing how to do the best distribution. They are short on staff. They are short of -- they

are just implement- -- they are just starting. That's why it's still a big problem.

And the other one is, for VFC providers, they will get the vaccines, but I think the last number that was shared that comes to mind was the reimbursement per vaccination is, like, three dollars. So they would say, no. I won't do this.

DR. THERIOT: Well, the administration fee is three dollars, but you get paid, you know, the 250, or whatever it is, for the actual vaccine. So there's different fees. So if you give -- and you can get -- some are three dollars; some fees are higher. And that doesn't count the actual reimbursement for the cost of the vaccine.

DR. RICHERSON: Thank you. We are right at time, so the next meeting is January 4th from 1:00 to 3:00, same time. And any --

MS. BICKERS: Yes, ma'am. Same time.

DR. RICHERSON: Any further

discussion?

MS. LASLEY-BIBBS: I just have one, Julia. Is there anything more for this group to do before we meet again? So when we do meet, we can have more of a pointed conversation instead of just kind of having a general discussion and -- kind of again.

I just want us to make sure that if there's one goal -- if mental health is going to be that SMARTIE goal that we think about, can we be having that as maybe some homework or maybe thinking about what that might look like when we come back together, just so we --

MS. ALLEN: We can definitely, too -- I wanted to mention with that particular goal in the behavioral health area, we can definitely bring some information to you about what we're currently doing to increase access, if that would be helpful, possibly put a PowerPoint together or something, just to show you all, you know, kind of, the things that we're doing right now ongoing to increase and improve access. It would be a good place to start.

MS. BOWMAN-THOMAS: I think that's statewide data, too. Someone had asked about statewide data that we can look at that really shows, you know, the gaps.

MS. LASLEY-BIBBS: Yep.

DR. RICHERSON: And then, also, what do you all know already that are problems that you're already working on in as much detail as possible?

MS. LASLEY-BIBBS: Yep.

DR. RICHERSON: Yeah. Anything else besides that, kind of, list we just went through for the next meeting with a definite focus on mental health and just everyone thinking about that and...

MS. HOFFMANN: Dr. Richerson, again, on -- Julia and I will pull together a PowerPoint that we've been working on, and we can include some things that Dr. Theriot has also worked on, just increasing access and coverage and things like that in our populations.

Again, our data, I don't know what we'll have right now. I can share with you what we've starting seeing that we've had to come

up with just recently related to some SMI, SED, and SUD substance use disorder information. But it's probably not exactly what you're looking at.

But, again, we've got to have a starting point; right? And I think the big picture to the data is going to be maybe a longer goal. I just wanted to share that with you.

DR. RICHERSON: Great. And then anybody, you know, think about -- talk to your friends and colleagues and patients and students and -- as many specific examples really help dig deep into the issue when we can talk about that 15-year-old who was just discharged from the hospital who isn't able to connect or -- you know, just as detailed as possible, I think, makes the conversations more fruitful.

All right. And then who's going to check on the rotating chairmanship plan?

MS. LASLEY-BIBBS: I think Veronica said she was --

MS. HOFFMANN: Yeah. I think Veronica is going to take that back and see if it'll mesh with the executive order in the

bylaws.

MS. LASLEY-BIBBS: Right.

DR. RICHERSON: I could just resign in three months and then -- we'll figure it out.

MS. HOFFMANN: Yeah.

DR. RICHERSON: Okay. And then -- I'm sorry, Vivian. Yeah.

MS. LASLEY-BIBBS: I was going to say it's been a good meeting, though, today. I'm glad we got to meet.

DR. THERIOT: Maybe you'll forget to resign.

MS. HOFFMANN: Yeah.

DR. RICHERSON: It's been a great meeting.

MS. LASLEY-BIBBS: There you go.

DR. RICHERSON: I'm looking forward to next time. Is there a motion to adjourn?

MS. WILSON: So move. Elaine.

DR. BAUTISTA-CERVERA: I second.

DR. RICHERSON: All those in favor?

(Aye.)

MS. HOFFMANN: Thank you so much.

(Meeting adjourned at 3:02 p.m.)

* * * * * * * * * * *

C E R T I F I C A T E

I, SHANA SPENCER, Certified Realtime Reporter and Registered Professional Reporter, do hereby certify that the foregoing typewritten pages are a true and accurate transcript of the proceedings to the best of my ability.

I further certify that I am not employed by, related to, nor of counsel for any of the parties herein, nor otherwise interested in the outcome of this action.

Dated this 16th day of November, 2022.

/s/ Shana W. Spencer

Shana Spencer, RPR, CRR