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**IMPORTANT NOTICE - Due to the provider sessions in the Northeast Region on June 4th through June 6th, the Managed Long-Term Services and Supports Subcommittee (MLTSS Subcommittee) meeting scheduled for June 4, 2019 has been rescheduled for Friday, May 31, 2019. The May 31st MLTSS Subcommittee meeting will be held at the Keystone Building, Hearing Room 1, 2nd Floor, 400 North Street, Harrisburg, PA 17120 from 10:00 a.m. to 1:00 p.m.**

DATE: May 3, 2019

EVENT: Managed Long-Term Services and Supports Meeting

>> BARB POLZER: Good morning we would like to get started in a minute.
Let's get started please.
We'll start off with introductions, Jim would you mind?
>> SPEAKER: Good morning I'm Peiffer, Presbyterian care and.
>> SPEAKER: Jim Pfeizer,.
>> SPEAKER: Blair Bore being.
>> BARB POLZER: Good morning Barb Polzer liberty community connections.
>> KEVIN HANCOCK: Good morning Kevin Hancock, Deputy Secretary -- sorry.
>> LINDA LITTON: Linda Litton co-chair, participant advocate.
>> SPEAKER: Theo Braddy consultant.
>> SPEAKER: Jessie Wilderman, SEIUU.
>> BARB POLZER: Good morning any committee members on the phone.
>> SPEAKER: Denise Curry.
>> SPEAKER: Steve Touzell.
>> BARB POLZER: Good morning.
>> SPEAKER: Ralph.
>> BARB POLZER: Good morning.
>> BARB POLZER: I'm sorry?
Did I hear Neil.
>> SPEAKER: This is Estella Hyde. Good morning.

>> BARB POLZER: Good morning.
Any other committee members?
>> SPEAKER: Terry BRennan, from good morning.
>> BARB POLZER: Good morning.
>> SPEAKER: Steve Touzell I don't know if you heard me.
>> BARB POLZER: Yes Steve I did thank you.
All right I'm going read some housekeeping committee rules please keep your language professional. Direct your comments to the chair and wait to be called upon. Please limit your comments to two minutes.
Our meeting minutes are posted on the Listserv and they're normally posted within a few days of the meeting. The captionist is documenting the discussion so please speak clearly and slowly. The meeting is also being audio recorded. And we ask that one person speak at a time. The meeting is scheduled until 1:00, in order to comply with the logistic call agreements we must end promptly that the time. If you have questions or comments that weren't heard, please send them to the resource account at RA-PWCHC@pa.gov the resource account is listed and the agenda. The exit aisles must remain open please do not block them.
Please turn off your cell phones, throw away your empty cups, bottles and wrappers, for the people on the phone would you please mute yourselves?
Thank you.
Public comments will be taken during the presentations instead of just being heard at the end of the meeting there's additional 15 minute period at the end for additional comments.
The 2019MLTSS sub-MAAC meeting web dates are available on the Department of Human Services I want to draw your attention to the fact we need to reschedule the June meeting due to other commitments. So we will be holding the June meeting May 31, and it will be a change in venue. It will be held at the Keystone building on the second floor, hearing room 1, that building is located at 400 North Street.
The address is at the bottom of the agenda.
We do have a new member starting today, William Spotts I don't think he is here at this point.
, am I correct? We welcome him when we see him we'll ask him to say a little bit about himself and, next up is, going to be Linda with the emergency evacuation procedures.
>> LINDA LITTON: Okay.

In the event of an emergency or evacuation, we will proceed to the assembly area to the left of the Zion church on the corner of fourth and market.
If you require assistants, to evacuate, you must go to the safe area located right outside of the main doors of the honors Suite. Oltl staff will be in the safe area with you until you are told to return back into the honors Suite or if you're evacuated. Everybody must evacuate the building.
Take your belongs you with do not operate your cell phones, do not try to use the elevators they will be locked down. We will use stairway one or two, to exit the building. For stairwell one, exit the Honors Suite through the main doors on the left side near the elevator.
Turn right, and go to the water fountain and stairwell one is on the left.
For stairwell two, exit the Honors Suite through the side door on the right side of the room or the back doors. For those exiting from the side door, turn left and stairwell two is directly in front of you. For those exiting from the back door exit, turn left, left again and stairwell two is in front of you.
Keep to the inside of the stairwell, merge to the outside. Turn left and walk down Dewberry Alley to Chestnut Street, turn left to the corner of Fourth Street, then turn left to Blackberry street and cross Fourth Street to the train station.
>> BARB POLZER: Thank you Linda.
We're going to turn it over to Kevin Hancock for OLTL updates.
>> KEVIN HANCOCK: Good morning everyone.
For my updates I'll focus first very briefly on update on quality survey for nursing facilities. Then I'll do an overview of the department's approach to implementing the required electronic visit verification, EVV systems that will be implemented formally January 9, 20, 20 the our partners the public partnership will provide their approach to the delivery of and the meeting requirements for EVV from the consumer directed model, perspective and then, Jill Vovakes will go into the data regarding
community HealthChoices
(laughter.
Okay.
(laughter)
So -- tough crowd today.

So, starting with the nursing facility survey evaluation, so as we have discussed many times in the past, we're using the Medicaid research center based out of the University of Pittsburgh, go Pitt to look at a lot of different aspects of the delivery of care, in the community HealthChoices program. This particular -- this particular survey is going to be focusing on nursing facilities and focusing on four key research questions. The first is, noted on the slide is first the CHC result in greater access to home and community based services shift the balance of care away from institutional settings for people who prefer to live in the community. I'm actually reading these are formal research questions from the Medicaid research center. What it is basing the first bullet is measuring is participant preference, if a participant identifies they want to return back to the community, how well, is that being facilitated by the nursing facilities? Among other things associated with that particular objective. Second is the CHC improved coordination of LTSS physical health care behavioral health care if you remember, with community HealthChoices, individuals who receiving long-term care in nursing facilities were part of the fee for service behavioral health system. They are now with the implementation of community HealthChoices, part of the behavioral health managed care, operations system and, we want to see how this transition with CHC with the role of the service coordinators supporting people in nursing facilities and the role of the facility itself, improving access and coordination of behavioral health services and long-term services and supports it's a really important question for this population. Third question is the CHC improve the quality of care and quality of life of participants in the family caregivers that's pretty straight forward. So, that will be a question we would be asking for any aspect of our program. And then, does CHC lead to innovation in delivery of the physical health and long-term services and supports? Also, pretty much, speaks for itself. The concept of innovation, is -- a little bit broad in this particular type of question. So we're looking forward to seeing what the research devolves the time line for this survey will be online survey open may 1 to 31, 2019, which means it's open right now, resident interviewing pretty much through the summer from May first, earlier this week all the way through to the end of August.

And we will have random selection process for providers and participants and obviously all information will remain confidential and obviously, we'll be releasing and also reporting back to the committee

the results of the survey we're looking forward to the results we're looking forward for it to be a baseline for how potentially these services can be improved and better coordinated for individuals in the long-term care system in Pennsylvania.
Okay.
Any questions about that before I move onto EVV?
Okay.
So, I'm going to preface, Kristen from the Office of Long Term Living will be answering all of our questions to be perfectly honest she has been our project lead from the Office of Long-Term Living perspective, since pretty much, it was discussed, and we became aware of the requirements.
So, I'll be walking through the department's approach and then I'll be turning over to PPL to be able to present their other approaching the meeting requirement physician a consumer directed model perspective.
Obviously, this is a topic of a lot of interest and we look forward to any questions as we go through it. But, I'm going to start by saying, that, this -- is, Federal law.
We do have clear requirements from our Federal partners, not only that we have to do this, but if we don't do this, and we don't demonstrate an audible amount of license for EVV or Federal match for our personal assistant services and RESPIT the two services covered by EVV, are -- that's of it's at risk.
I think statistically of all the services that are received in the community for home and community-based services past services are 78 percent of the total number of services you can look at 78 percent of the services the Federal match for 78er of the services is at risk without our being compliant with EVV.
And I would also like to throw out anecdote maybe a little bit later when I was in Texas last month, and a discussion with EVV in Texas ADAPT it was very interesting. Okay.
So -- the EVV requirement, it is part of the 21st century cures act it is a stated Federal law. The two key dates for EVV implementation are first, for -- what are defined broadly as personal care services, they do have to be implemented this was delayed it was originally January 1, 2019. They did delay a year it is, now required for January 1, 2020 at this point. And then, home health-care services, home health licensed home health services are to be implemented January 1, 2023 with the Office of Long Term Living in some cases with the office of developmental programs the first implementation

date is key. We as I stated, for home and community based services past services or pass consumer care key component for home care, we have been focused or the early implementation the cures acts requires EVV system verify the following I'll read these for the record -- the type of services provided.
Individuals receiving the service.
Individuals providing the service. The date of service, the location of service delivery and the time of the service begins and ends . So there is a detailed record that has to be created, that captures all these elements.
And that has to be tied to any type of service claim, that is associated with the service, and -- what it does, it creates audit trail for each of these 7 variables. And the services that the Office of Long Term Living is focusing on specifically for EVV as noted, are personal assistant services for agency and participant directed. Participant directed community supports and, RESPIT.
So Kristen, anything you should add?
>> SPEAKER: Nope.
>> KEVIN HANCOCK: I'll ask her every single time she is trying to make sure I don't get into trouble. The location requirements is important this is where I'll throw out the anecdote of Texas ADAPT I was very impressed by the Texas ADAPT they entered into a summit meeting for electronic visit verification vendors I a tented and involved the centers for Medicaid and Medicare service Federal partners they rented an interesting case on the concern they have about, location of services.
And, how that relates to EVV they called it geofencing the use of geotechnology which is a term that was new to me until that point. It is a, type of using technology that would be invading the privacy of participants in the program. The case was basically that the use of this type of technology might inhibit freedom of movement for a participant which is something obviously we in the Office of Long Term Living in Pennsylvania, are adamantly trying to make sure that is not going to happen.
But, the reality is, it's not really about location that the argument that had to be clear is it's not about location. It is about proximity and even with proximity which means there has to be a proximity relationship with the direct care worker and with the participant who is receiving the services.
But even with the location there has has to be room for exceptions I

think all of the systems I'm sure PPL will be scribing how their own system will be able to accommodate exceptions, when you go through that, your model of care. But, that was one of the biggest concerns raised by Texas ADAPT clear what they were trying to articulated I appreciated that type of feedback.
The other feedback they focused on was the concern about, obviously we are in a national crisis for direct care workers we just don't have enough to be perfectly honest and we are looking for different ways that we can make sure that, that we can stimulate interest in this, as a type of profession and also to look for ways to be able to, to develop our retention mechanisms for the direct care workers and, some direct care workers part of the Texas ADAPT presentation also presented concerns about the burden this could be on direct care workers and, I think that speaks to the fact there hasn't been enough messaging about EVV how it could make the lives of direct care workers easier when it comes to submission of time and payments and I'm hoping that PPL when they go through their system talk about some of the attributes of the system they're using how it will ultimately, make the submission process for direct care workers maybe not necessitatesly easier straight forward and create a level of accountability that might ultimately reduce potential risks for direct care workers receiving the payments I'm putting all the burden on them.
So just to go through this a little bit. The EVV system will only collect GPS latitude and longitude at clock in and clock out, which means there's a point in time, when GPS is going to be working in the system at least in terms of the requirements. Just, what that translates to is that we're not going to be tracking, it is not really a tracking device. That's -- has been something that's been characterized as a concern and, it really is kind of like a time clock of a -- location based time clock in away that, people will be clocking in and out. It's not really that, compared -- when people are paid an hourly wage not necessarily salary they do clock in and clock out, the concept to me seems to be the same it's a little bit more flexible it uses technology that is usually smartphone based. So there is a lot more flexibility when it comes to how that will be working. So, providers and participants will be able to add and additional addresses to the system which means location will be not be one location will not necessarily be the barrier for flexibility for movement of participants.
If the visit begins and rents outside of any other registered locations, the not create a visit exception, so there are a lot of

different ways that will -- a lot of different ways that, that flexibility will be able to be, be included in the implementation of the program and direct care workers will with their participants will be able to go pretty much where they want. DHS will evaluate the efficacy of the location technology throughout the implementation this is an obvious case it's not just for the, for the department, solution that is being offered, obviously would not be with the solutions being offered by PPL or the CHC MCOs but really any provider technology is part of the evaluation process we want to make sure that the implementation from at least from the Pennsylvania perspective, does not have any unintended consequences we do not want to restrict any movement, for participants, as we talk about the implementation of EVV. That is key point.
>> BARB POLZER: Kevin before we go any further there was a question that came in over the phone, would REZ providers need to implement PVV since PAS is part of the definition of RESHAB.
>> KEVIN HANCOCK: Not at this time.
>> BARB POLZER: Thank you Her mon.
>> AUDIENCE MEMBER: Finish with your bullets.
>> BARB POLZER: Use the mic.
>> AUDIENCE MEMBER: Before you move onto the slide I'll let you finish the slide.
>> KEVIN HANCOCK: I'm done.
>> AUDIENCE MEMBER: Okay.
The second bullet, the questions -- is this quarter mile, something that is part of the Federal necessity?
>> SPEAKER: So the quarter mile is, something that we have established, after looking at what other states implemented early have done. Many states have actually chosen a shorter proximity and, that has been an extreme burden on individuals.
So the reason we chose a quarter mile is to leave that flexibility particularly in rural areas and to account for the inaccuracy with GPS sometimes GPS uses the mailbox for the particular building it would be registering.
And that might not be, carefully close to the building itself.
So, the other thing to remember with the quarter mile is, that quarter mile proximity is for the specific location that the system thinks you're at. There's no limit to the amount of addresses you can put into the system, to be a registered location.
For each of those locations, it will give you a quarter mile proximity, for that location.

