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>> **CART Captioner:** I have tried to connect by the link and by the phone but the numbers are invalid. I am working with the office to get the correct information.

>> **CART Captioner:** I am connected to the webinar through the correct link. Thank you.

>> Good afternoon, everybody.

This is Kevin Hancock. Today is the third Thursday webinar on May 21, 2020. We'll provide a quick staffing update. And then we'll go through the COVID-19 updates for the group and then we'll present on the educational supports and clinical coaching program acronym sometimes called eskip. I made the decision some time ago actually before the emergency crisis that I was going to be leaving the office of long-term leaving after this was implemented I thought it would be a good time for somebody who has a background as a project manager and implementer to sort of -- to give up the stage to something who would be a moving the community health choices to a much more operational platform and I thought that that would be a good time to do that. Of course, then we moved into a period of global pandemic and that changed the schedule of my leading. I moved my departure date a month.

During the time period we went through a recruitment process. My successor has been selected and right now she has started working in the office of long long term living going through a transition process. I would like to take this opportunity to introduce Jamie. She's going continue to introduce herself to you as the new future

deputy and talk about her background and aspirations as well. I'll turn it over to Jamie.

>> Good afternoon, everybody. It's a beautiful day and I'm excited to be here with you virtually and on the phone today. Many of you hopefully are familiar with me. I spent the last four years working for the office of medical assistance programs and I also often attended the Max if a tend. Earlier on in the enemy tenure with omap I worked on the implementation of all the ACA affordable care act related provider enrollment changes we had to make. I was often at the medical assistance advisory committee giving updates on the implementation of all of our ACA related changes. Last year I was -- I took on the acting policy director role so I was attending obviously the mac and consumer submack regularly and may have been acquainted with some of you then. I did spend time working in the office of long term living back in 2011 and have relationships with some of the stakeholders from that time. Prior to that I worked in the DHS policy office from 2008 to my

time until I went to the office of long-term living. I'm really excited to come back to the office of long-term living. I'm very excited to reengage in the issues. A lot of them found familiar to me but with a different spin, CAC changed the way the office of long-term living I want to say does their business. I'm excited to learn more about that and become involved in those efforts so I think the goals I have for at least the rest of the time I will be deputy secretary is really to improve upon what Kevin and the team has started. They've done a wonderful job during he implementation of health choices. Looking at what they've done and what the team has done and looking for opportunities to improve that work. I know there's work that that needs to be done around the life program and the personal care homes and assisted living residences so I have issues we're working through there, too. Obviously COVID-19 has really changed the way -- changed the way that I

think we look at long-term living services I think it brings opportunities and I can't wait to start and start with the office of long-term living and looking at the way we're doing things and how to maybe do things differently for the benefit of the populations that we serve.

So that's it. Any questions?

>> Thank you.

>> So Jill and Kristen are collecting the questions. We'll leave a minute open to see if questions came in for Jamie.

>> We did not get a question for Jamie yes. However, we did get a question from and I'm going to call you out Carl, Carl Berry wants to know on webinar how does one give a standing ovation for Kevin Hancock.

>> Thank you, that's very kind. It can't be done. Since I mean I do think that we had a lot of success over the last five years. I would attribute that the incredible team at the office of long-term living as well as engaged and open minded stakeholders including Carl with PACA and provider across the system I should be the one giving up everybody up for the success we've been able to achieve.

This is the last Thursday webinar. I want to note that I have -- as well as stakeholders. I learned from you every day, all of you and you've worked with us to make a better system. And thank you and give everybody else a hand.

>> with that as Jamie pointed out I wish her the best of luck. We have a lot to do with COVID 19 to jump into the COVID-19 related update.

>> Just to emphasize again what are the OLTL priorities during COVID-19. First and foremost this is to do whatever we can to put measures to make sure staff has equipment and supports they need to avoid the infection as much as possible and if there is an outbreak or infections that affects them directly that they receive the treatment they need. And also that they are in a position to be able to protect other people from the infection. We really are looking for every opportunity to keep people safe but in the event of an infection we want to make sure we're doing all we can to make sure that the disease doesn't spread any more that we have to. That's across the system. It's regardless of whether it's facility based care.

It's the first and foremost objective. Doing whatever we can to stop the spread of disease if we can. In addition to that, pry your objective we're looking to opportunities to minimize service interrupts and provider capacity issues. They can occur and service interrupt corruptions can occur in a lot of ways related to COVID. The first is that participants may make the decision that they do not want to receive certain types of services because they are afraid of having somebody there because of fear of the infection which is understandable but at the same time but a lot of these services in people's homes are life sustaining so we need to know and make sure that participants are covered through their services. That includes evaluation of back-up plans and it also includes consideration of other ways that services could be provided whether it's tele-phonically or otherwise. Provider capacity issues can occur for a lot reasons not the least of which is if staff are

infected by the infection. But there are also considerations for provider as well including child care issues for their staff. So many of the schools have been closed, it might be a situation where staff may not be able to work the same hours that they were working in the past simply because they need to be available for child care and we want to make sure that all of those points are taken into consideration.

