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Date: 12/02/2021

Event: Managed Long-Term Services and Supports Meeting

>> Testing .
>> Testing. .
>> SPEAKER: Good morning, this is Jeff from Pennsylvania back and filling in for Matt who had represented at the board meeting and asked me for future let you know if there's a possibility to better coordinate meeting with other state agencies of the are not overlapping, thank you.
>> Thanks Jeff. Another problem the ideal that we schedule a year in advance. If you are currently overlapping with the managed-care subcommittee - -. I'm not sure how we did that. So sorry about that , we will try and look at that. We are looking on the dates for 2022.
>> Yes, I think the other - - and OPR are out there. Is there a giant state calendar that has all the everyone's meetings on it? I know that is a lot but I am wondering .
>> JAMIE BUCHENAUER: Not that I know about, I don't know if anybody else knows about that .
>> SPEAKER: Maybe that is a governor's office question. Okay, thank you.
>> JAMIE BUCHENAUER: Jeff, when I worked outside of state government, I thought there was an organization that used to do that for all of the organization that subscribe to it. I cannot remember what the name of the organization was. It was also the wanted all of the legislative analysis , attended all the meetings and gave synopsis is of all the meetings. Pennsylvania legislative services I think did it .
>> It's interesting you mention that, we did this subscribe to PLS there definitely outside state government. They used to be - - there is go net and one other one that does that now.
>> You are right, probably nothing inside state government.
>> LINDA LITTON: Good morning everybody. I believe we should start this meeting . Excuse me . The last meeting that I remember to participate in in the managerial position - - it has been very nice working with the older people that have come before and people now . I am just sorry that I never got to see your faces while we were talking. So, does everyone want to introduce themselves and go around the table?
>> SPEAKER: This is Jermaine, I am the division director - - policy Bureau . I handled the attendance this morning .
>> LINDA LITTON: Thank you .

>> JERMAYN GLOVER: Do have Allie Conley?
>> SPEAKER: I am here, good morning everyone .
>> JERMAYN GLOVER: Cindy Seeley ?
>> SPEAKER: I am here to thank you very much .
>> JERMAYN GLOVER: Neil Brady?
>> Good morning everyone .
>> JERMAYN GLOVER: Dana Johnson?
>> Good morning .
>> JERMAYN GLOVER: Denise Curry ? German Parodi?
>> JERMAYN GLOVER: One either gray?
>> Good morning .
>> JERMAYN GLOVER: Linda, you are obviously here . We have Lori - - as absence today. Luba Somits?
>> SELLERS DORSEY: Luba Somits is on what she's unable to speak to to laryngitis .
>> SPEAKER: This is - - currently attending the OVR board meeting going from 9:00 to 12:30 on our behalf and maintain that - -4 future reference MLTSS can take a look at other state calendar of other meetings there's not much overlap with disability . We know the managed-care subcommittee is going out the same time.
>> SPEAKER: Can you hear me? This is Rick - - and joining by phone .
>> Is Mark here?
>> I do not see Mark .
>> JERMAYN GLOVER: Monica - -?
>> I am here .
>> JERMAYN GLOVER: Tonya - -?
>> SELLERS DORSEY: I do not see Tonya .
>> JERMAYN GLOVER: William - - ?
>> SELLERS DORSEY: I do not see William .
>> JERMAYN GLOVER: Linda, would you like me to do the housekeeping talking points?
>> LINDA LITTON: If you can do that that would be great .
>> JERMAYN GLOVER: Please keep the language professional. The meeting is being conducted as a webinar and streaming. All webinar Christmas except for committee members will be a listen only mode during the webinar all committee members potentially of the speaker webinar we ask that you use the mute button when not speaking. This will help minimize background noise and improve the sound quality of the webinar. We asked Crispin to submit your questions and comments into the chat box located in the go to webinar on the right side of your screen. To enter a question or comment, type into the text box under questions and press send. Please hold all questions or comments until the end of each presentation as your question to be answered during the presentation. Please keep your questions or comments concise, clear and to the point. Transcripts and meeting documents are posted on the listserv under MLTSS meeting minutes. These doctors are