Now, if you're not in any of those locations, if you don't know the address of the place that you're at on a given day it's not always easy when you're at a building to identify the address and zip code everything like that, that will still be entered into the system. It will not create a flag and it will not prevent that visit from being processed and paid. The only exceptions that we have built into the system for visits are exceptions, that will create flags when all -- all of the cures act mandated in have gone is not present. So if the location was not present at all, it will be flagged. But if there's a location it will not have any type of flag. If there's no clock in time or no clock out time, that will create a flag. That will be the only time that the visits will be flagged prevented from being fully processed without a correction.
>> AUDIENCE MEMBER: GPS what mechanism, what is the piece of peck nothing that participants are to use to clock in and out of the visit.
>> SPEAKER: So you have a couple of options you can use a land line telephone if you don't want to use a --
>> AUDIENCE MEMBER: Land lines are corrected to GPS.
>> SPEAKER: You can use land line alternative, that's one of the device U.S. do not have to use a GPS you can use a land line telephone as alternative or you can use a smartphone or tablet as long as it can connect to the internet and submit the data.
>> AUDIENCE MEMBER: So to consumers that do not, own a land line or smart device, are you accepting them?
>> SPEAKER: What do you mean by accepting.
>> AUDIENCE MEMBER: Are you providing them a device.
>> KEVIN HANCOCK: PPL will talk about their initiatives which includes looking for opportunities to be able to provide smartphones to direct care workers.
>> AUDIENCE MEMBER: My concern is even if it's the current provider does this, what is the feet future going to entail, what is the are they going to do the services are being provided and paid for and have it -- there seems to be like, there are people that do not have a phone line or you know technology they still need services.
>> KEVIN HANCOCK: Sure.
>> AUDIENCE MEMBER: -- how are you accommodating them? Right now, the State doesn't maybe the provider will.
>> KEVIN HANCOCK: I'll answer two ways people with receiving agency model care the expectation agency models will work with the direct care workers to have the tools they need to be compliant with EVV

requirements.
PPL will go into more detail about this, but they're actually for direct care workers, so -- significant number of direct care workers already have smartphones and, the PPL will talk about how, this specific to the consumer model, PPL will talk about how the direct care worker will be able to load the app how much data is part of the app loading model when it comes to directed care worker that's may not have a smartphone this is specifically direct care workers PPL is going to be working with a couple of different entities that help provide smartphones at no cost, is that correct? And they're going to talk about how they're going to be working with the direct care workers to make sure that, that -- they have the tools they need to be able to to be compliant with the rule.
>> AUDIENCE MEMBER: For the record I would like in the future when perhaps we don't have one provider for FMS or this provider, this initiative is passed along to whoever gets that, because -- we have to have the feature to come. There is no extra money accountable to the attendant if they are part of this system.
>> KEVIN HANCOCK: Can I repeat what you just said to make sure it's clear. At least to me.
So what you're suggesting part of any agreement requirement that exists for any financial management services vendor, that EVV which will be part of the has to be part of it, because it is Federal law they would also, be cleared and demonstrated requirements, that the financial management services vendor, work with the direct care worker to make sure they have a, a tools they need, which may include smartphones or other future technology to be able to be compliant with the electronic visit verification with no cost to the direct care worker or the consumer.
>> AUDIENCE MEMBER: Yes. Thank you Linda.
>> KEVIN HANCOCK: That's fair.
>> AUDIENCE MEMBER: Now --
>> SPEAKER: Friendly amendment, hopefully friendly which it is not only the device but also the, access to data or, I know, folks can use it when they're in a space that has free Wi-Fi I think is good, people can go somewhere and -- my understanding of this is that, we're all clear, if someone doesn't have Wi-Fi service or, at that moment, or doesn't have access at that moment it will still collect the data, when they get somewhere, where they can hookup it will download the data, that's my understanding.

>> KEVIN HANCOCK: Mine too, PPL will go into that wonderful details, but --
>> SPEAKER: That is accurate for the State system as well.
>> SPEAKER: Part of it is, as we think about making this easy for people, in addition to maybing them survive it, is having the resources to have data, on their phone not just the device itself but that's other piece of it.
>> KEVIN HANCOCK: We agree.
>> BARB POLZER: Question over here.
>> AUDIENCE MEMBER: You're talking about the direct care workers being under the Federal law and mandate. Correct?
>> KEVIN HANCOCK: Talking about the services, identified services as being under the Federal law?
>> AUDIENCE MEMBER: Okay so the services are under the Federal law. Okay.
Now I would like to question about S, P services if there's a case worker would that being covered?
>> KEVIN HANCOCK: I'll answer the question the way I think I understand it.
>> AUDIENCE MEMBER: Just one second.
>> KEVIN HANCOCK: Sure. Would a direct care worker, um, counted for support service provider SSP?
>> KEVIN HANCOCK: I don't know of the -- actually, I'm looking at Jen and Patty as well.
I don't know, we include SSP as part of other component of service definitions, so -- would that be part of, would that part of personal assistant services doesn't sound like it would be at this point.
The requirements --
>> AUDIENCE MEMBER: They said it's only for home care for direct care worker I'm just wondering about SSP services.
>> KEVIN HANCOCK: I don't think it's -- SSP specifically, I'm thinking, that -- it is not one of the services we are --
>> AUDIENCE MEMBER: What about a direct, a deaf person who is a direct care worker providing direct services to an individual who is deaf.
>> KEVIN HANCOCK: Okay that's a little different, someone is a direct care worker and providing is personal assistance or the other covered services for EVV, this would apply to them.
>> AUDIENCE MEMBER: Okay.
So all direct care workers are under the Federal mandate and they're

Federal employees?
>> KEVIN HANCOCK: Better way to state it, would be the 3 services that OLTL identified as covered by EVV are, are -- the covered services that have to be compliant with EVV.
So if a direct care worker is supporting those 3 services in any way, they would be covered by -- they would be part of that compliance requirements for EVV as well.
Very.
>> LINDA LITTON: Real response but I'm trying to be clear.
>> AUDIENCE MEMBER: So they would automatically be provided with an interpreter to facilitate that communication if that -- um, consumer goes to the hospital or in a nursing home or they have a vital meeting about their okay? would all those services have an interpreter included?
>> KEVIN HANCOCK: You're asking if -- I think that -- I'm not sure how it relates to the EVV question.
>> AUDIENCE MEMBER: Okay.
For example, I know several deaf individuals who are working as direct care workers.
And they sometimes experience challenges in their job, because interpreters are not provided and in that kind of job, you know they are considered a deaf employee under that Federal mandate.
I think they should automatically be providing interpreters for them to communicate.
>> KEVIN HANCOCK: I agree interpreters should be made available for people who are hearing impaired no question about that and there are communication requirements throughout our system, that would, assure that interpretation, interpreter service, is made available.
I have to say though I don't see the relationship between the implementation of EVV and that requirement I think they -- that requirement is separate, from the implementation of the EVV.
>> AUDIENCE MEMBER: I do want to emphasize that I think it is preferrable, for deaf direct care workers who are deaf, to be working with deaf consumers you know it's direct access without needing the interpreter, that's what we prefer but --
>> KEVIN HANCOCK: Understood.
>> AUDIENCE MEMBER: Another example -- okay.
Go ahead.
>> KEVIN HANCOCK: Okay.
Great.

Hermon any other questions.
>> AUDIENCE MEMBER: Just one.
With the location, let's say that address is the same, would
services being paid and provided if the address put in is out-of-state?
>> SPEAKER: Yes.
>> AUDIENCE MEMBER: Out of the country.
>> SPEAKER: The policy rules for where services can be provided are
not changing.
>> AUDIENCE MEMBER: Out-of-state yes, ought of the country yes?
>> SPEAKER: I think that depends, I'm not sure what our rules are
--
>> AUDIENCE MEMBER: No, services are provided out of the country. >> SPEAKER:
Okay.
They are not currently provided outside of the country even without
EVV. So, no. It would not.
>> SPEAKER: Okay.
>> AUDIENCE MEMBER: Okay.
>> KEVIN HANCOCK: No changes in the location in other words, EVV is
not effecting where people can, or cannot receive the services.
It is, just the requirement for --
>> AUDIENCE MEMBER: Just changing -- and lastly, if people -- if
people that just, you know, now they have been putting in I'm sure it
will be explained in more detail about the electronic time sheets.
Is this going to be double or will this replace the electronic time
sheet.
>> SPEAKER: It will replace it.
>> AUDIENCE MEMBER: Thank you.
And then lastly, quick question one more complicated might be, in
case of a major disaster where the GPS, electronics are gone for --
perhaps 3 weeks,
(laughter)
>> KEVIN HANCOCK: That would be terrible.
>> AUDIENCE MEMBER: If it happens --
>> KEVIN HANCOCK: Can't happen -- yeah.
Okay.
Frightening for a lot of reasons but go ahead.
>> AUDIENCE MEMBER: It is --
>> KEVIN HANCOCK: I don't know how to read a.
>> AUDIENCE MEMBER: I was in Puerto Rico weeks after the hurricane
hit, it was very frightening and dangers forget about getting paid for 3

months the back pay is a --
>> KEVIN HANCOCK: Great example yes.
>> AUDIENCE MEMBER: My point to this is that, when that happens, what are the safety nets prepared ahead of time for, people like me and people like you, and the system, to have some level of preparedness and, for this not to just be another big stop, we're not there, it needs to be prepared hopefully there's some language before that, before EVV is put in place and lastly, you said, it is going to be in place by June 1, but, does the State --
>> KEVIN HANCOCK: January 1st.
>> AUDIENCE MEMBER: January 1st, no the this year?
>> KEVIN HANCOCK: January 1, 2020.
>> SPEAKER: We have a soft implementation date we'll get into that time line to speak about your question of disasters even in a lesser disaster situation, maybe what you're referring to, if for any reason, for a week or two weeks or you're getting to the end of pay period and you're unable to enter that information, for whatever reason, we will, always have an exception process to where you can submit a time sheet through the online portal, through PPL you can submit a paper time sheet if you needed to fax it in, what you're reserving to, you'll not have being is he is to your computer or your fax, whole other thinking. But, we have to establish as a state, what we expect as far as the percentage of visits, you have each month, that are entered on EVV. And, how much of those visits can be acceptably entered in an alternative format we have not done that yet we're carefully considering and looking at experiences what would be a good percentage for that. But there will always be exceptions because we understand, phones break, they call, and you know lakes or whatever, may happen.
-- so --
>> AUDIENCE MEMBER: That specific, that specific is when we would love to see the numbers when you have them.
>> KEVIN HANCOCK: Okay thank you.
>> AUDIENCE MEMBER: Thank you.
>> BARB POLZER: Question from the phone.
>> KEVIN HANCOCK: Great.
>> BARB POLZER: Based upon the requirements of EVV, the cost to providers will increase significantly.
Has OLTL given any thought or consideration to increasing the minimum rate that MCOs must reimburse providers for PAS services? The current rate, in the southwest is 17.52 an hour. The margins on

this rate is Nill, to date the MCOs are not willing to negotiate rates.
OLTL must intervene on behalf of the providers many of whom are
non-profit agencies who provide PAS services and fill the social void
that for profits entities would not be willing to enter the market, of
PAS because the rate is so low.
>> KEVIN HANCOCK: So I appreciate the comment.
I will have to make the statement again, that in this particular
budget cycle, the only increase we have for any of the long-term
services that are over seen by the Office of Long Term Living and
obviously this is, in the fee for service system are for increase in the
Governor's proposed budget to accommodate the minimum wage increase for
personal assistant services and direct care workers otherwise we had no
other baked in increases for any of our long-term care providers.
So that's the affirmative answer. But, do very much appreciate
the comments and, obviously it's something we'll continue to monitor.
And the managed care organizations are also very much aware of the
requirement, as well, they are required to be able to accommodated it
as part of the agreement, they're all very much in flight for
implementing their own EVV systems and requirements. My strong
recommendation to that particular provider is to have conversations with
the MCOs with which their contracted to talk about the -- the burden of
implementing EVV, or the -- any financial constraint that may exist.
And, talk about what, the managed care organizations would be able
to do to help.
I know that all 3 managed care organizations are offering a solution
for EVV and, could be that working with managed care organization on the
solution might alleviate some of that financial burden again I
appreciate the comment.
Okay.
>> SPEAKER: Kevin -- this is Tanya I have a question really
quick.
You guys mentioned something about what we get flagged earlier. As
an employer, is there going to be a way for me to go back in and fix it,
if something does get flagged if someone forgets to log out, and how
long will it take for like flagged issues, to be resolved? When
someone forgets to clock out, when they're done with their shift, will
they still get paid in that same time frame or, will it take longer for
that day to be processed? What can do we have to go through.
>> KEVIN HANCOCK: I'll turn it over to Kristen to answer in much
more accurate detail thank you Tanya.

>> SPEAKER: As the employer, you will style have to approve the entries submitted you can do that every day, as they're entered or you can do that at the end of the pay period it's absolutely up to you. When you go into the web portal to approve those time sheets, just like you would today, it will present any visits that have a flag that need some type of correction. So, if it is missing a clock out time, because the worker forgot, it will flag that for you and you can modify that, right then and there. You can do that the day of.
It is almost near time transfers information in almost realtime the only reason I hesitate to that is based upon internet access. You'll be able to change that and when you edit that and you sign off and submitted that time sheet, it will continue on the time sheet process just like any other time sheet.
PPL will get into a little bit more about kind of why that will ease some of the process going forward.
>> KEVIN HANCOCK: Okay.
Thank you Tanya thank you Kristen I'll try to go through --
>> SPEAKER: Just a quick follow-up to that. So -- if -- will the employer consumer agency employer, have ability to make a change to time sheet without notifying the direct care worker if someone says this one, this is screwed up the person didn't clock out, didn't clock in or something happened or -- for some reason the wrong hours, someone didn't clock out until they got home, there's how will the direct care worker be notified that in case there's a disagreement about modification to their time sheet so to speak.
>> SPEAKER: I think that's going to look a little bit different, differently depending upon which system we're referring to and the scenario. So, um as far as, edits, that they would make after the fact, without -- rejecting the time, PPL will have to speak to what that is going to look like. If there's a disagreement with the worker enters time and the employer disagrees with it completely they will reject that . And that will bounce back and notify the DCW that it is rejected.
>> SPEAKER: So but the direct care worker will be notified if time is edited or rejected? You know, my concern is, frankly less concerned about consumer directed side than the agency side, someone said wait a minute this person wasn't supposed to work they were supposed to clock out, at this time and they waited an extra hour and clocked out, actually in normal situation, if you work the hours you got to get paid even if those hours were you know, the agency can come back and say you're not allowed to do this they cannot pay you for the hour you worked.