We want to make sure that participants are -- have access to the life sustaining services that they need without interruption if possible. If there's interruption that there's an effective back up plan in place. We've been looking for all ways of ways to use federal flexibility and authorities to be able to broaden the way that we've approached the delivery of community health care choices as well as the other programs. The two thirties we continue to modify are the 1915 appendix k authority. We mod fight it pretty frequently. We have done it at this point. You can correct me if I'm wrong three times. The modifications are designed to adapt to the situation on the ground and to be able to make sure that the program is meeting the needs of the participants. 1915 waiver is expansive as well that has allowed for a lot of opportunity to be able to decrease requirements that providers may need to be able to support the service

s as well as decreased other types of regulatory burdens that codes this with the program. We've also been involved in the submission of what is called a disaster plan amendment. We've done that in coordination with office of medical assistance programs and office of mental health and substance abuse services and the office of programs before Medicaid program offices and the department of human services to be able to make sure that the state plan services are ompeded as flexibly as possible. We worked with the care organization and community partners for the access of PP everyone. We focused on the participant directed work force simply because unlike some agencies or other providers they don't have the purchasing ability for prch prch E that some other entities may have. So in many ways they are on their own. We prioritized that with the community partners and the MCOss but we worked with the department of health, Pennsylvania emergency

management agency and providers to see if there opportunities for prch prch E as well. We know it's improved but still scarce. That scarceity continues to change and we monitor it. They've been an important partner with us to identify the scarceities and ways to get around as well. We continue to distribute information to all stakeholders including providers to participants and managed care partners to be able to make sure that the most up to date information is made available to them. We sent out dozens of different types of guidance and information to all the stakeholders related to COVID and COVID related activities. We'll continue to do so

throughout the crisis period and probably well after to make sure everybody has the most up to date information and transparency it's a situation. To be perfectly honest in my career I have never faced anything like

that and I'm sure many would agree. It not only changes on a daily basis, it changes on an hourly basis and sometimes a half hour where the landscape shifts and we need to keep the information related to those changes as up to date as possible and make sure it continues to be relevant. Providers have been helpful in providing ideas on what type of guidance has been needed. We appreciate that very much as well as many participant advocate stakeholders as well. Quick update. I love the YouTube segment with John Craig, some good news.

This is some good news we distributed packets to direct care workers our community partners direct care representative as well as public partnerships. We're we were involved in distribution. They included 2-3 masks and handouts with instructions on mask maintenance and universal precautions to the workers and as more of this becomes available and as more becomes available through the managed care organization the more it will be sent out. Is it enough? No. Do we want to send out more? Yes, but at least it's something. The participant employers are hardly in a position to access PPE with them so it's critically important that this is made available and we're glad to work with partners that we're able to do this. Some good news. They've been a full partner and priorities are focused on monitoring incidents of COVID related diagnosis. This is most specifically for home and community based services. The managed care organizations have been engaged in

outreach to facilities but nursing facilities which is a key care service. They have other avenues where they can report their cases including the department of health, they are responsible for licensing them and also with PEMA as well. This is an emphasis on community based service because it makes sense there's greater focus -- there's 32 home and community based services associated with community health services and they've really had to focus on making sure that those services are being delivered, also focusing on risks of interruptions of services and making sure that the back-up plans actually are in place to be able to support the participants and if the back-up plans are really not feasible which has often been the case unfortunately the MCOs have known to make sure that services are in place for those individuals in a priority way so that they are really a limited risk of interruption of services. In addition to focusing on services

themselves they've also focused on any other other type of need including home and medical supplies or home needs that participants have to live safely in the

community. They are also full partners in assisting with PPE and that is as mentioned for the work force. Quick update on and just for a lot of clarity on what it means for the office of long-term living and services from transitions from red to yellow. He wanted to make sure we're making this clear because of the fact that red to yellow could be viewed as something different. It will move as part of wolf administration reopening process. Many have been named. Many are reopening I think even tomorrow including counties across the Susquehanna river.

In our situation moving from red to yellow does not change any and I mean any of guidance we've sent out so far for nursing facilities or home and community based providers. We are strongly promoting the use of CDC guidance as well as the department of health guidance on re-entries and long-term care programs and we're also strongly encouraging the continued use of PPE and other types of protective equipment for home and community based services as well. In short when it comes to the long-term care system in the community or in facilities there are no changes. Red to yellow does not mean less restrictive in the long-term care system according to guidance and I hope that's clear. We're recommending no changes in the approach to the delivery of these services and we're not recommending for example, the changes to anything with regard to visitation and nursing facility services as well.