not posted in a few days or receiving the transcript . The caption missed his documenting discussion remotely so it is very important for people to state their name in the chat box otherwise they may not be able to capture the conversation. This meeting is also being audiorecorded. The meeting is scheduled until 1:00 p.m. . We will end probably at that time to comply with political agreements. If you have questions or comments, please send your questions or comment to the resource account . They reference, the accounts listed on the agenda . Public comments were taken at the end of each presentation said during the presentation. There will be an additional period of the in the meeting for any additional public comments to be entered into the chat box . 2021 MLTSS meeting dates are available on the service's website and 2022 days will be there shortly. Thank you.
>> LINDA LITTON: Looks like we have three - - coming up to speak and the coordinator role and community resources.
>> SPEAKER:
>> SELLERS DORSEY: Before we moved to the MCO, Jamie wanted to make an announcement .
>> LINDA LITTON: Okay, I am sorry. Jamie will speak .
>> JAMIE BUCHENAUER: Thank you and I appreciate it. Sorry about that. First and foremost I want to thank Linda and Luba Somits for your outstanding leadership the past year and being the committee chair and cochair we really appreciate you stepping up and taking the position and leading the MLTSS. You did say is your last meeting but obviously is not the last time you will hear from both of you . We hope very soon that he will someday again gather in Harrisburg or in other locations and you will get to see people face-to-face again. We have received questions about honestly when the MLTSS and once again be an in person meeting . We have talked about that as the Department of human services and really, we will be following the Mac once the Mac goes back to in person meetings. It's my understanding the subcommittee will follow the lead . We talked about as the Department of human services the timeline on that and honestly, everybody wants to get through the holidays and maybe even January. Last year, you may remember that Covid cases like that around at the holidays. There's a real concern that we do not want to do an in person or seven in person meeting for December because I was people were altogether hopefully engage see loved ones over the Thanksgiving day holiday and over the Hanukkah or holidays celebrations in December , you have gathered again with family members. He went to January again to probably meet again online and look at the Covid County case counts and make sure we are making safe decisions within the Department of human services when we bring back large gatherings and large public meetings. Just know that we are monitoring the situation. We want to meet in person again but obviously safety of our participants and those that will be attending these public meetings is first and foremost of importance to us. Knowing what happened last year , we are in a wait and see holding pattern. The next amount announcement I wanted to make is really the announcement for the new chairs for 2022. Again, thank you Linda and Luba Somits for your leadership and

participation in being a committee leader for 2021. For I want to announce that Michael Greer was currently the Executive Director of the PA Council on independent living will be out here for . Many thanks to Michael for agreeing to be the chair. He has been a board member for the MLTSS since 2019. In January, Michael will assume the chair position . The vice chair will be David Johnson . He currently works for the Center for advocacy for the rights and interests of the elderly. He will be the vice chair starting in 2022. Many thanks to David Johnson for stepping up and agreeing to be the vice chair for 2022. A congratulations and I thank you to Linda and Luba Somits. Thank you for Michael and David for being the new chair and vice chair for 2022. The only other thing I wanted to mention to everyone at this is an evolving situation and it was evolving so much that it's not actually added to the agenda when we release it, I wanted to give everybody some updates on the American rescue plan act funding and recent developments. So we held a stakeholder meeting , hours or two weeks ago now at the Department of BF - - receive a 10% for home and community-based services. As you know, the Department of human services has released a plan for 10% enhanced funding and released at a high level what are detail was for the use of those funds. At the stakeholder meeting, we did let stakeholders know that the primary use of home and community-based funding that enhance - -4 the office of long-term living is really to enhance payment rates in the community health choices and overall labor programs starting January 1, 2022. That was no surprise as you have heard that before. The new piece of information be released is that we intend to enhance the payment rates will provide an 8% rate increase for personal assistance services. I want to make sure the committee had that information if you do not already hear it. That 8% rate increase again will apply to agency enforcement directing models of personal assistance service and it is the departments intent that the increase in rates will be sustained at the American rescue plan act funds have been exhausted. Some of you may have seen the act want the public notice , it was published in the Pennsylvania bulletin reported that 80% rate increase . It is the intent that our community health choices MCO will pay at least that overall waiver rate starting on January 1, 2022. They can pay more but they cannot pay less for personal assistance service rates. So just wanted to get everybody that information as we have sent that publicly. That is some latebreaking information and I want to the MLTSS to have that information first and foremost. The other this information I will share with you , maybe everybody has questions on is that CMS, not yesterday but the day before in the evening has approved the Department of human services American rescue plan act plan from a 10% usage. We did receive that conditional approval so obviously some of you may have seen a press release I believe it went out yesterday from the governor's office . More information to come obviously, but I want to make sure you get the information on rates as we have been talking about it in different places . I was not sure that this committee had all the information. I know you will be presenting , excuse me, I will not be presenting. I'll be out of the office at a conference next week that we have both the consumer subcommittee and that Mac next week and the following week we have a long-term services and supports