Would this system I want to make sure, that people can't make edits to the system without, direct care worker, being notified about it and understanding that, so they can, if they have concerns, raise those concerns.
>> SPEAKER: So for the agency model side, only agency staff will have access to the back end of the system to make edits to do analytics that's really for privacy purposes.
But the direct care worker in the app will still be able to view their past visits I think at the moment for the state system, it is ten days. They will be able to review the past ten days I think that's the maximum that we were able to do with the app.
They can go back and review the last ten days and verify, if it had been changed but there will not be a formal notification of changes.
>> SPEAKER: Yes. So -- that may be something we want to take a look at because I can foresee a situation where I think it happens fairly regularly where someone will, work a little bit of extra because, you know, one reason or another that happens and then, someone says wait these are not hours -- so the first time the direct care worker figures out it is happening when they get their paycheck it's short hours they thought they had worked.
And that will -- obviously create a whole process around how we can try to get that, those resources back.
>> SPEAKER: It's a complicated scenario the visit itself, has to match up with the claim the provider is going to submit.
So if the worker, worked more hours than were authorized on the service plan the agency is still responsible for paying their worker the time they worked.
But they cannot submit that EVV visit, for more time than is authorized on the service plan.
So, that's where this gets a little complicated the visit itself would have to be edited to match with the authorization for the agency to get paid, but that does not excuse the agency, from not paying their worker for the time worked.
>> KEVIN HANCOCK: We know where you're going with this Jessie.
>> SPEAKER: That's my concern, is we'll end up in a situation where agencies are because they have the ability to edit, they can go back and edit, and say, sorry you were -- the person actually worked. So I get a lot of people saying, I worked this and maybe I shouldn't have, I still worked it, by law you have to pay me for it. So it seems like there needs to be some way to if the agency has total carte Blanche to

edit where they see fit that will be challenging.
>> SPEAKER: Yes. Well, we'll work on it.
>> KEVIN HANCOCK: Might be part of the communication we have the agency and the deployment of this.
I'm not a lawyer but, what you're describing, sounds to me like a violation of the fair labor standards act. So obviously we want all of our providers to be compliant with the law that is not a legal opinion that is an opinion
(laughter)
So -- okay.
All right. I'll -- unless we have more questions I'll go on, Kristen answered a lot of the questions, in the presentation I think I'll be able to go through some of these additional slides fairly quickly. So, what DHS is doing in terms of a model we are, using a model that is tied to our Medicaid managed informs MMIS or promise. The entity, which you described a little bit later, is going to be used both as an offering for providers that may not have their own EVV system and also, as a repository for the audible records that will be sent in by providers as well as the managed care organizations it's going to be our source system, of record for EVV.
Is there anything you want to add to that
>> SPEAKER: Nope.
>> KEVIN HANCOCK: Okay.
And moving on -- here's a little bit of the time line, we'll be sending out, frequently asked questions I can't wait to see them. Technical specifications which means providers will know the file layout will have to look like, for what has to be submitted to the department to demonstrate they're in compliance with the EVV requirements. And also addendum, to distributed providers to provide background information, technical specifications are the file layout as well as, some specifications for how submission will be managed. From August through October, provider training that is offered and that I believe we're going to be doing direct care worker training as well. On the submission and use of EVV, and if providers are using their own system, they should be working with Sandata and testing and certification of the process. So the -- for the providers in the room I would equate this to a much simpler type of claim submission in other words. If you've ever had to do claims testing with the managed care organizations or with the department I would see this as being similar a much simpler file layout we'll have a soft launch it's now, October, if

I'm not mistaken, providers will be able to start using Sandata in September but the soft launch we're asking for providers to start with compliance in object we'll use October through December to shake out any issue with the others with the department system and the submission process itself.
So we'll be ready for a January 2020 full implementation.
So next slide we already kind of talked a little bit about Sandata will be using a mobile application as well as telephonic, Kristen went into detail about that.
>> SPEAKER: Real quick on the soft launch will that only be in the CHC counties or fee for service counties?
>> KEVIN HANCOCK: Statewide I believe.
>> SPEAKER: And then for --
>> SPEAKER: So there's a little bit, there's a little bit of a caveat to our soft launch when we refer to OLTL fee for service counties so, for individuals providers, for agency providers, currently serving individuals under the attendant care or independence waivers we'll be transitioning January 1, they need to be working with the MCOs this fall to do testing and training and be ready to use the system on January 1st.
They unfortunately will not be be able to take advantage of the soft implementation with the managed care system beforehand.
So that's what they need to be focusing on. We are not expecting providers in OLTL fee for service programs to implement a fee for service system in September through December.
Unless they are serving people ongoing in Act 150 and OBRA waivers will be continuing after the full implementation of CHC.
>> SPEAKER: Thank you.
>> KEVIN HANCOCK: Thank you for the clarification. So just, touching on EVV provider training.
So the training models offered, it is I guess we'll be allowing two attendees from each provider agency is that correct for the in person training formats will include classroom training obviously.
Webinar training, self-paced training and additional resources and -- as noted on this slide, there is a link to where daytimes and registration instructions are available. So we encourage you to take a look at that at least, if you're a provider and you certainly want to learn more about EVV. So -- next slide, shows the CHC approach to EVV.
So for providers working in the active CHC zones, first of all you want to contact the MCO which your networked to, to find out their

approach. But providers in CHC have the option of using the MCO internal EVV system which I believe for all 3 of the MCOs is HHS exchange at the current time.
And the MCOs can answer that question for you'll want to work with the MCO for the submission requirements for that as well I manage it will be similar a standard file layout they will use and provide submission instructions to be able to send in that audible record.
And then, you also want to work with your MCOs how they will be offering training and systems options as well.
For the final phase I think Kristen you went through what the requirements are as well. So, we're trying to make sure that, there isn't too much of a headache for providers going through the final phase with an overlap for E have, V we're also recognizing it's going to be a challenge for those providers going through a, a -- Federal requirement change for EVV as well as, a -- a payment systems change with managed care.
We're going to be covering this in much more detail for providers that are part of phase 3 in the provider session that's are going to be scheduled starting actually the week after next, and, we do have a break out session for home and community based providers for EVV is discussed so FYI.
So PPL will be going into much more information about participant directed service in EVV it's a requirement for them as well as the agency providers and the CHC MCOs, PPL will be providing the detail there.
But before I hand it over to them, are there anymore questions?
For Kristen
(laughter)
Just kidding. It's Friday. Geez.
Must be raining out, that must be the reason. Okay.
>> SPEAKER: And we also listed the DHS RA mailbox if you have any questions after the meeting, that is the email that you can send questions to, we'll be able to get back to you.
>> BARB POLZER: Okay we'll turn it over to PPL, we have Terry Resser and Miranda list and a Colin, welcome.
>> SPEAKER: I'm Terry Reeser I'm the account manager my co-presenters Melissa and Colin Thomas a senior account specialist. Our topic for discussion today, we're going to cover the overview of the PPL EVV solution we'll talk about training topics.
Our implementation time line, as well as some are alternative

solutions to the EVV.
Which includes life line program as telephony, now, PPL solution is app called time 4 care. This is
fully compliant with the EVV.
It offers multiple, some nice features one of the features is this
sign on you create a log in through the application or you can create a
log in through the PPL web portal.
It works with any mobile device or tablet GPS enabled device.
Another feature it has a calendar easy to use screens when you log
in, with EVV, there's going to be a one button sign log in and one
button log out.
The app includes a privacy touch ID for secure unique log in
access which is bio metrics of fingerprints.
It also pops up reminding direct care workers about their time sheets,
and it also will provide a reminder to the Commonwealth employee or
participant to approve the time sheets.
Next slide please.
The app is available for iPhone or Android through the app store or
the Google play store and this is just a picture of what the phones look
like.
Next slide are the highlights. The app is a free download.
There's minimal data usage with the PPL time for care mobile app.
On average, it takes about 2.25 mbs per month, for a direct
care worker, working two shifts her day.
Now, that's equivalent to someone visiting a web site. A single
web site. So it is very low data usage.
And it also works in offline mode. The way that works to be EVV
compliant it will capture the time clock in or clock out and at the same
time it will capture the location and the services that have been
provided.
And when an individual connects to Wi-Fi, it will up load that data
into our system.
And also, if an individual has no data remaining on the phone, depleted, it will connect on Wi-Fi or connect when the data service becomes available. The system
is configured for dual log ins, there's a unique log in for the direct
care worker and also a unique log in for the participant.
Next slide.
Okay.
I would like to mention a few things about our trainings for
Commonwealth employers. Our training will include an over all

utilization of the time for care mobile app. Including how to download the app, creating the user profile, if they don't have one. And then how to approve time sheets or reject the time sheet.
One of the questions earlier is what happens if a time is incorrect. With our system the participant would reject that time and it will be corrected by the direct care worker and resubmitted.
And also realtime integration, with our better online web portal.
It will accommodate any exceptions due to maybe a missing clock in, clock out or any other issues.
We are planning to have training videos available on our port toll, when an individual logs in to our system.
Now I would like to look at the direct care worker training.
The direct care training will include an over all utilization of the app, how to download it, how to create a user profile. The various methods for time entry, and for direct care worker how do you modify any time and if they do see an error, or they forgot to clock in, they can clock in, when they remember and they can add a note. It also integrates with our better online portal.
Now as far as the implementation time line, in June, we will start communications to the participants and the direct care workers.
And then in July, we will, the training will begin. We'll be doing a combination of, of online training, and in person training.
In October will be the soft launch as Kristen had mentioned and then January 1, is the full implementation of the EVV.
Now, I would like to talk about our alternative solutions.
The first -- the first alternative solution we have is we have an arrangement with life line where we will help facilitate a process to work with the life line for individuals that do not have a -- have not taken the advantage of the Federal benefit.
And to qualify for the life line we have to be on SNAP, Medicaid,SSI, the Federal public housing assistance pack, the veterans or Tribal programs what PPL will do through our customer service will be train to work with direct care workers and participants with the life line enrollment process to help them get their phone.
Now it is important to note it is limited to one phone per household.
So, if the participant or the direct care worker already has a phone through life line they will not be eligible for a second phone.
We also have a telephony option that will be available. This option will capture all of the six required data elements. And different users can use different options they can use the mobile app or

the telephony or use a combination of both.
The telephony option will -- an individual direct care worker participant will need to work with us in advance of using the telephony option. And then what we'll do is we'll verify the addresses and we'll need a land line. We'll configure that into our system.
And then, in order to use the telephony system the direct care worker will clock in and clock out using a toll free telephone number enter a unique ID. They will verify the participant for whom their providing services for and then they will follow the prompts for either a clock in or clock out.
And the options available to the participants will be, to they can approve their time sheets via the Telephony system to do that they're going to enter their own ID and they will hear all the shifts -- that are available, that they need to review for approval and they can either approve or reject an individual shift or the end hire time sheet.
Now I would like to open up for questions.
>> SPEAKER: Yes, I would like to ask question, this is Juanita Grey , with the life line system, they don't allow you to have internet with the life line, am I correct or no?
>> SPEAKER: Yes. There will be internet with the life line program, there will be facilitating with participants and direct care workers will have internet data capabilities.
>> SPEAKER: Okay thank you. Thank you I like that. Thank you.
>> AUDIENCE MEMBER: Thank you.
I have a question.
>> THEO BRADDY: It may be more for Kevin.
With that same time line of implementation of PPL, will EVV with phase 3, who is going to be in charge of that? Would it be a combination of OLTL and managed care organizations? Following that same time line she just described for EVV, implementation?
>> KEVIN HANCOCK: So, just to clarify your question you're wondering who is going to be supporting providers in consumer directed workers for phase 3EVV.
>> THEO BRADDY: Agency model.
>> KEVIN HANCOCK: And consumer directed model, Office of Long Term Living will be working with providers and PPL for the implementation. But, we expect managed care organizations to have engagement with providers for their training to know what they need to do to meet the system it's a shared responsibility with the way I would say it, ultimately, it accountable entity would be us.