>> So another bit of interesting or good news relating to how we're trying to address the COVID 19 area is opportunities that have been presented by the federal partners on the use of civil monetary penalty funding. It's funding collected through penalties issued by the department of health and for licensing violations. It's a pool that could be used for different training or initiatives the facilities could have in place. They have -- our federal partners have expanded the use for how the civil monetary penalty money or funding can be used. An example is the use of communication technology to allow nursing facilities to use virtual social or tele-health visits to allow residents to have a lot more opportunity for communication in the situation where visitors are not able to enter to the facilities. For example, family members are not in a position to be able to visit their loved ones in nursing facilities during this

crisis period and that includes yellow areas as well. This technology that may be available may help continue with communication and certainly ease the mind of family members and revenues. We're encouraging that this is something that facilities take a look at. We included a link in the presentation itself. We're encouraging facilities used to go through the application process to be able to obtain that technology. This flexibility is kind of ground breaking.

We certainly hope it continues throughout the crisis period and we're looking for facilities to continue taking advantage of it. Communication. All communication attributed through the list serv. We could encourage you to do that we continue to use our Coronavirus 2020 landing page as a repository for that communicate. All of the communication can be viewed on that page. We encourage to you review it. It will be placed there's a quickly as possible and as it does, as I mentioned earlier provide the most up to date guidance because guidance has to change frequently with the changing landscape of COVID-19 and the way that it has to be managed. With that I'm going to pause to see if there are questions before we jump into the educational support and clinical coaching programs. Joe or Kristen, any questions?

>> We do have quite a few. Do all participants need an informal back-up support?

>> It is a standard practice with home and community based services that, yes, all participants are to have a workable back-up plan.

As I mentioned earlier, in many cases the back-up plans have been found to be unrealistic and if they are it's when the providers have prioritized those individuals to make sure they have limited disruption of services.

>> Are you looking for more P.P.E. partners?

>> We are always looking for P.P.E. partners. I would recommend if somebody is interested in being a P.P.E. partner or has information about P.P.E. partners reach out to the office of long-term living or three managed care with any information you may have.

>> Who were the packages mailed to? Directly to the home health aids?

>> Directly to the director of workers, correct.

>> And can you please advise who we should contact regarding participants who were not transferred to HHA exchange the first few months of implementation of CHB. It looks like we need to follow up with this individual and reach out to see what participants they may be referencing. So I will forward that over to that group in OL GL.

>> Thank you.

>> No problem. Will the appendix K and 1135 waivers be extended beyond June 30, 2020?

>> at this point that is not determined. We'll make that call on or around June 1. But since the COVID crisis looks like it's going to go past June 30th.

>> When a participant receiving PAS or a person with whom they live tests positive for COVID what protocols are CHC MCOs supposed to follow to ensure the participant's needs are met particularly where the back-up plan cannot be implemented? For example because of the back-up provider is also ill?

>> Unfortunately, these are real scenarios. It's always going to be case by case. If the participant -- hopefully the participant themselves if the caregiver or worker testing positives hopefully they will be tested to determine whether or not they have -- their exposure to the infections they would have been exposed to the infection. Whether it's led to positive tests.

Hopefully they'll be tested and then it will be truly a focus as to whether or not it's not just a CAC protocol. If the person is living in the community the request is whether or not they have to be quarantined or if other people have to be quarantined as well. There's a lot of different scenarios that could relate to any individual case. Once again it is case by case. But the protocols are testing, social distancing and quarantining and treatment of the symptoms if this exacerbate.

>> and additionally to that question, Kevin, is a question around the MCOs role in that protocol.

>> So the recommendation would be that the participants or caregivers report the condition to the managed care organization so they can support the efforts of the participants and their caregivers in accessing the type of treatments they may need be able to deal with the symptoms of COVID-19. That would include accessing testing, potentially through the doctors, primary care physicians or otherwise and accessing physical health services to be able to support recovery from the symptoms of the disease.

>> Has the department contemplated how eligibility will be treated after the emergency period is over? Specifically for individuals who maintained Medicaid eligibility during the COVID-19 emergency and are subsequently found to be ineligible what will be the effective date, the date that is the common post emergency period or date back dated to when the eligibility should have been determined. The concern is if the date is backdated this causes problems for claims payments.

>> So this is an incredibly good question for which I do not know the answer. We'll have to get back to that individual and as a follow up we'll make sure that that is -- we want to obviously confer with the partners in the office of income maintenance on that answer and it's a good question for which I do not have the answer. We'll get back to you and we'll have to make sure that that answer is broadcasted broadly once it's been determined.

>> Again we have someone additional that would like to be a PPE partner. Who or where should that -- individuals interested in being a P.P.E. partner who do we want them to contact?

>> They can reach out to the three managed care organizations as I mentioned or the office of long-term living.

>> Is there an end date for the recent guidance an agency may extend the geographic service areas adjoining counties do.

They have to dispatch the client or can they continue servicing the client?

>> I don't think we've made that determination at this point. That is something we could confer, Jen can chime in they would like? It might be we would let them unless we are prohibited by a federal authority. I don't know if Jen would have anything else to add.