>> THEO BRADDY: We'll be getting notification from -- the agency models from you OLTL.
>> KEVIN HANCOCK: I would think yes.
>> SPEAKER: Our soft launch in October will include all the participant direction consumers and direct care workers.
>> THEO BRADDY: I got you on that, I'm thinking about the agency model.
>> SPEAKER: For agency model we will be -- we have set up a unique EVV Listserv we have also set up a EVV web site on the Department of Human Services web site that will be constantly updated with the most recent information and we'll be sending all of that information out on the OLTL provider Listservs as well.
>> THEO BRADDY: Thank you.
>> AUDIENCE MEMBER: For individuals who are participants in CHC, but also, have serious mental illness which in times include dilution al beliefs and concerns of a paranoid nature regarding electronic intrusion into their lives are accommodations made for that or way those prepare the consumer, in some way that will hopefully not involve, ramping up that psychosis in that process?
>> SPEAKER: So Telephany is the ideal option particularly if there are concerns about privacy and GPS.
And, there is -- absolutely the option for combination, depending upon the day and what that individual's preferences are, they could choose to have either the app or the Telephony based system and mixed between the two.
>> AUDIENCE MEMBER: Thank you very much.
>> LINDA LITTON: My question goes back to one telephone per household.
What if you had a house and a wife or -- whatever, it would be -- two people living in the same household, each person doesn't get that option to have a phone?
>> SPEAKER: Thanks for that question Linda.
So, these are we added notes that those are the requirements of the Federal life line program. So they dick indicate that, it is one phone through that program per household.
>> SPEAKER: Just couple additional clarifications to that, um, both husband and a wife, could use the same phone so, one could have if they have two workers, they could have each of their workers logging on the same phone.
>> LINDA LITTON: What if they wanted to speak to each other --

during whatever, activities they might be doing?
>> SPEAKER: Only time, so they would still have complete use of
their cell phone it would literally just be for however long it takes
the 30 seconds or minute it takes for the worker to clock in, they close
that app their phone is, once again functioning and they can use that --
>> LINDA LITTON: Okay but -- I'll just drop it.
>> SPEAKER: If you can give me more information --
>> LINDA LITTON: I was saying that if say, the husband and wife
went to Walmart and he is on one side of the store and she is on the
other -- and wanted to just, text -- you know, information I'm over here
by this, do we need it, whatever.
So, there's only one phone per household that's what I was saying? >> SPEAKER: In the
life line program.
>> LINDA LITTON: Okay.
Thank you.
>> BARB POLZER: Blair?
>> SPEAKER: Hi. With the time for care app and the clock in and
clock out process, is that -- only done by the direct care worker or
does the participant have a role in needing to verify that clock in and
clock out process?
>> SPEAKER: The participants role is to approve the time sheet. They
can approve either a single visit one at a time or the entire time
sheet all the at once.
>> SPEAKER: Okay.
So, through that process, should catch if there's any situation
where the clock in and clock out, someone is in the driveway for 20
minutes when they got there earlier that should be caught for that.
>> SPEAKER: That's correct.
>> SPEAKER: Thanks.
>> SPEAKER: Just a couple of, comments on this, sheets tended -- because they didn't
do something right, how many
adjustments are being made to time sheets how many workers are
out of compliance with using the system. As we have gone through the
transitions before the consumer directed side whether it was transitioning
to a single FMS none of us want to go through that challenge again or
-- um, the -- implementation of over time.
I think we all know this is a high stakes transition.
Because, it is these are low income folks workers and -- um, when
their time sheet guess pended for one pay cycle it can cause major
disruption in people's lives. So, during this soft launch trying to

measure in realtime how we're doing to be able to say in this situation, 3,000 people would have their sheets pended, what would that mean when we get to the full launch we I know that's the intent of it. But -- being able to, measure those, that data, and realtime will be useful so we can try to solve those problems before it's actually, people's money and then, once we go live, you know, in January, I think, having a way to almost have a -- um a dashboard to help solve those problems quickly would be super useful that's maybe all part of the plan all right.

>> SPEAKER: It is, Jessie if I may respond to that, Kevin mentioned earlier the advantages for the time 4 care APP and EVV one one ever the advantages is realtime capables the goal is for realtime workers to know what is going on not to have surprises because it will be realtime they will be able to see if their time sheeted is pended, they'll be able to see the reason why, no more faxing in time sheets and waiting a week or two, to find out what perhaps is the reason for the delay.

Um, they will be able to see it right on the app.

>> KEVIN HANCOCK: Just to speak for the department we agree with you completely. This, the biggest risk of implementation like this, any type of technical implement is the disruption of payment for providers or direct care workers. So -- the reason for the soft launch is to do exactly what you're describing to measure and, also to make sure, that if there's any, risk of disruption of, payments which is the -- the worse possibility outcome that it could be adjusted, as quickly as possible.

We did plan this project, in Pennsylvania, based upon a lot of experience from other states we talked to Ohio for example. And Ohio actually did have a problematic launch for EVV. They implemented early. So we their lessons learned and we were able to incorporate those lessons learned to get ahead of the project we've been in communication with other states as well that are going through this process right now, Pennsylvania has a pretty good plan and part of the plan including the soft launch is a lot of realtime monitoring of how it is actually working not just for the participants but the direct careworkers and the compliance with the law.

We were absolutely committed to making sure this is not something that will risk any disruption of appropriate payment or direct care payment as well.

I'm sure you'll let us know

(laughter)
>> SPEAKER: We will. Um, I appreciate that and, just, then one other thing to switchgears for maybe the committee to think about and for us to think about I know the first phase of this is surviving the implementation of it, which hopeful little we'll be able to do, but, it is speaking to something Hermon raised earlier once -- one of the challenges of the work force it is very disbursed and so, it is hard to get information whether it's the transition to CHC or the you know, implementation or EVV or any changes that happen to the system, getting, to work hes up to speed what is happening is always a challenge. And the fact that we'll at some point, you know if we do this right, most people will have a smartphone where we have a direct way to communicate with them, about things that are going on, that they may need to know about. Thinking about EVV not just as a, clock in and clock out as a way to help engage and empower front lines, so for example the -- the example Hermon was using disaster that happens and people need to have some critical information quickly about how to deal with something, they have a app on the phone we can communicate with them to say here's you know, here's the resources you you can have available those kinds of things.
I know that's a phase two kind of idea, but, making sure we can use the technology that we're requiring people now, post people are requiring to have some version of it to also, lift up the work force and provide them, information, and -- um, things that will, empower them and help them you know, to complete their work successfully, to be sort of a phase two thinking about that. That is in my mind that's the other side of the EVV the opportunity side of EVV opposed to just meeting the minimum requirement.
>> KEVIN HANCOCK: We're definitely going to be looking for secondary benefits of the tech nothing that's a great point thank you.
>> SPEAKER: My name is Shaylin from north central PA ADAPT I have a few questions first clarifying question the unique ID for PPL support workers.
That is going to be one ID per person not based how many consumers you work with, as it has been in the past, is that correct?
>> SPEAKER: That is correct.
>> AUDIENCE MEMBER: Thank you. And I have a question about the location and when you're offline and if you're capturing that offline, if you go back online and you're not in that same location, are we sure that is -- it has captured that offline location since it's offline and,

we're told it needs to connect to the internet to capture that?
>> SPEAKER: Yes the location is tracked, when you clock in and when you clock out.
So it's at that location, at that moment.
>> AUDIENCE MEMBER: Okay.
And, it was offline is what I was talking about specifically.
>> SPEAKER: Just, to clarification on that, and -- may or may like this about your phone, but your phone actually the GPS function does not function on the internet.
So, it will not need that.
>> AUDIENCE MEMBER: Got it, the clarifying question, or follow-up, to what Linda brought up about the people living in the same household a consumer and the worker, that consumer can clock in and then, the worker can then approve after on the same phone in the same house obviously the same house?
>> KEVIN HANCOCK: Isn't the other way around.
>> AUDIENCE MEMBER: They can use that same phone for the same purpose?
>> SPEAKER: Yes. So the consumer and the worker can use the same phone, and the consumer, if they're a common law proper could have one tablet or phone in the house all of their workers just clock in on that, it is up to them or they could require their workers to of their own phones.
>> AUDIENCE MEMBER: Thank you. One last thing I was thinking about, that Jesse alluded to is over time hours we're seeing already, with the roll out of the MCOs the authorization of hours if it doesn't show those over time hours the authorizations are not happening.
I've personally experience the that as a direct community worker.
That my full amount paycheck was not get provided to me because those organization are authorizations were not being made for the over time hours what are are we doing to ensure the people using their over time hours regularly those are a safety net some people use them on a regular basis, um, what are we doing to ensure that those authorizations are happening quickly efficiently, and correctly?
>> KEVIN HANCOCK: Do you want to talk about that? Maybe PPL may want to answer that question from a technical perspective I'll answer from a policy perspective if that's all right. We do believe, getting back to the point that Jesse was making earlier people need to be paid for the hours they work over time or otherwise it's the law to be perfectly honest that will be something we would, we would want to make

sure that is -- continuing.
From a policy perspective though just in terms of over time, over time should be the exception. So when the department communicates, the issue with over time, over time, we do, have a growing concern about the number of hours of over time the direct care workers are actually logging in, it's not as much a health and safety issue as it is anything else.
We are concerned -- normal workweek is 40 hours.
There will always be times when people have to work more than those hours when it comes to this type of work because it is not you don't schedule this type of work. So, but there's also reality that someone is logging, 65 to 80 hours every week, then, you know they're going to not -- risk at being burned out there's a real health and safety risk for participants. Over time from our perspective should be the exception. We want -- we want people to be paid for the hours they work. But from a policy perspective over time should be the exception and it really, and it is obviously challenged by a lot of factors not the least of which is we don't have enough direct care workers to be able to do that the work. We know that, but -- as we go forward, with the addressing some of the issues we have with the direct care work force over time from our perspective for
the those involved, should be the exception.
>> AUDIENCE MEMBER: I would like to hear from PPL to your point Kevin it's concerning because we have a lot of direct care workers that live in the home with their people that they work for. And, they are using those over time hours because there aren't a other attend wants they don't show up they're not getting paid enough to do the work they're doing the hard work it is. He's just -- that's a little bit concerning I hear what you're saying but, I just -- I would like to hear more from PPL as well. Thank you.
>> SPEAKER: The EVV compliant mobile app will work the same as it is today with the mobile app or the E-time sheets, pay time sheets aces time sheets are submit they had are tested against our business rules an in authorization must exist, for regular and over time hours in order for the time sheet to clear for payment.
>> AUDIENCE MEMBER: Okay thank you.
>> SPEAKER: But just -- to add one more thing again with EVV, the worker will be able to see if there's an issue you can get ahead of it and contact PPL we may assist.
>> AUDIENCE MEMBER: Thank you.

>> BARB POLZER: Matt?
>> AUDIENCE MEMBER: Something I'm not -- I'm not clear on.
The quarter mile pinging or whatever GPS whatever you call it.
That's a quarter mile of the residence or quarter mile of the participant?
>> SPEAKER: So it is, it is a quarter mile of whatever registered locations you have added into the system. So, if you have your home residence in there as a place you regularly decree care it will be quarter mile of that residence, if you have unlimited amount of locations in the community, that you regularly visit your worker is clocking in and clocking out at that locations you have those in the system it's a quarter mile whatever -- whatever location you have as the registered location for that visit.
>> AUDIENCE MEMBER: Well I'll give you hypothetical going back to Linda -- when you're talking about going to Walmart.
So I have a 7 to 10 shift whatever.
And I want my direct care worker to meet me at Walmart at 7:00 p.m., or wherever I want to go, how -- that's not a registered location.
>> SPEAKER: You have two choices if that's something you regularly do, you could add that as a registered location.
If it is not, it is just a one off thing, your worker can still clock in, the location will still be, entering and, recorded and it will not inhibit payment at all.
So we don't want to require you to have to enter every time you go to a different store.
>> AUDIENCE MEMBER: Okay.
Thank you.
>> SPEAKER: One thing to add the PPL app will allow you to enter some notes about that location.
So that gets recorded along with the service.
>> BARB POLZER: Sir?
>> AUDIENCE MEMBER: George Gilmore, this might have been discussed before, but if I could ask you to reiterate it.
There's just attention in the news lately about children what delays them in learning.
And a lot of that is, dyslexia.
So there's a huge amount of people that really never caught on because of their dyslexia that is now notated in primary education.
They're just implementing those things. And those are markers for people's success for later in life. Now, go forward.

We have all of these workers many of them, may be dyslexia, ADHD, et cetera, et cetera.
Even blindness.
So now, we have people that don't know how to smell. They trans pose number, they transpose things we'll put them on an app that we're kind of like destined to have information that does not seem to be quite straight forward how are we addressing that?
A great percentage I've had attendants for too many years I find not to be able to put all the pieces together.
Now we're negating that population as those that are going to do these jobs which typically are there I will not say typically often they're there because they could not make it in life in other things.
And driven to this, as a last resort. How are we going to appreciate this population and what we're doing thank you.
>> SPEAKER: Couple things on that, is the first is that -- every system, presentation I have seen by every EVV vendor is always emphasizing simplicity and usability in the system. So -- to start there, in addition to that simplicity, part of the reason that we plan this soft launch from October to December after the training has occurred, is so that we can look -- we can look from an analytic perspective and see okay on PPL side what workers does it look like are struggling with the system they're constantly having to correct the information, the information is constantly being missed and then on the agency side we can continue to do the same thing where we can look and say okay, who needs additional hands on support?
Who do we need to reach out to see are you having an issue with this because you're struggling with the system, itself you don't know how to use it, are you having an issue with this because you're not having consistent access to the proper technology? So we have that time period to look before the pressure is on for payment come January 1st. To look and see, an offer hands on support for the individuals who need it.
>> LINDA LITTON: Do you think between you and your -- your care person that between the both of you because you have to authorize what they put in so you would kind of catch it if they had this dyslexia.
>> AUDIENCE MEMBER: If I may, right brain thinker and left, ADHD and Dyslexic myself I'm checking the number and strands posing letters from different lines I have a worker that's doing that too, okay.
I might not be the fail safe. So once again we have an issue.
Phonetics is what they're teaching children now it is not just

letters and numbers. We have to put all of the things together, Phonetics we'll go back to young brains retrain them these are older people.
How are we going to recognize, this may not happen? happen? Paragraph our brains are matured at third grade we're
patterned we're set.
>> SPEAKER: So I think we, have to consider this a learning experience as we go. We will always have exceptions, to where if the individual needs it, they can enter a shift, through the telephone or they can enter it on the web portal for an exception. But we're going to have to, this is a learning experience we're all going to have to work through this and, when we see individuals who are struggling we'll have to provide them additional assistance.
>> KEVIN HANCOCK: Only thing I would have to add to, Jessie's point, we have to monitor the roll out, to see if there are any issues have to be addressed for whatever technology is being used I think you're raising a important question for cases, hopefully that have to be addressed, but, maybe more cases that are on the margin compared to so we're building up a project meeting the requirements, taking into consideration the general view of how this has to be implemented. But there are always some specifics that have to be
addressed when it comes to individual population requirements. The soft launch will identify some of those cases but throughout the life of this, this meeting this requirement, we'll probably learn a lot that will have to require adjustments work with our Federal partners to be a little more flexible in away that we're meeting the requirement that they're specifying so really good point.
>> AUDIENCE MEMBER: Thank you.
>> BARB POLZER: Question that came in through the phone will providers who are only billing through MCOs for services be able to bill through the free promise EVV system?
>> SPEAKER: So providers who are working with the MCOs will need to work with the MCOs for their system.
The Sandata P system is specifically designed to spend information, back tots Sandata system and aggregate to the State democrat it not going to reverse to the MCO to the State system in this particular circumstance with the managed care the MCO is going to be kind of the middleman or the aggregator of all this information.
So the provider will either need to work with the MCO to use their system or they will need to use their own internal system but the State free system will not be able to send information to the MCOs.

>> BARB POLZER: Any other questions for Kristen or PPL?
Well thank you.
Thank you all of you for your time.
Kevin we're running behind. Do we want to do the data or save it until the end if we have time?
>> KEVIN HANCOCK: So we can take a vote how many people want Jill to go through all the data? So we have the data, as part of the record for MLTSS.
Is there anything -- I don't think there is anything in particular Jill you think we should highlight, there's not much of a change.
>> AUDIENCE MEMBER: No.
>> KEVIN HANCOCK: No real data anomalies if we have extra time at the end of the session maybe we can jump back into it, since we're so far behind on the agenda, with the committee's permission maybe if we want to move onto the performance improvement projects by the MCOs.
>> BARB POLZER: Okay.
All right. That being said, we're going to ask Dr. Appel and the MCO s to come forward we'll learn about the performance improvement projects.
>> SPEAKER: Excuse me can you post the data as part of this meeting on the web site.
>> KEVIN HANCOCK: Absolutely.
I'll give you a copy of the data now if you want it.
>> AUDIENCE MEMBER: Thank you.
>> DR. APPEL: Good afternoon.
Thanks so much, Kevin and Barb for inviting us and the MCOs to speak about the performance improvement projects. This is actually, very, very exciting. The all 3 plans have developed, innovative, somewhat exciting performance improvement projects, related to the two topics of strengthen care coordination and, nursing facility transition.
Next slide.
So the two performance improvement project broad areas, as I just mentioned are strengthening coordination and nursing if a sill take transition when we talk about strengthening care coordination this involves discussions between the CHC MCOs and the, dual special needs plans, the providers, hospital systems, behavioral health MCOs and behavioral health systems and the performance improvement project for strengthening care coordination is dedicated to all parties working together, so that participants do receive streamlined, efficient and as optimal care as is possible in a somewhat complicated system.
And as far as nursing facility transition, this involves creating a

smooth transition between the nursing facility after participants who are in a facility and would like to go to the community and it's deemed feasible that they receive their care in the community this involves, that transition going extremely well and smoothly.
I'm excited to say that all 3 plans have been innovative. All 3 plans have taken this very seriously work together.
(pause)
Excuse me.
Sorry.
I do have a loud voice I guess my kids are right
(laughter)
>> KEVIN HANCOCK: Very enthusiastic about the subject too.
(laughter)
>> DR. APPEL: Without further ado, it is exciting to introduce the plans to discuss their presentations related to these two performance improvement projects. Next slide.
I believe, UPMC has volunteered to go first.
>> SPEAKER: Hello everybody. I'm Jamie Kennedy with the quality department at UPMC health plan.
And we are excited about the topics that were chosen for these two FPIPs, they align with the goals and alone with UPMCs target for this program as well. So, first I would like to describe what the barriers we found in the southwest region, that helped us come up with the intervention strategies we'll outline later.
To find the barriers, we did a lot of research, both in journals and with the data that we had available to us, we also, presented this topic to our participant advisory council to get participant input on, what they thought that the barriers were to, successful discharges from an in-patient stay -- with the hospital for 30 days, what we found is -- participants, often have trouble with arranging the follow-up care and that first visit back to their PCP.
Post discharge sometimes they have difficulty with understanding and implementing those discharge instructions.
They may need additional support and services after an inpatient stay. That requires a lot of coordination, phone calls -- expressing that need for additional support and getting services authorized.
They also, um, get contacted by multiple people after a discharge from a care coordinator from the physical health side, providers who are looking to come back on shift figure out what they may need, maybe family members and service coordinator as well it

can be confusing after you're trying to get better after a discharge. Often those services and supports at that time really do need to be coordinated to help, so the participants are just able to rest and relax and heal. Then, of course, um, everything goes back to -- a lot of the help, is available, to them, if a service coordinator and a care -- the care coordinator receives notification of the admission and of the discharge from a hospital or a different in-patient stay this is the crux of the problem we're finding but
rather expand on that, that's something my counter part from PA health and wellness will be able to cover in her presentation some of the data issues are with receiving admission and discharge information.
So some of the intervention strategies we want to -- we have already implemented, um, in the southwest region we're doing a lot of this already in the southeast region, includes improving the communication between the care coordinator and the service coordinator within the day of admission so not waiting until a discharge to ensure that the participant's needs are going to be addressed when they come out of the hospital.
And then the service coordinator, contacts the participant within a day of the notification much the admission. So, once again this goes really well once we have that notification they are in the hospital.
And then that service coordinator serves as a point of contact throughout the transition of care. That service coordinator also then does home visit to the participant within 48 hours post discharge. If they're aware of that date that the person is discharged and they want to ensure that all of the services are in place, they do that comprehensive needs assessment again and see if the service plan needs to be adjusted, and additional services need to be authorized. Then the other intervention strategy that all 3 of the MCOs share is, establishing contracts for data sharing with the other payers and hospitals so that we get better notifications on a timely basis.
So moving onto the next PIP which is really trying to get more people to be successfully coming out of a nursing facility and staying within the community for at least six months or more. We once again discussed what these barriers were wanted to find out from participants if what we're finding out in the research was really true and what they're experiences were with the barriers to staying out in the community successfully if they had to stay in a nursing facility for either a short term or long term stay.

What we found is that we need to make sure we're doing a very careful evaluation of the activities of daily living needs and the strikal activities of daily living so that, it is not under estimated the support that they need when they come out.
There's a high risk of reinstitutionalization and readmission to a nursing facility. It is sometimes very difficult to find sustainable affordable and accessible housing after transition. And we are noticing that in the southeast region, this is becoming a much more difficult problem than we saw in the southwest.
And then transportation for follow-up appointments and access to the community after transition, arranging for all those transportation needs really sometimes hinders the successful community transition.
And then, having a reliable network of support once home. And really the way that advisory council explained this is that there's often either caregivers that are not trained or, um, able to provide the specific type of support that is now needed after a person comes out of a nursing facility. They're not being properly prepared or there's caregiver burn out if the right services and supports are not in place right away. Then that takes a toll on the caregivers in place in the home.
So the intervention strategies that we have implemented, we continue to evaluate and improve on, include making sure that the nursing facilities are using the service coordinator that is assigned to their facility, as soon as they know and identify a person is ready for transition or who has voiced they want to transition out.
So that service coordinator can evaluate the MDS minimal data set assessment. And then, also, touch base through interviews and quarterly evaluations. Finding those people who are ready or wanting to move out so that the transition process can start. And then, we do have on occasion, nursing facility, nursing facility communication issues where outside of our quarterly contact and face-to-face visits, that our service coordinators make they need to remember that, if someone else in the nursing facility hears that a person wants to transition out, they're contacting a service coordinator on a timely basis so the service coordinator could make contact with the participant within one day and start that conversation.
And then the service coordinator immediately if someone is wanting to move out, they contact the nursing home transition service team so that, it can start, evaluating the whole picture. The needs of the person, the home environment, where they can go to, setting up maybe a

new home arrangement making sure it's accessible if that is what is needed and any other supports that need to be evaluated put in place nor a successful transition.
And then once the person does transition out to home, receiving a visit within two days, 48 hours to ensure that all of the services and supports are in place and that if anything needs to get adjust it had can get done on a timely basis so that I'll take questions or I can turn it over to my counterpart from PA health and wellness.
>> BARB POLZER: Go ahead Nancy.
>> AUDIENCE MEMBER: With that being said, what is UPMC doing so that people, don't go into nursing homes? Is there something along that line?
>> SPEAKER: That's a great question I think that the -- the goal with the high frequency of contact with participants, um, who by the service coordinator, to evaluate any type of change in need and to do a reassessment or to call the providers and touch base when there are issues, especially on regarding the first PIP which is after a regular hospital stay. Because if the, the -- discharge planning and transition after in-patient stays if those, if that failed discharge at that point, that's off often what leads to
a nursing home stay we have to have success after we what we're doing after in-patient stays so we're preventing nursing home admissions.
>> AUDIENCE MEMBER: My concern is yesterday, UPMC, did a presentation in the Williamsport campus on how to put people into nursing homes.
Which we had some people go up there and it was devastating to us they didn't seem to understand about community they said it takes too long to get to the community, getting the nursing home faster they -- the social worker even said she tries to discourage people from that. So they did a presentation for direct placement of skilled nursing facilities and that, to me is a extremely upsetting.
>> SPEAKER: Okay.
Thank you.
>> KEVIN HANCOCK: Nancy can I ask a clarifying question.
So was that a UPMC hospital system doing the presentation.
>> AUDIENCE MEMBER: Yes.
>> KEVIN HANCOCK: Thank you.
>> SPEAKER: Okay.
>> BARB POLZER: So -- aid.
>> SPEAKER: If a person is in a nursing if a sill the NHT team

comes in and evaluating the individual, what role does the ombudsmen have in the scenario, who normally overseas that particular facility. Are they involved in the discharge process? Do they assist with advocacy for the consumer?
Would you describe what that would be?
>> SPEAKER: Um, unfortunately I'm not able to expand on how much we get them involved, because often they have to be contacted we can loop them in, but I know the social worker from the nursing facility and they're aware of transitions to talk to the person make sure this is in their best interest. But we're not, initiating a lot of those initial contacts with the ombudsmen for that person, because we are also, looking out for their best interests. We don't want to, to sway that, if there's any like, I guess issues with that we want to make sure that they get involved.
Um, but I -- unfortunately would not be able to answer that as well as the people more interest matily involved with the nursing home transition process I don't know if you guys can answer.
>> SPEAKER: I think that's one of the things we can take back and research, get back to address your exact question.
>> AUDIENCE MEMBER: Thank you.
>> SPEAKER: Do you see any changes in what the process looks like now for NHT and what you plan to propose as any particular changes or improvements? And the -- the one question that I had was, um, perhaps I misunderstood, um, was that once they're in a community you're looking at services. And so, I'm assuming that all of those things happen when the individual is placed in the community, as far as housing coordination of services, supports in the community all those things are in place as that person takes their first day back into the community? >> SPEAKER: That is always the ultimate goal.
>> SPEAKER: Okay.
But is that the way, do I have the sound picture as far as how that would happen.
>> SPEAKER: I would say that's the happy path that's the path we always intend for everything to follow.
I think that, you know the only other barriers that sometimes have occurred is that if people want to fast track it you know depending how fast they're wanting to get out. Or how fast the, eligibility for HCBS services move, because that requires the eligibility from outside entity to make sure that they, the they're passing through the eligibility process and that starts in the time line that this person is ready to

transition out.
So, as long as everything can happen according to the time lines and the participant or their family or whoever is really driving the transition out, in the speed in which they want it to happen, as long as that can occur, within -- how long it takes for everything else to get lined up it has gone really well. It's when people want to fast track or sometimes we've had people who want to maybe discharge before certain things are in place they think, you know if it's just going to take a couple of days, to get that lined up I'll go ahead and rely on my family or natural supports and know things are going to get put in place that's sometimes, the barrier we're also finding that people, don't realize that, they should have waited maybe a little bit longer for things to really get lined up before the whole transition occurred.
>> BARB POLZER: Patrick?
>> SPEAKER: One other question, one point do you see the -- the home care agency, being involved in the process and helping with that discharge?
>> SPEAKER: Well the nursing home transition provider, that the MCOs use, usually tries to identify those providers and bring them apart of planning meeting that the person centered planning meeting, to help prepare them for all of this person's needs. So that, when they start providing services within a day or two days of being home, they are already aware of how to serve that person and support them.
So that is part of the role of the transition provider is to not only identify providers that can help and just help them be prepared for that.
>> SPEAKER: One of the reasons I'm asking that question is that currently, there seems to be a challenge for providers to obtain what would be considered the -- the task list or that, that last list on the authorization form, as far as the things that we're expect today do.
So do you see changes in that process where we would be getting that task list, it's also DOH requirement for us to have that, we're explaining to the consumer that these are the tasks that we're going to be doing as a provider going in, so -- there's a lot there, so I would encourage having communication with the providers, um, ahead of time to make sure that all of those things are known by the consumers provided by the provider themselves.
>> SPEAKER: We'll take that feedback back and make sure that hopefully that's -- um, something we're checking off before we're saying that the transition is ready to go. That we have done that, and --

have the information of the provider to best support the person.
>> SPEAKER: That will be great thank you.
>> SPEAKER: Okay.
>> LINDA LITTON: I have a question, as far as hospitalization, if you know that person wants to go into the community how well does the hospital staff social worker whatever try and find out what is available in the community before they decide oh it will be easier to put them into a nursing home facility and then go from there to the community?
>> SPEAKER: Well, I would say it's been pretty, it is consistently done well when it is identified, either by the participant or by looking at what program their on, that is -- eligible for. Oh, they're CHC let me contact who -- find out who their service coordinator is. So that is those conversations can happen. Where we have -- we have done education to hospitals and social would workers and state helps facilitated those conversations to try to, make sure that these connections are happen.
I think that when it falls apart is when the how hospitals or social workers who have some have not heard the message or are not aware of CHC or how many sports are available they don't do the digging to find those answers.
>> BARB POLZER: Patrick?
>> AUDIENCE MEMBER: This is Patrick speaking I wasn't sure if you are aware about guardianships and how guardians, um, I mean, there are some guardians who are aware what is going on but there are guardians who are not aware, it becomes a barrier for information for a person. So person might be placed, sometimes in a nursing home and in a guardian might be filed for this person, and they might not be aware that there is an option for community based living.
So, do you have any plans related to guardianship and how to get them involved with understanding the options that are available in the process.
>> SPEAKER: I don't know of anything we've done that is specific outside of what we normally do which is if a guardian is identified, with a person, we try to include them in the person centered planning meetings and assessments so that they're aware of all of the options that are available.
Um, and to have their opinions shared and be apart of the decision-making process.
So, um, you know the goal of the program is usually expressed at the time we want to make sure people are in their desired setting where they