>> I agree Kevin. Is there a rule that providers may conduct phone supervisions of the direct care workers at this time. If, yes, then when is the role good -- how long is the role good for?

>> Not really sure I understand the question.

>> I think it's regarding providers have oversight of direct care workers. Perhaps the individual can clarify their questions, send it back in for us.

>> I really appreciate it. Do you know if OTLT has made a decision regarding Medicaid case mixed for nursing homes? Meaning have they decided to continue rug four are will be going to PDPM for payment?

>> Very good question. It's our understanding that the federal implementation of the sort of the -- sunseting of the requirements or changing it has been postponed. The plan is eventually to modify the process but it looks as if we have more time to be able to do that. At this point it's likely to be able to minimize

disruption during the crisis period especially for nursing facilities to use that time to be able to -- and just continue status quo and to be able to use that time to take a thoughtful approach in the way that the rate setting process would change.

>> Okay. Given OLTL staffing updates is the enrollment RFA still coming out with before the end of May 2020 with the conference on May 27 as shared on the MLTSS sub mat call?

>> So it looks as if the enrollment services RFA will be pushed out at least one month and that is to evaluate this RFA has to be aligned with another procurement for case management services. Pushing it out a month -- just to be clear it's ready to be released today if we need it to but it does have to be aligned with the enterprise case management procurement as well and we're taking that additional month to evaluate the time lines to make sure that the two -- the platform that will be used for enrollment services, the technical platform used for enrollment services will be available when the services program is implemented. So it's pushed out at least a month. And so will the timelines change for the conference, et cetera, et cetera.

>> Okay. The clarification is regarding -- on the previous question about oversight is regarding field supervisions of the direct care workers by the registered nurses. Can the nurse conduct phone supervision at this time? And we can follow -- we can follow up directly with the person regarding regulations.

>> Okay. I think that that would be a better approach.

>> and that's all we have right now.

>> Thanks very much. Great questions. The eligibility question in particular is one - I'm actually looking forward to hearing the answer to that one but I don't know it. Thanks to the person who asked it and all of the questions that we received. They are thoughtful and very much appreciated. So now I'm going to turn it over to Willmarie Gonzalez.

>> Good afternoon, everybody. I hope everyone is doing well and keeping yourself safe. I'm having the pleasure of talking to you a little bit about an initiative that OLTL has been leading with the help of a number of people here as well as DOH and CDC, the educational support and clinical coaching program called escpp. It's really interesting. There are 45,000 individuals living in 1200 personal care homes and assisted living throughout the state. Many of the residents have preexisting conditions that particularly are susceptible that have outcomes for the

pandemic. As you know, the facilities are designed and small and large facilities serving various individuals. Sometimes we started receiving concerns and issues by providers at OLTL since you know we oversee licensed homes we started worrying a little bit about providers. Unlike the skilled nursing facilities many of these facilities

usually don't have clinical trained staff. Without as you all you know without proper training and access to resources, it does become a little bit challenging and difficult for providers to access this type of resource. So one of the things that we were able to do is we knew that there were health systems out in the state already reaching out to many of the facilities around their service territory. And we also know that there were some resources that were being provided to many of those providers. So OLTL along with the clinicians at DHS in each of program officers as well as other operational type staff within DHS started designing and sort of formalizing and capturing what they've been performing and providing to many of our -- of these providers. We also know that we -- there was one thing we really wanted to do and that was leverage what was already existing in our state. And so we reached out to some of the health systems around we

created the ESCCP program. We also knew many of the providers shared their concern with understanding how to deal with this pandemic being that it was coming in very, very fast and obviously not only impacting residents but also staff. And so they were looking desperately for some assistance. The ESCCP program then got created. So if you look a little bit about some of the goals that we wanted to do the program is designed having two different and distinct components. The first component is creating an educational support component to again not only provide training and sort of a centralized area for providers to have access to training and information but it also meant to create a centralized area where they can also access the various resources that are coming out from DOH and the DHS and CDC and PEMA. We partner with the Jewish health care foundation who has done work with nursing homes to leverage expertise and experience in creating webinars but conducting

webinars and providing this type of opportunity for providers. The second component which is very crucial is we knew that many of the -- our providers wanted to get some direct outreach and technical assistance in the clinical side to, again, help them with not only with their residents and also their staff. The ESCCP program what are the things we wanted to do? We wanted to leverage what already existed in resources and expertise and the various resources the CDC released out not only in our state but for folks to walk through and also use. We created a

partnership. Next slide, Kevin. We wanted to make sure when we created this sort of formal type of program was to make sure that the health systems did a number of things. Not only provide clinical consultation, specifically and leveraging their expertise with infections control type practitioners that they had but making sure that they had direct contact with some of our facilities. They already

had experience in doing sort of assessments and sort of providing, again that kind of guidance to our providers and so, again we wanted to make sure that the health systems understood that this was something that we wanted to do and it was a great need that our providers identified. Many of our providers shared a lot of concerns about, you know, how do you access PPE and what do we do with educating again our residents and our staff as well as facility to make sure we understand what we need to do during this pandemic. And finally getting a better handle on how do you access testing.

What do you need do as providers so they are prepared?

>> Next slide? I think what is important to know for the ESCCP program is when we started having conversations with the health systems we wanted to make sure we secured real time support or tele-health clinical consultation for these providers and all of the health systems participating in the ESCCP program agree that this was the kind of support that they were interested in providing and many of them confirmed that they were already doing it. We wanted to make sure that they also provided support and intervention type of processes to the administrators and staff to make sure they can handle not only the pandemic but understand the issues they were dealing and how can they provide and get the clinical guidance and support. When you look at the ESCCP program it aisle say multihealth partnership.

Its a collaboration of health systems covering the entire state.

There are seven health systems that are operating as part of program. Next slide, Kevin. We operationalized ESCCP program. We developed a tracking tool to make sure they did an out reach to all 1200 personal care homes and assisted living. We centralized that information so we can capture it and we know and kept track of various activities. Activities not only about contacting each of the personal care homes but identifying I talked about the fact that we partner with the Jewish health care foundation and leveraging their expertise and experience in developing web nars and educational resources. We establish a learning network which many of you on the call today are participating they've been able to schedule two web stars weekly and they've done 14 with over 1900 participants on the webinars. I think

that tells the story of great need that is out there that providers are really looking for. We are grateful that I think the

providers are not only participating in these webinars but they are actually responding and they are identifying topics and areas to get more information and tap into the expertise that the health systems are bringing in as our partners. We meet with the health systems daily. Similar to the approach we're using with the community health choices program where we work and talk to managed care organizations daily. We use that same approach with the health systems. So every day we get to not only hear what the status is, how many facilities they've reached out to, but what are the real concerns, the trend obviously and it's something that has been validated and that is, you know, the need for more P.P.E. access. The need for more testing. The understanding of what to do as a provider in appropriating their facility whether they have a COVID 19 suffering or not what are the preventive measures to be able to do that. The ESCCP program has been around

over a month and a half. Most of 1200 providers have been contacted. The health systems continue to have follow up conversations with them to make sure that they know that that resource is available. We have also made sure that whatever activities and issues are.

Cog up through the health systems it's if something that need it's be referred over to DOH or prch EMA or CDC we're doing that. We're coordinating those efforts and information. The department of health has reached out to us and said, you know, can we have the health systems also provide additional resource and support to some of our nursing facilities who may not have COVID-19 positive residents or staff but could use some assistance and the health systems have been able to do that. They've done a lot of outreach as well. Again, the daily phonecalls has really helped us make sure that we're connecting all of the activities and all of the things that coming out of the health systems and providers to be able to be more responsive. The next slide really shows some of the best practices that I think the health systems along the with the Jewish health care foundation and us have been able to do. That is making sure we're leveraging resources already available.

The CDC released a tool an assessment tool called the I cart tool we're leveraging. They are using it it's the tool designed to sort of help the individual contacting a nursing facility and asking them specific questions about what necessary steps are you taking to prepare your facility et cetera.

So we're doing a lot of preventative work as well through the health systems to make sure that again the nursing facilities are also tapping into the resource that

we have. Not to say that we're also collaborating with the health care coalition that do exist regionally. It's another resource available to the state. Really the goal of what we've been doing with the ESCCP program is doing a lot of coordination with all of the resources that are already existing in Pennsylvania and making sure that that collaboration is solid and they are all working together and we're sharing information to again provide more assistance and support to our providers. Next slide. I said a little bit about some of the other supports and leveraging we've been able to do. I'm trying to see Dr. Opel are you on the line?

>> Yes, I'm on the line, hi.

>> Okay. So doctor, I'm inviting him to talk a little bit about some of the other work that the ESCCP partners are doing with the work on the eskip under the program.

>> Thanks so much. It's been exciting tow part of ESCCP program. It has enabled the department and collaborators to provide support to personal care homes and assisted living residents just fingertips away. There are some really exciting things that have gone on that built from the foundations of the ESCCP program and are starting to blossom. In the west there are collaborations among health systems and these unique collaborations among health systems allow service coordination between both these two large health systems in the west and also DOH, DHS, local departments of health and other health systems in order to really make sure that needs are being met in real time for the personal care home assisted living residences and others. In the southeast collaborations include local department of health and city departments of health with the health systems and with us in order to again facilitate regional needs very accurately and closely in

-- as close to real time as is possible. Particularly in the southeast this has been very beneficial as they've been very hard hit in the congregate care settings and the large health systems there have provided excellent collaboration with both the local DOH, departments of health and the ESCCP program. In the northeast 24/7 hotlines are available by RNs with sufficient back-up Poe vieding potentials for testing, P.P.E. instruction, video education request SNTs and clinicians. In the central area some unique webinars at that have complicated the Jewish health care foundation webinars have been developed for nursing facilities and they are expanding to personal care facilities as well. So it actually goes further than that. In the western region and in other regions, some of the health systems have taken it upon themselves to voluntarily at times to provide P.P.E., go on site, relationships have developed. Personal care homes are calling back

the health systems on a moment's notice because they feel like they have a clarification or a new guideline comes out or they suddenly have a resident at a hospital returning home and they have the relationship already in place so they feel very comfortable calling. Staff at the facilities has been very supportive. You can go ahead with the next slide.