want to live and we can get them to wherever that location is, they want to live, um, and receive support.
So I'm not sure if we, have done anything outside of that to do extra guardianship education but I can look into that.
>> AUDIENCE MEMBER: Thank you.
>> BARB POLZER: Shaylin.
>> AUDIENCE MEMBER: Shaylin again I would like to amplify Nancy's last point that of about the presentation held in Williams port yesterday we are rolling out soon in region 3 and it is our understanding as community members and in the same community that the MCOs are going to be doing reach out to providers and information sessions and providing them the information they need on CHC and community living and, living in your own home not nursing homes.
So, would love some clarification as to why a providers are trying to educate doctors on how to place people directly into nursing homes even quicker than they already are.
Um, and also, what are not only, UPMC but all 3 MC, Os doing for region 3's roll out with how rural it is, UPMC has up a prominent presence in that area and in the rural areas being they own nursing homes we see that's a conflict of interest being an MCO owning nursing homes how are we getting people out of nursing homes making sure they have that information to get out.
And resources.
>> KEVIN HANCOCK: So, should -- someone from Brendan Harris a spokes pen from UPMC answer that question.
>> SPEAKER: Good morning -- good morning, hi Brendan Harris vice president of the government programs with UPMC health plan the note about Williamsport and meeting happening there, that is news to me we're going to up to Williamsport on Tuesday to actually sit down with our system Susquehanna up there to really kind of bring them up to speed and educate them, a lot of our focus as been making sure the roll out in the southeast has been successful we're shift understanding around phase 3 focus the up coming provider sessions making sure we can educate folks about the person centered planning and focus on the rebalancing that's really been a large focus that we UPMC have we're really excited about the opportunity that, in, working with our systems to be able to really kind of focus on community-based living and, various services along with those lines so I'm going to follow-up, with our team in Susquehanna I already actually already did to figure out what happened, to try to prevented that from going forward but -- we are really excited

as we roll into phase 3 about the opportunity to really focus on community based services in there.
>> AUDIENCE MEMBER: Thank you very concerning when we're not even in the roll out for phase 3, for region 3 and there's already talks of the MCOs making direct placement teaching people how to make district placement into the skilled nursing facilities and, especially right now when we're trying to emphasize and promote, community living integration in your own home and in the community thank you for that clarification.
>> KEVIN HANCOCK: Just to emphasize your point, the number one goal for community HealthChoices as stated, is to provide services for people in the community, which reflects their preferences that's not going to change and we'll be, very much a point we emphasize with all of our managed care organizations.
>> AUDIENCE MEMBER: In order to make that happen, all the providers and medical providers and long term service providers have to have the correct information and providing that information, to participants and consumers across the Commonwealth.
>> KEVIN HANCOCK: I agree completely. They also have to have the education to understand what community support actually are and there has to be an easier way to be able to if a I will Tate that transition back to the community, I agree.
>> SPEAKER: Just so hatch that facility is associated with UPMC, if they feel that way at the if a sill facility, there's other facilities that feel that same way, performance room in accordance with managing SNPS, they're, working with them -- there's opportunity to make sure that we're helping guide those facilities.
>> SPEAKER: This is Tanya from the center of independent living in north central PA I was actually at that meeting in Williams port, it is called fast track to a nursing facility.
And their goal is, to educate the doctors, and to move those people into the nursing homes.
>> KEVIN HANCOCK: Just to be very clear, I think Brendan is going to follow-up on this, on behalf of UPMC, it is something that the department does not endorse we want, we always quote the statistic 95 percent of the people that need long-term care want to receive the long-term care in the community we also acknowledge that nursing facilities are always going to be an important part of the long-term care system they do, reflect preferences for some people to be able to be receive long-term care in facilities but the program is designed, for community based long-term care because that does reflect participant

preferences.
It will not change.
And, we will love to have that conversation with the UPMC partners to learn a little bit more about that program I would have to say that's, the people that I work with, at UPMC on the health plan side are very much in support of community based long-term care. But it sounds like we have to have a conversation with the UPMC about the messaging coming out of the health system which does not reflect the objectives of the community HealthChoices as well as our stakeholder community.
>> BARB POLZER: We have a number of questions that came in over the phone. How is UPMC reducing the overlap, between SC and care coordinator responsibilities?
>> KEVIN HANCOCK: Good question.
>> SPEAKER: We are, it depends on whether the, the person is aligned with UPMC like having our DSNP or one of our Medicare products or a care coordinator from another external DSNP, um, and so -- this service coordinator, aligned people they are -- touching base with the care coordinator at the admission when the transition planning begins. So that, they can have one point of contact and still offer that support to a person that the care coordinator who is usually a nurse can provide the education on medications and in such but when it is an external DSNP, we -- that goes back to the data sharing issues that we're having if we know who their payer is we have notification of that, then the service coordinators are working towards finding the contacts with the care coordinators at those agencies, to do the coordinated follow-up and figure out who should make the contact based on the needs of the person. But that's still definitely a work in progress.
>> BARB POLZER: Thank you.
You noted that for hospital discharges the service coordinator visits participants within 48 hours of discharge to do a needs assessment to determine if they need to change in their services. Why can't the assessment be done as part of discharge planning so that additional service needed are in place upon discharge? Wouldn't that be more appropriate than someone being discharged home with less care than they need?
>> SPEAKER: When we are aware of the admission and the service coordinator can touch base during -- within one day of admission, then the assessment process can begin there and they might be able to get all the questions answered. But often the questions that are answered in

the assessment, also evaluate the home environment any environmental factors that might need to be modified or changed to adapted to whatever the person's new conditions or changes in the condition are, that's why both are needed we want to touch base with someone while they're in the hospital, to begin the transition process. And then make the whole visit so that any other things can be evaluated or put in place if needed so hopefully, both working together makes successful transition happen.
>> BARB POLZER: Thank you.
I think the next one is more for Kevin.
Is there a push to make the notification of hospitals/nursing facility discharge more timely across the MCOs? And would the department consider implementing a statewide health information exchange to improve transitions in care.
>> DR. APPEL: I can help with that.
Yes.
>> BARB POLZER: Sorry.
>> DR. APPEL: That's ok.
>> KEVIN HANCOCK: More of an authority than I am that's for sure.
>> DR. APPEL: There is actually a push and it is actually reflected in the stringenthing care coordination performance improvement project it's also reflected in our dual special needs plans quarterly meetings that we have. There's a push for data sharing that identifies just what you're speaking of. Which involves, information being transferred from hospitals, to payers both dual special needs plans and CHC MCOs and for exchange between those. It is emphasized at every meeting that we have. As far as the health information exchange there's also a push on multiple levels for membership in health information organizations there are several in the state, and the health information organizations, um, make up the health information exchange.
And, all -- pleased to report that all 3CHC MCOs are strongly working towards this goal. The State is very well aware of the critical role of data sharing in good participant care. And things are moving rapidly.
>> BARB POLZER: Okay.
>> LINDA LITTON: Just with someone signing off that yes -- you can share my data.
>> DR. APPEL: Consented, and -- consenting to those is part of that .
>> BARB POLZER: Any other questions for UPMC?

Okay thank you.
My guess we'll move onto -- PA health and wellness.
>> SPEAKER: Thank you, good morning I think.
It's good afternoon. I'm Marci Cramer director for quality improvement for PA health and well ins I'll talk first about, we request move to the slide please.
I'll talk about how the global pieces how we put together are PIP interventions and innovations, so first all, right out of the gate we developed performance improvement team teams for each of our PIPs to the nursing home transition as well as the improve willing service coordination. As you know, the cross departments in all the pieces we need to put together to make our interventions effective.
Currently we're collecting data manually for intervention tracking measures. Our systems were put in place before we were measuring these types of measures so we're looking at the systems themselves, figuring out where we can improve those systems to collect the data, electronically rather than has been manually. We continue to work with our partners CHC MCOs
on data sharing among those with the aligned DSNPs that is very helpful as secondary payer most times we don't get current and relevant data for our participants. And finally, and very importantly, we -- continue our efforts to work with the behavioral health MCOs last month we talked about the coordination between the CHC MCOs and the BH MC Os our BH manager works with -- each of the BH MCOs meets with them monthly coordinating we're working on data sharing through FTP sites as you know because of confidentiality issues, we're working through those very slowly we have progress, have seen progress with two of the BH MCOs at this point we're really excited about that.
So, those are some of the barriers we've experienced as we move forward. And we're constantly evaluating how we need to improve those processes, as well.
Um, so -- I'm going to talk about the approach to our tracking measures for each one ever our performance improvement projects so first of all, our service coordinators are completing face-to-face visits with all of our participants who don't have a waiver on file. One of the things we want to make sure as was mentioned earlier to make sure when people transition into the community, that they actually have the services that they need, so we need to make sure that all their -- the waiver program is in place and they have a support and the coverage to transition into the community.

We're also developing templates to review and capture information that is not currently captured by our systems. We want to make sure that the information we get from the nursing facility, is complete and comprehensive put it in our system and then we work with our medical directeddor to make sure that all those needs are met and in conjunction with the service coordination and development of the PCS the patient centered service plan.
We also, as I just mentioned, we do referrals to the our medical director post discharge and what happens here is the service coordinator during the transition period, reserves the case to our medical director what our medical director does is, hopefully contacts the persons PCP, before they actually go to their first visit in the community and, they discuss all of the as much ass, supports and, all the needs that the participant may need. So that we have the ability to coordinate the whole care plan for the participant.
And we also are identifying mentors in the community who have already transitioned from the nursing home to the community in hopes we can connect some of our participants who are might be feeling maybe they are not sure if they want to go in the community, if it's safe or they have everything together. So we're getting people who successfully transitioned into the community, to work with those folks that may want to transition. So that's it for our -- nursing facility into the community.
If we go to the next slide please.
Okay.
So strengthening care coordination, we're piloting archiving and transfer processes with the BH MCOs because part of the PIP is not just discharged from the acute facility but also from a behavioral health inpatient visit as well.
Also doing a complete inperson comprehensive reassessment post discharge and, as Jamie mentioned that's really important because you know within the 48 hours we try as best as we can, as long as we know that -- as long as we receive notification of in-patient admission.
Developing data exchange relationships with the DSNPs, we're also initiating discharge planning for all participants being admitted to the hospital at the time of notification of admission. Over and over it's -- sometimes it's very difficult to get that notification when we're the secondary payer, but we're working on processes to make that happen, quickly with our relationships with the DSNPs.
And finally, real important reassessment is completed for each

participant following the qualifying trigger event and a trigger event is anything such as a changes in caregiver, caregiver, in-patient admission, any request by the participant for an update in their plan. So that's what we have in place on a high level for interventions and if you have any questions, we'll be certainly glad to entertain any of those.
Polythink Jamie had to field all the hard stuff
(laughter)
>> BARB POLZER: Nothing came in over the phone either. Thank you.
>> SPEAKER: Good afternoon everyone this is Danielle director for "Management with AmeriHealth Caritas Pennsylvania. CHC and Keystone First. CHC that's always difficult for me to spit out. So -- just like with Jamie and, Marcie our interventions and goals and barriers are very similar, we, too, did our research to determine where we wanted to address and, the PIPs help us to align our goals, over all.
So, over all our goals are to promote the smooth transition home in coordination with our participants so once they identify that they want to go home, we help with that.
So this is related to the hospital discharge so we also wanted to make sure that with that hospital notification we're also educating our participants as well to notify the service coordinator so we're not just totally dependent on the data we also have that repour they build they can tell the service coordinator hey, I'm in the hospital and then we can start a little bit sooner too, that's part of our process to notify.
Um, so some of our goals are again the early notification of the in-patient admix, from acute or behavioral health facility. Again that's data driven we want to increase our participant engagement within 30 days of the discharge and, you know, to do another reassessment of their needs at that time, do a medication reconciliation. So we'll sit down with them. And to review the discharge summaries with the participant, while they're in their home, they can you know, bring in any guardian, appoint anyone as a team, as long as the participant is willing to did that that's in addressed in the person centered service plan as well we try to bring in as many people as the participant wants. During that time we assist with scheduling of the follow-up appointments, whether it be the specialist or a PCP, um whoever they may need to visit, we will help at that time as well.
And in the end the barriers the hospitals

are notifying the primary payer we sit along with the OLTL with the hospital association to determine what are some of the barriers might have been then it is, it seems to be right now, as the hospitals are addressing the primaries we're working together to change that so they know there's a CHC now there may be a secondary. And sometimes we're finding that our participants are refusing that service coordinator, within that 30 days. So we're trying to develop more education for the service coordinator, to you know, reach out to the participant to say how important it is to have that face-to-face we understand that it may be tiring for the participant when they come out of the hospital, um, so we can, you can break it down into short increments we need to make sure we're trying, so that's part of our goal to improve.
All right, so now we'll move onto the nursing facility transition to the community.
Again, over all goal is to transition to the community. Once the service coordinator we have a service coordinator that is assigned to the nursing facilities they go in and review the MDS and once its identified adds a goal it becomes a priority goal for the service coordinator participants who work towards that transition
they work well with the nursing home transition teams, the nursing facilities, um, social workers and, it comes together as a large team to get the participant home. What they desired.
Again we have the same issues with getting notified of the notification of the admission to the nursing facility and then again with the discharge. So basically, the once one main barriers we're finding with the nursing facility would be the eligibility once they come out so we will work our hardest with the service coordinator and the team within the nursing facility to get what that participant needs before they find out what their eligibility is, that's something worked on from the State perspective as well.
So over all, our interventions are common. We are establishing agreements with the DSNPs and other payers and behavioral health managed care organizations for that notification of admission and discharge.
Again, developing the relationships is key, education is key for the participants as well as our internal service coordinators and relationships that are strong so that we are keeping the lines of communication open.
Any questions?
>> SPEAKER: I have a question, regarding to Medicaid eligibility, so -- if I'm understanding the -- when a person goes into the hospital,