>> So the areas to support are kind of what we touched on. There are communication and language differences that some of the health systems reported back to us and they've been very innovative. They've about interpreters. They've had language speaking medical residents and nursing students speak. They have understood some of the dynamics related to the time, technology, using iPads and tele-health and also they've developed their human capacity as well. Again, I think the overwhelming big thing they've done is really try to stem that current tide of fear of staff feeling like they are just not safe to go to work. And made the administrators and staff at personal care homes and of course the residents feel more comfortable doing the right thing and staying safe with the confines of facilities. They have intensified their responsibilities and encouraged patients, families and the hospital partners to talking to

the and that has gone on and will continue to go on. We've been active in participating in developing some of the guidances that have come out about testing and hospital partners and when people should go back and discharge instructions and also just having patients feel more comfortable with families and visitation. The other thing that has been done is that this has helped get a lot of different care delivery systems together to form a much more interoperable network. Next slide. As far as recommendations providers seem to be benefiting with the support and now the health systems seem to be moving towards an on-site response or rapid response support. We've heard from a lot of partners on the calls that we have with the health systems. Some have said in the nursing facilities and in the personal care homes that there's a lot of benefit to them going on site to the facilities. So the providers are benefiting from that. That is starting to happen. Another area talked

about is how to use tele-medicine and who should use it and what should happen from a medical standpoint related to reopening. How can some of these facilities residents receive some of the care through tele-medicine that they normally receive when they go to the doctor's office? It's a lot of coordination and outreach between stakeholders. It's been very excited and it's been very, very beneficial to the facilities. Next slide I think. So some other things include public education. This is the in the form of understanding the challenges that these long-term care

facilities face. I think it's news to many that personal care homes are a social model not a medical model and this public education goes a long way to people's understanding and being able to assist and families expectations of visitation as well. Another thing is information exchange. We're working with the HIOs, health information exchange, to provide more realtime information related to COVID

outbreaks and also general care in the facility. We are looking with COVID to develop strong capabilities all the way across for rapid on-site assessments at the facilities when they become vulnerable or if there's a suspicion of COVID-19 outbreak or spread. And also another area that is strongly explored is on site testing at facilities. Right now the department of health has put this out for the nursing facilities but it's certainly being explored at personal care homes in assisted living residences as well. Next slide. So thank you all very much and we are certainly happy to take any questions.

>> Yeah. Thank you, doctor. Sorry, Kevin I wanted to make sure I think it would be helpful to mention that there are seven health systems. They are Guyton, Penn Penn state, temple health system, Penn medicine.

Allegheny health system and UPMC. Thank you.

>> Thank you. Before we jump into questions relating to this initiative, I did receive an answer to the income maintenance or eligibility related question regarding the loss of eligibility. An MA cannot be back dated they'll be given 15 days advanced notice before a benefit is closed.

We're finding that our federal partners they are still discussion how cases will be reviewed and how quickly they need be reviewed after the emergency ends. Hopefully that answers its he will ij yinlt question. We appreciate it and with that I'm going to turn it over to Jill and we received quite a few questions and we start with the specific questions. Are all nursing fashion sits required to participate in the ESCCP effort?

>> Yes, the ESCCP effort is completely voluntary. It is not funded by the state. It truly is say volunteer. It's a good faith of that effort in making sure that we're all doing the right thing and providing resources to our providers. Thank you. The next question is an occupational medicine fansition part of ESCCP team? Are they part of response teams or other collaborations mentions?

>> Yes, each health system assembles their own team and they tap into their vast resources individually. So we don't necessarily have a prescribed constituency of

team members but they've been utilized when appropriate by different health systems.

>> Thank you, doctor. The next questions are more specific to OLTL and the not the ESCCP program. The first one since we're talking about personal care homes is it true that residents no longer need to be recertified to remain in a personal care home and will they just be assessed initially to apply for the state supplement?

>>

>> I'm not sure about the -- we're very, very careful as just as I mentioned earlier when it comes to answering eligibility questions. We want to make sure we're answering correctly on behalf of partners with the office and maintenance and we'll make sure that we get an answer back to the person who submitted directly.

>> Okay. The next question is why is the personal assistance services.

>> We're talking about the fee for service personal assistance rate that was established did theist biewtion -- the region rates were established some time ago and they were largely based on factors that were built into the rate such as staffing cost, insurance, training, et cetera, et cetera. So that the regional rate for the fee for service system reflects regional differences. The community health choices program the managed care organizations may be using the fee for service rates as the threshold but they also have flexibility to develop their own rates for personal assistance as well.