there's a fast tracking for them to be determined whether or not they're Medicaid eligible.
I assume that's correct. If there's the fast tracking understanding that they're Medicaid eligible potentially they go into a nursing home facility I would hope you as MCos, would jump on the process the stories you heard of people trying to apply for a waiver, takes some times 8 months, so -- I'm worried that, consumers will be in nursing facilities longer than they should be. Over an application process.
The concern grows not only with that initial application, but with reassessments and -- consumers not having assistance with reassessments . That process. So -- anything that you can offer as far as information how to make that system smoother what is in place right now to have consumers in the nursing facility the least amount of time they want to be there, and can you also address if a person already has a place to stay they have to be in a facility for medical reasons, there's no other alternative they have to be in the facility for a few months. How do you maintain their place of residence and secure things and who is role is that the service coordinators role to assist with that.
>> SPEAKER: So with respect to the second question that's part of the nursing home transition team, so they will evaluate, how long a stay will be held. So, if they will have a discharge planning date in mind, so then they know the time frames to achieve that, so they will start searching beforehand to see what placement they have, if there's something how long they will hold it, is just case by case dependent.
>> DR. APPEL: And regarding the first question we certainly are beginning to evaluate that process with the MCOs as far as transition from the hospital, to a nursing facility and how enrollment and eligibility take place in that setting with the goal of ensuring both timely enrollment and timely transition.
>> KEVIN HANCOCK: Only thing I would add to that, as part of the requirements of the program itself, managed care organizations are required to have a hospital transition coordinator role that is meant to work with hospitals so that, opportunities for individuals to be able to transition into the community happen as smoothly as possible then maybe working with someone who -- one of the nursing home transition teams, or whatever whatever role it is being fulfilled but it is a requirement to support participants as a transition out of in-patient hospital stay, transitioning into the most appropriate care setting which may include community if it's something that is -- that's

relevant to whatever service requirements they may have.
>> THEO BRADDY: I have a question, well not necessarily a question but a statement. For the MCOs I would encourage you all to work with Centers for Independent Living. We have been doing nursing home transition for quite some time now.
And, have become very good at it. And I think it will be a very -- it would be a over sight to not involve us, with I keep hearing transition and teams and so forth in the nursing facilities.
So it would be very key to have centers of independent living at that stage and not doing that, I would encourage you to do that.
>> BARB POLZER: Nancy.
>> AUDIENCE MEMBER: --
>> KEVIN HANCOCK: Before you begin Nancy just to -- not just CILs have been doing the nursing home transition as the areas of on aging and other areas across the State have been involved in long standing relationships with the nursing home transition as a service so -- plug for the CI Ls but also a plug for the AAAs.
>> SPEAKER: We did much longer than the AAAs at least 15 years longer my question is we meet a lot people who just became disabled and had no income.
So, what about transitioning people out with no income have no place to go.
>> KEVIN HANCOCK: Good question.
>> SPEAKER: Good afternoon everyone, I'm Susan McAlli is. Ter chief medical officer at Keystone, what happens when you're newly disabled you don't have income I would say that for these cases, we process or take care of our participants on an individual basis we do case rounds throughout the week, those case rounds are held with myself our pharmacist, our behaviorallist or employment specialist our housing liaison and our service coordinating either external entities that we have trained on how to work with us during rounds throughout the week our internal service coordinators when those cases come to us we take each case on a case by case participant by participant basis. What are the participants preferences? What do they have available? What has the assessment shown as how we might best serve them I think it is a case by case when we come to those issue we have not come to a system wide how might we handle this issue.
>> AUDIENCE MEMBER: Except that you know in most cases it takes, six months to two years to get SSI.

So here's where you'll have to be innovative because you cannot get subsidized housing on zero income. You used to be able to. But that stopped about I don't know about six or 8 years ago.
>> SPEAKER: Yes.
>> AUDIENCE MEMBER: It's very expensive to keep them in there but with no income, they can get food stamps when they can get out they can get food. They can't get anything else.
>> AUDIENCE MEMBER: Liam Dougherty, Philly adapt, I just had a general observation, um, about OLTL I think a lot of us in this room, are terrified but not surprised by UPMCs event yesterday.
I think including UPMC is one of the MCOs it is the slight level of conflict that is really troubling.
I think coming from the perspective of owning a nursing home and monetizing people in that way I think, I really think OLTL needs, I can't believe that this the first you're hearing about it this event I think we need moreover sight and, all that is before the fact that the same organization is writing the report about CHC I think the conflict is absurd and you know, I mean, yeah I think from what Nancy was saying including you know, third party including the CILs in the process would be beneficial, rather than someone who make listen to go someone who runs nursing homes we're hearing one thing and obviously seeing another I think this is
(inaudible)
>> KEVIN HANCOCK: Thank you for the comment Liam, speaking this is the first time I've heard of -- the health system portion of UPMC providing this type of guidance first of all it is it's -- nonsense call from my perspective that they would be providing this -- it shows a lack of education on the part of the health system for different types of options that may exist for people in need of long-term care it shows a sophistication it does show a
lack of coordination between the health care system and the managed care organization itself.
I am giving UPMC health system a -- the health plan that works with the community HealthChoices the benefit of the doubt, because we do monitor their activities when it comes to the nursing home transition we monitor the activity when is it comes to meeting the objectives and performance and improvement projects that Dr. Appell was talking about in regard to new balancing we monitor that and the success we will know if there are red flags when it comes to the -- to the operations of the

health systems side of UPMC and when it comes to nursing home transition. And if it looks like there's some sort of a filtering that is taking place which is in violation of their agreement then we will take action to prevented it from happening in the future that being said, we're going to let them have a chance to be able to respond they being the health systems the health plans the people who we work with, who have the contract with, we'll give them the opportunity to respond, and, to talk about if any, corrective action needs to be put in place to be able to make sure that is not coming out of the UPMC system it's not obviously a message that the office of long term endorses, it runs contrary to the design of this program.
So --
>> DR. APPEL: One other question not necessarily related to any one specific MCO, is this the only instance of something like this, that has been heard of? Related to any MCO.
>> AUDIENCE MEMBER: We don't know. It could be.
I mean -- there could be many more though we don't know.
>> DR. APPEL: Sure good enough.
>> AUDIENCE MEMBER: I would just like to add, um, to Kevin's point, you know, it does show, yesterday's instance the lack of education and information and those sort of things like you were saying. But that just shows you where William, that area Williamsport in this instance the surrounding the area the rural areas are at right now before MCO even comes in. And that shows what the stigma is, what the people's perception is of disability and that you're disabled you should go into a nursing home that's a real problem, that's what we really want to see changed as the next region rolls out I would love to see a presentation from the 3 MCOs on, what correct I have actions they are taking, from the past two roll outs what are the lessons learned and practices going to be put in place that will be different for region 3.
>> KEVIN HANCOCK: I think that's a fair ask.
>> AUDIENCE MEMBER: One we've been asking for for awhile. Any time soon --
>> KEVIN HANCOCK: To be fair to the committee and to the MCOs we have presented on lessons learned with every single one of the phases we did that last year. Certainly we did it in multiple times we've gone through individual, we have, presented in this committee and it is a matter of record, on lessons learned we have also discussed lesson learned throughout every one of our presentations that being said we're constantly learntion so, talking about, having an opportunity to update,

the committee and to the audience on what are the lessons learned is something we, we more than than willing to do, we can do it in the next meeting if you think that's.
>> AUDIENCE MEMBER: Well especially since we are getting to the time period where we're going to start sending out enrollment packets this fall those sorts of things I think this, this group, you know we have people coming from the community to get more information, providers, we all deserve that information and not only lessons learned but what are you going to do for the next region what? Are those changes going to be for that region we can expect that we, can also hold you guys accountable to and, hold each other accountable this is what was said this is what, we are to be expecting. But we want to see real lessons learned but also what is going to happen with those lesson s learned.
>> KEVIN HANCOCK: As I said that's a fair ask.
>> AUDIENCE MEMBER: Thank you.
>> BARB POLZER: Patrick.
>> AUDIENCE MEMBER: This is Patrick speaking. I want to say I've noticed very similar things.
For people who have tried to share information about community HealthChoices, with the deaf community as well.
It seems like we need to have more awareness in the deaf community and we need more deaf leaders that can then share the information you know including us you know, as well.
But, there are a lot of people who need to take -- there are more people who need to take responsibility to share information to the deaf community because often what happens is the deaf community has no idea that, um, community living is an option and they're always seems the last ones to know the information is delayed getting to them.
>> KEVIN HANCOCK: We appreciate the feedback.
That's something we will certainly look for every opportunity to be able to improve.
I would actually emphasize the point about community leaders, being a voice for the community and helping to continue to push the message.
>> BARB POLZER: Anymore questions for the MCOs?
>> SPEAKER: I was going to mention to the point about the no rent available for folks with no income we have utilized affordable housing the nursing home transition programs through the PHFA through the counties they will pay a minimum of a year I think of rental subsidiary or more, just maybe something that, that people might be interested in

exploring it's actually under utilized program in Allegheny County.
And there are affordable housing communities it has to be apartments availability, which is sometimes -- which is sometime the issue.
I think it is a program that's not well-known around the State. So might be interesting to have someone from PHFA at some point you know maybe do a couple minute presentation on that program and talk about don't know if I'll be able to do that.
>> KEVIN HANCOCK: Bryce Morosky has presented from PHFA has presents I don't know if he talked about the specific program we would love to have him come back the point that Nancy, I'm not going to speak for Nancy I would never speak for Nancy to be very clear.
(laughter)
But it is -- the under writing point is a lack of affordable and adaptive housing that is, likely --
>> SPEAKER: Completely understood I certainly wasn't trying to mention that. It is something I know a lot of providers don't happen to be aware of in my experience speak.
>> AUDIENCE MEMBER: We are aware of the money the problem is we can't be certain when their SSI would kick in they become homeless we can't depend on that there's no way to know anymore it's only I think the situation is only going to get worse in Pennsylvania as far as people actually getting it.
>> KEVIN HANCOCK: That's a good slightly separate policy point of SSI eligibilities. Thank you Nancy.
>> BARB POLZER: Okay.
All right.
Thank you doctor appel, oops.
>> AUDIENCE MEMBER: Patrick again.
I am sorry the question I had earlier I am still confused by the answer so I just want to clarify again about the question that I had previously what I want to clarify is whether or not direct care workers are considered Federal employees or not I just want to get clarification on that.
>> KEVIN HANCOCK: They are not.
>> AUDIENCE MEMBER: Okay thank you.
>> BARB POLZER: Okay.
All right moving along the 3 plans are going to present on cultural competence.
>> KEVIN HANCOCK: I'll set the stage for this a little bit.
>> BARB POLZER: Absolutely.

>> KEVIN HANCOCK: This request came from committee member Heshi Zinman is advocated for the LGBTQ community when we asked, we asked the MCOs to actually present the way they're going to be approaching on the cultural competency we weren't specific to the LGBTQ community but Heshie's emphasis has been in that area. There might be a little bit of a framework for manufacture the presentations you're seeing.
But the requirement for cultural competency goes -- certainly, to a very broad very broad can't think of the right word, so -- we're looking forward to the MCOs talking about their entire approach to cultural competency and also the views of some specific populations as well.
>> BARB POLZER: Who is volunteering to go first?
Okay.
>> SPEAKER: All right I'll go first, Jen Burnett Pennsylvania Health & Wellness I want to thank Heshie for bringing this concern to us and asking us the questions that he has been asking us about our inclusion and our approach to serving people who are in the LGBTQ community but we at Pennsylvania Health & Wellness have sort of broadened that question to really think about how the whole plan is addressing the issues related to the LGBTQ community we really do start with the participant and I'm here with Jim Swilgle who is a member of our C pride, seen teen pride program, national appropriate sponsored by the corporate, all the health programs part Centine, to be part of it, Jim used to be the co-chair, co-president. Committee. Yeah.
(laughter)
Yeah.
And -- um, Jim knows a lot more about the work that we're doing at Centene and Pennsylvania Health & Wellness, but I think, what it has done for all of us, at Pennsylvania Health & Wellness you know we're in the midst of launching the large program and sometimes things issues like this kind of get put to the wayside and this is really kind of shining the spotlight on it for us, Jim I'll let you talk a little bit I'll fill in the blanks about the model that we're looking at in terms of how do we approach the LGBTQ community
>> SPEAKER: Okay thank you Jen. So of course, we always start with the participant and they are the center of our focus.
And we broke this down into 3 sub-groups that I'll go ahead and describe now.
For the providers, we want to make sure that we have provided clear

expectations of how they will treated this community.
We want to give them training. And if they ask we want to offer surveys on how we as the health plan are helping our participants in that community.
And we want to give them resources and many of the resources will be available as links on our web site.
We want to make sure that the providers are using correct pronouns.
We want to especially for our transgendered community we want to make sure that the participant feels comfortable when they're in that doctor's office.
We also want to make sure they're using the correct terminology.
We want to have inclusion of spouses and partners, significant others while they're at the visit. And, we want them to have respect for our participants and certainly confidentiality.
For our PHW employees, we offer a new employee orientation and I have been asked several times to be one of the guest for especially in the Pittsburgh office where I reside that I introduce myself and make them feel very comfortable to ask me questions through their orientation.
We offer ongoing training through our PHW university. We seek to understand while we're on the telephone with our participants, if there's ever a question that is brought up, we ask, seek to understand questions. Again we encourage everyone to be themselves as employees of PHW. We offer knowledge checks throughout their employment and we do annual training. One of our initiatives is we are going to possibly have a Fireside chat and this would be with all of the PHW community and we would like to invite key members of the LGBT community to be our guest speakers.
And lastly, of course, we demand confidentiality when speaking with this particular subset population on the telephone.
And in public. So the last of our subsets are the public. We do have a web site and there are links on there for specifically the LGBT community. We're proud to be a high ranking member of the equality index through the HRC. We have many resources for different communities and different areas geographic areas where people can get more information.
We participate in community events such as pride events, community days, public awareness days and we are going to start inclueding venues such as pride in the Lehigh Valley in Allentown and, FACT up in strodsburg, which is fighting aides continually together. So just to name a few.
And -- we are very proud of the work that we do here and for me to