>> If the FBI clearance takes more than 90 days to complete account worker still continue working?

>> Can you repeat that question, Kristen?

>> an F.B.I. screening takes more than 90 days can an employee continue working or begin working? I think it's 90 days -- can they continue working if they were provisionally hired or can they begin working if they had not yet started under the hiring?

>> I believe it's part of appendix K if Jen can verify this. We allowed for the availability or provisional hiring without the F.B.I. screening but past the 90 days is a question that I don't think we have quite yet answered.

>> Past the 90 days it's outstanding we'll have to follow up.

>> Okay.

>> Next question has OLTL considered allowing video conferencing in place of face to face visits for comprehensive needs assistances for service coordinators? Currently we're doing tele phonic assessments only.

>> the answer is yes yes. We're working to talk about the alternative approach and something definitely on the table.

>> Can a direct care worker work if there's a quarantine?

>> [inaudible]

>> the answer to that would be broadly yes in a case by case situation obviously and. They are working themselves and because of exposure it's in the best interest of the person they are serving that they don't continue to work but all of situations are case by case.

>> Next question when residents are up for renewal for Medicaid if the assistance office does not receive the paperwork on time from families, they are being taken off of Medicaid and thus they are CHC plan is there anyway around this?

>> So during the crisis people people are not to be losing eligibility. If they have a specific example please send them our way and we'll follow up with a county office.

>> a long-term care residents newly enrolled in medical assistance are not given a choice of plan to choose. It seems they are auto assigned to one. Sit this correct? How soon can they switch CHC plans and what is the easiest way for the family member to do this?

>> Under normal circumstances this will happen if they don't have the plan. They would be able to make a plan change at any time and if they make it -- make the plan change in the first half of month it's first of following. It's effectist of first of month after that those are informal rules. We look for a period for managed care organizations to be able to minimize the service disruptions that occur when plan changes occur and I believe that that is still something evaluated. As to whether or not it's something we would be able to implement the next question is for ESCCP. Is it only for nursing facilities or can home and community based providers participate as well?

>> As I mentioned before we did start this program as a resource to personal care homes in assisted living because that was the immediate need or initial need and also the webinars at the Jewish health care foundation is able to provide for the past couple of weeks. What we're finding is there are other providers participating on the webinars. It's a good question. It's one I can follow up with the health systems. I suspect that some of them are getting contacted directly by providers and they are reporting out to us whether or not they are getting providers contacting them directly for clinical support. I will tell you as they mentioned they are different in design of internal teams but certainly we can follow up with them.

>> It looks like we received additional clarification on a previous question. If a participant is COVID 19 positive, can the direct care worker continue to provide service or suspend service?

>> Dr. Opel?

>> If the participant receiving home and community based services test positive for COVID can they provide services or continue to suspend services.

>> No, they with appropriate PPE and appropriate understanding that the participant is receiving all the care they need, in other words they do not need to be under more medical attention provided by a direct care worker in a home setting. They can continue as long as, you know, they are appropriately gowned and masks howfer, they need to make sure that the participant is being treated for COVID appropriately. Thank you. And some follow-up on question Kevin previously answered and I think you partially addressed this. They are looking for more detail around the rationale behind stopping CHC plan transfers during the emergency.

>> the rationale is that we know that plan transfer cd often lead to service information issues between the managed care organizations and our risk of service disruptions and we wanted to minimize that during the emergency period. We wanted to.

wanted to minimum Ms. Risk.

>> Thrairchg you next Quebec. Do CHC rates increase every year to account for inflation or fixed for three years?

>> It's a complicated question. CHC rates may change based on -- they've been set during historical utilization and trends for enroll and trends in growth for service plans. Usually it reflects experience. It's not based on inflation.

>> Okay. At this time that is all the questions we've received.

>> Thank you. We'll wait a few more minutes to see if more questions come through.

>> did receive an additional question.

If an employee is positive and self isolating do we still have to pay for 14 days?

>>

I they where need more details to answer that question. Don't you agree.

>> If the submitter could clarify that would be great.

>> Right.

>> I think there's a follow up question is the CHC rate the same as the medical assistance rate?

>> It may or may not be. I mean -- I assume they mean the fee for service rate. It may or may not be the managed care organizations have the ability to noting with providers so there may be some difference in rates.

>> Okay and who will cover the cost of personal protective equipment so prond to COVID 19.

>> Depends on the individual. We've talked about how the participant directed direct care work force receiving PP rch distributions through PPO and CHC/MCOs so the cost of those distributions have been covered for the individual direct care workers for agencies and nursing fashion sits et cetera. Home care agencies it's often the case that the providers themselves cover the cost of prch prch E. In some cases some providers may receive a distribution from either prch EMA or the department of health depending on the level of infection in the facility.

>> a few more follow ups on CHC rates. My understanding is the initial CHC contract term is three years and the floor rate can change. Is the rate next fixed per

the contract? -- rate not fixed per the contract? Rnch they talking about nursing facility services? Did they mention that specifically?

>> That is not clear.

>> Okay. I think we probably need further clarity. There was a rate for developed for nursing facilities for a 36-month period.

That's correct. And that was set -- that would experience after the third year for the southwest region but the 36 months begins at the point of implementation. So it would be three years for phase.

>> Okay. That is all the questions we received but we've received many best wishes for you as you move forward.

>> That's kind to hear. Since we have a few minutes a good news plug. Secretary Miller presented this in the stakeholder call. Tomorrow is the 143rd day of the year and Mr. Rogers as some you know considered 143 a special number. He once said it takes one letter to say I and four letters to say love and three letters to say you 143. There's a tribute for people who will supporters of this type of approach from Fred Rogers where you are encouraged to do some sort of community service or some sort of good work out reach in memory of Mr. Rogers. Keep in mind tomorrow is the 143rd day of the year and it's a good day to do good works in the community. A plug for doing good things. I'll keep it in mind as I go through the day tomorrow as well.

Unless we have any more questions I think we're going to close it out.

>> We have a couple more. Additional clarification. This agency has an employee who is positive and in quarantine. So they are asking if they have to continue to pay the direct care worker while they are not working due to being quarantined.

>> Sorry, folks trying to get back to the presentation here. There we go. Share the 143 day on my screen. Could you repeat the question?

>> Yes, an agency is asking if an employee is not working due to being COVID-19 positive and they are in quarantine do they have to continue to pay the direct care worker for 14 days?

>> That's a tough one. The participants and direct care workers are not eligible for sick time so if it's a participant directed direct care worker and they are not working

the hours with the participant, I would say that the way that the policy reads the answer would be no.

>> Okay. And a similar question, if there's a participant being served by a direct care worker and the participant has COVID 19, will the direct care worker receive hazard pay? To be determined there's multiple providers received augmented care support and it's being reviewed by the general assembly. To be honest, hopefully, yes, I wouldn't call it hazard pay but I consider it a hazard bonus. The hope is yes for direct care work force and other providers.

>> Okay. And we have a question about P.P.E. So partially a statement P.P.E. is not or has not been a requirement for home care services, how can home care providers source P.P.E. if providers are finding it to be -- hospitals are finding it to be a challenge.

>> It's a great question. It's the question for P.P.E. I'm not sure that the doctor wants to chime in as well. Sometimes breaking up its conduct for the department of health can give direction on where P.P.E. may be sourced. As will PEMA but it has been a consistent challenge. It's my understanding that it has gotten better. But it's still far from perfect. I wasn't share if he had anything they wanted to add but that's what we're hearing at this point.

>> the next question, what paperworks or documentation needs to be maintained by a provider agency if an employee or participant is COVID-19 positive?

>> If this is for home and community based provider, long-term care facilities have a different series of reporting requirements associated with COVID positive cases whether it's staff or residents and some cases they reported directly to department of health or some other resource. We encourage them to report to the managed care organizations. The testing and positive test outcome referred to the department of health but by reporting to the managed care will allow for additional documentation as well. I wasn't sure if Jen has anything she wants to add to that.

>> I think you covered it, Kevin.

>> Thank you.

>> If an individual is approved for social security disability and Medicare during the COVID emergency would they also still be eligible for MA or medical assistance during the same time?

This we have to apply for it but -- and they should actually. That's a very strong possibility that they may be eligible.

>> We received additional follow up regarding the 36 month rate period. With the 36 month period in mind for skilled nursing only, is there any -- is the rate fixed for a 36 month period?

>> It could be higher than the floor depending on the negotiation between the CDC/MCOs and facilities themselves. Nursing facilities themselves.

>> the last question is ask you Kevin if the favorite third thirs webinar was your cat joining and meowing during the webinar.

>> Memorable but I have to say my cat has zoom bombed so many different public meetings that he is a lot more famous than I am at this time. No, I've had lots of really good third Thursday webinars. The earlier ones were interesting because the questions before we ask -- developing the questions asked at the beginning. They to help frame how to communicate and develop the program. The early ones I considered impact -- it's a form of transparency and sort of even a watch dog. The kinds of questions people are asking during the third Thursday implementation have helped us to continue to focus on the program to be either reformatted or even to consider how we wanted to approach monitoring as well. They've all been pretty good. We did our best to answer them. Some of them were painful because they were actually pointed out a real efficiency in the approach to the program or something we didn't think of. Those were the most

impactful because of changes. The third Thursday this experience has been one of most important parts of helping the program be -- helping the program be successful and I appreciate all of them. So -- although when Oliver does appear it creates a little bit of buzz. Thanks for the question.

>> That's all the questions we have.

>> Okay, once again we appreciate all of the time people have spent the webinars and I look forward to meeting and talking to you many of you in -- as I move out to the private sector. Best wishes for everybody and please stay healthy during this crisis period. And happy 143 day.