have been elected co-president nationwide of C pride, says a whole lot to our role here in the community.
Thank you.
Any questions?
>> SPEAKER: I'm Dan I'm from UPMC health plan, I know I realize that I I think I need to let this you know my wife always yells at me -- you have to calm yourself.
(laughter)
I think it's my daughter just consistently yells frozen songs at me all day I feel it's the only way I can get through I promise I will be -- I'll be quiet.
But it's an honor to be here I work in our government programs department within the health plan and Kevin it's nice to meet you first and finally, before we get into it I want to say what is being done in Pennsylvania is, is true leadership across the State across the country, Heshie you and Kevin and many colleagues of yours in department, Todd on the Commission and secretary Levine the work that you all are doing is, continuing to press us in all of our communities, areas I know in Pittsburgh and beyond.
To be the best that we can possibly be I think we're grateful to have you as partners for us, um, you know -- I will start with, Jim your point about participant I'm a Sis gender straight man what do I know about this specific needs of the LGBT community I don't. So -- our number one principle is to listen and understand. So what we did first was, a couple of years ago I think we realized we have a large system but at the health plan within our Medicaid department we realize we need to do a better job explaining what was covered what was not, this is before CHC but it kind of leads into where we are with CHC.
So we built a team we built a dedicated member services team that involved individuals from different departments obviously everybody, we want everybody to be friendly.
You know, but really this was truly meant to serve our trans members in the best way possible, understanding what was covered and what was not. Through that, what else we heard, um was that we wanted to friendly and competent providers what does that mean? Again you know we -- we know there's no national certification for what constitutes LGBT competency what we have tried to do do develop on our own something we can have a marker we started in a lot of ways on the medical provider side we're hoping to move into the HCBS sited in the near future we're going to be having kind of preferred netted works if you will, across

the five zones. A different types of procedures, surgeries primary specialty care, that individuals are really asking of us and that's incredibly important to us in terms of training again, building up what Jim said we want to be able to provide the type of trainings to our providers we developed a partner with the Fenway institute that does clinical training we partner with PERSAD and centers a and providers across the Commonwealth do a great job of training we're really excited about that I think, you know where our CHC team has lead the way has been training our service coordinators some we heard we wanted to make sure the staff we heard from I can't tell you how many people nurses, SCOs others who said look I want to say and do the right thing myself I make a mistake -- almost everybody day.

And -- I'm grateful for the, the grace that I'm shown by individuals in the community to help me learn that's what we want to give to our team and staff I know I can speak behalf of the MCOs that's what we want to do we know that comes with, dedicated training that is beyond friendliness we try to do is, is assist people look you'll be in someone's hoax for several hours how do you ask questions appropriately how do you understand get preferred pronouns preferred names to be in the forefront? So I think for us, to -- to kind of build a little bit on that, is we're also working and CHC will be a flag ship for us here as well in terms of data collection, changing our systems within our medical system and also in the health plan system, to really make sure that we have preserved name, preferred pronoun up top and then also a larger inventory when someone would like to share a little bit more so we can understand where someone is within a transition especially with the transgender community.

You know, we -- I was at a health center recently, and one of the nurses said to me she had used someone's dead name because -- it wasn't in the banner bar they're preferred name, again the individual, was so kind, and -- was so kind to her shared such compassion to the health care worker they felt so bad that's on us, that's onuses to make that change. So those are the kind of stories those are the things we want to hear we want to do.

I think, you know for us as a -- health system, as health plan CHC plan we have a chance to build something we can be very proud of it's going to be something that will be driven by, community needs we'll be doing some focus groups across the Commonwealth, starting in Pittsburgh, which needs all of your help to identify the right individuals to tell us what we need to be doing to do better. And Jim has done a quite a

bit of work in his world that's just wonderful that's partnerships we really want, you know to continue to build. We are also grateful we just earned 100 percent for the human rights campaign corporate equality index I want you to know our next goal to get all of our hospitals on that, huge part of that is how they are in the CHC program who they are to the most vulnerable and under served communities. The things I can guarantee I cannot
guarantee the answer will always be, what someone wants to hear but we will listen. No matter what it is, that is what helps to make the change make the case to make these changes we want to.
So I guess lastly, um you know we're just grateful, to people like Heshie I look without him there would be no chance these movements would be going this is one of the issues of our time you know we'll continue to make actionable progress and talk beginning of the journey not the end we appreciate your faith and grace and partnership. So that's our perspective, any questions?
You can always call and ask, doesn't matter what it is I'm always here
>> SPEAKER: Okay.
My name is Patty Wright, Keystone AmeriHealth as well as Jen Rogers he want to share with the various areas employees providers service coordinators as well as the communities and -- um, I'm really very proud to be working for Keystone AmeriHealth and I find they have probably one of the most extensive and inclusive nondiscrimination statement as a member of the LGBT community for a very long time that is one of the things I look at and read you know before I kind of join a company. Um, and not only is our statement very extensive but it also is very clear about both gender identity and sexual orientation.
The organization as a whole has a very strong commitment to having a very open and inclusive environment. As a matter of fact the week of April 22nd and we have one of our members much our lead team here we have a diversity and inclusion team which Danielle brooks is apart of , one of the thing we do, and we'll be continuing to do, as we actually had a full diversity and inclusion week and that included that is not limited just to our Pennsylvania health plan it included our DC, Michigan and North Carolina plan and, all employees were able and encouraged to sign up, to attend either in person by webinar. The company made any time allotment or kind of, reassignment to their schedule so they could participate. We had many topics, topics that ranged from women veterans, topics that were carrying for LGBTQ

members in the community, disability etiquette, demystifying health equities and success through diversity inclusion as well as it really did cover supplier diversity, because we have that same expectation of even those that are business partners, to have this openness and acceptance.
And one of the things that we will be doing in PA, is extending some of the topics like the LGBTQ to work with Heshie as well as other groups and the disability etiquette workshop that we have was really well received and one of the thing we want to do it was actually run from our DC team we really here in PA want to reach out to the Centers for Independent Living and have it more targeted for our PA plan for the community HealthChoices staff.
And in addition to that, all employees we have cultural linguistic and disability competency it is in our handbook it is all part of our On boarding training as we look at providers -- we have orientation for new providers, it is part of our orientation process. It is in our handbooks on our webinars it is part of all of our forums. We do have a cultural competency education program that is available to our providers it is web-based. We do ask them but it is self-at testatin we have taken it, we want to go
beyond that we're working with some of the organization those help us provide more LGBTQ training for our providers and we're trying to right now see how we can reconfigure our system so when we have providers that do attend these sessions and complete the training, that we will be able to identify that next to their names on their provider directory that is something we're really looking to move towards and expand when it comes to our service coordinators we have all the cultural competency tests, exams, I'm sorry -- webinars that we're doing.
And, one of the things we do is we have used the -- the family institute modules for all of our service coordinators and contact center staff, Jen do you want to talk about the components of the Fenway.
>> SPEAKER: Good afternoon everybody. So this actually stemmed from a conversation posed to the sub-MAAC a little over ago when Heshie brought this to our attention. So -- um, gearing up for the launch in the southwest we had a conversation and found that the Fenway institute has a great curriculum we have integrated into our on Board the and annual training for service coordinators so the modules we have found successful include affirming LGBTQ people through effective communication, achieving health equity for LGBT people and improving health care for transgendered people as well as caring for the

LGBT older adults that is just some of the curriculum we have weaved in as part of our on boarding and annual training for all service coordinators who are participant facing.
>> SPEAKER: The other thing we're doing we have received a lot of feedback both from Heshie as well as really our service coordinators that are out in the community working with the participants it is how do we help the participant know that we want to encourage and are very supportive to openness and acceptance?
So one of the things that we're doing now is we're working on what we're kind of calling a conversation paper that's just a working title internally with Heshie and members of our team to create a leave behind that we can share with participants that helps reinforce to them, that we want and support an openness and be able to have the conversation to help them be able to have the conversation with us and that we can have the conversation with them.
So that's something that we're working on now. And we're also looking for groups especially to help us with like attendant care agencies, with the adult day care programs, for training that we would absorb the cost of those trainings to go into those settings, to help them become a little bit more comfortable and we recently spoke with someone that is working with center in the parkings senior center, that is starting to do some dialogue around with seniors how do we make senior centers more accepting of LGBT community we started some dialogue with that organization as well.
Any questions?
>> THEO BRADDY: I have a comment.
I hate to be the one to say this I have to say this.
I want to congratulate Kevin and OLTL, for -- acknowledging the fact that they need to do a better job with gender and so forth.
I felt myself get a little light headed up here listening to what you just said because I wish this same kind of Zeal and effort would be put into acknowledging the cultural I believe competence for people who are deaf-blind, thank you all Keystone for really looking at a real comprehensive plan instead of transgender.
There's a lack of sensitivity, lack of effort, a lack of understanding, for people who are deaf-blind just as much as it is, for people becoming more sensitive and aware of the transgender population. And it hurts me, to see such an effort being made to get a better understanding of that when people who are deaf-blind need the same kind of understanding and effort and no one

wants to really put the Zealand zeal, and energy into it as well. That's my problem, when you talk about cultural competency, we leave out people. We leave out groups.
And so when I see how much you all are putting into this, it bothers me that the same kind of effort was not put in to people who are deaf-blind.
>> KEVIN HANCOCK: Just responding generally, might be a feature opportunity to have this as a focus of a topic for cultural competency for the deaf-blind population talk about the efforts on 3 managed care organizations to address. The deaf-blind population.
Can I ask a question?
(laughter)
So, very recent news was published out of the Federal government that there is a new ruling that is, the Federal administration is having or allowing practitioners of health care and long-term services and supports make decisions of consciencous based upon faith for example, I know this is a controversial question and you may not have enough of an answer at this point especially AmeriHealth Caritas may have to check with your lawyers)
Laughter)
How --
>> SPEAKER: Thank you for that cover already.
(laughter)
>> KEVIN HANCOCK: UPMC has to answer.
(laughter)
Okay.
So -- adapting the MCOs you should see how hard I am on the MCOs but, how are you going to accommodate this, within your own networks? Knowing that this is something that has been allowed by the Federal government and knowing what you just said about cultural competence for the LGBTQ community
>> SPEAKER: I mean against I'm required a response -- our nondiscrimination policy flies in the face of that we'll be following our policy and continue on from here forward that's the way it's going to be that will certainly the way we'll be with the health plan that's who we are, that's -- I guess the most direct way I can respond to that one.
>> KEVIN HANCOCK: Thank you.
>> SPEAKER: We have the very strong nondiscrimination policy as well we're going to continue to use ours, Patty I'm not sure if you want

to answer too.
(laughter)
>> SPEAKER: I will take the fifth at this time.
(laughter)
I will give you a formal response at
the next meeting
>> KEVIN HANCOCK: Thank you for that.
>> BARB POLZER: One did come in earlier over the phone we held to the end this is in regards to the nursing facility surveys.
What is the survey target geographically across the State? EG, southwest, southeast I would say zone 3.
>> KEVIN HANCOCK: Right am I think for this initial target if I'm not mistaken it is, the two zones actually not positive I think we need to get back to the person on that.
>> AUDIENCE MEMBER: 3, all 3 the whole stay.
>> KEVIN HANCOCK: Pre, and post survey for the State.
>> AUDIENCE MEMBER: Yes.
>> KEVIN HANCOCK: Okay.
State.
>> KEVIN HANCOCK: Statewide, I thank you.
>> BARB POLZER: Anyone else have any questions?
Is it possible we're going to end early.
>> AUDIENCE MEMBER: I have one.
Pat is it coming through.
>> SPEAKER: Coming through I'm typing now.
>> SPEAKER: Okay.
>> KEVIN HANCOCK: We have still five minutes to go through the data if we want.
(laughter)
Do you have the metrics for April statewide FED results of NFC and NFI
>> KEVIN HANCOCK: Not yet we'll be publishing that, just as a reminder we implemented functional eligibility determination tool on April 1st we have now full month of -- determination for, for -- how the FED identified if someone is clinically eligible for function tally eligible for long-term care we can provide April data we think in the next sub-MAAC on May 31 VI that's very good question it will be part of a future future sub-MAAC presentation.
>> BARB POLZER: Mat?
>> AUDIENCE MEMBER: You're probably aware Secretary Oleksiak put out a letter in the PA bullet continue Office of Vocational

Rehabilitation started the process of having a waiting list closing the order of selection.
I brought employment up here a number of times it's part of that the services.
Now, that a waiting list is effectively being created at OVR how is that going to effect this future?
>> KEVIN HANCOCK: So I mean you know, as well as I do, that OVR it's a Federal requirement, for the assignment of services before we make other types of services available.
The MCOs have to follow the same type of requirement. It is I mean, to be perfectly honest it's a will which edge.
I would love to be able to -- bring up conversation at the sub-MAAC about employment services it is a challenge we're working with our partners in the Department of Labor and Industry to be able to address it but -- obviously we want people to work if they want to be able to work and this does present a barrier.
>> AUDIENCE MEMBER: Okay.
>> BARB POLZER: You want to present data.
(laughter)
>> KEVIN HANCOCK: Ah I think we only have 3 minutes.
>> BARB POLZER: Okay that being said thank you everyone for attending and for participating in the next meeting remember is the May 31st and the venue is the Keystone building on 400North Street.
>> KEVIN HANCOCK: For the folks staying with us to talk about the home modifications DME we'll be staying in this room you can forward yourself up to the table.
(meeting concluded)