subcommittee . He will likely be releasing additional information about our enhanced funding plan for the office of long-term living. The other thing I know we have scheduled at least tentatively right now is a stakeholder briefing on the office of long-term living parts of the plan for the week of December 13. Much more information to come as we have said publicly. The largest part of our plan is that 8% rate increase for personal assistance services. I want to make sure those of you on the call have that information. So with that, I can quickly take any questions or wait until public comment. It is up to the members of your committee.

>> SPEAKER: This is Monica reprinted the brain injury community. If it's okay I look to raise a topic relevant to the rate increase . The concern is coming from the - - providers who they don't specifically have PAS, they have direct service providers who do PAS like things in the context of their work and they're having a lot of difficulty hiring and retaining . We are thinking that the rate increase might apply to those workers who were also doing personal care are not categorized as that.

>> JAMIE BUCHENAUER: You raise an interesting point to communicate with the brain injury providers. In terms of our discussion with them. Increase the personal assistance service rates first and foremost, our goal was to obviously and we heard this from many providers raise the rates individuals were making that nine to $11 per hour as a personal assistance service worker. We many times over and over again from personal assistance service agencies and actually the participant directed model that because people are making much less than individuals can make at a sheet or Walmart on many of the fast food locations, they were unable to recruit or retain their workers because obviously the rate is being paid by those other entities. We were trying to address that really low rate of pay for direct care workers in our system. We need to ensure that there are direct care workers providing personal assistance services presented in service as the backroad of our program both community health choices and acts 115. If there are not direct care workers available to provide personal services to the individuals in our program, they are not going to have good outcomes. I think everybody understands that. For the brain injury providers, we have talked to - - and obviously the brain injury providers and they have, we do have some support in our American rescue plan act for those brain injury providers Monica, honestly more information to come on that .

>> Thank you, I know they are collecting data about direct service care providers they have, how many vacancies there are and difficult they're having with staffing . I hear you loud and clear. People cannot be safe when manage without them so thank you.

>> SPEAKER: This is Jeff from silk, can you hear me?

>> SPEAKER: Yes Jeff .

>> SPEAKER: Appreciate the rate increases it is applicable to - - and act 150 correct?

>> JAMIE BUCHENAUER: Great question Jeff, it is applicable to act 150 but I did not talk about accepting the beginning of the funding. The funding will obviously be used to support the rate increase for CHC but since act 50 is a state-funded program, state funds

will support that act 150 rate increase. We thought it was very unfair obviously to increase personal assistance service rates in - - to the detriment of act 150.
>> SPEAKER: To other quick questions. Medical since education program, can you tell us if any of the funds are going to be used for that? That was part of the approval ? The second question on disability employment as you most the attendees are aware, there is an agreement between DHS and OVR on disability improvement or any of the funds being used support employment for people with disabilities?
>> JAMIE BUCHENAUER: Good question Jeff. Employment providers may be eligible for funds through some of the other funding buckets that we have provided. One of the pieces of our plan or buckets of our plan suggests a grant program for providers who want to enhance or improve home and community-based services. We are working on the details of the grant program , but it could be something that employment , those providers who provide employment services in the CHC and over waiver programs may be available for. They could apply obviously for funds to address the social determinants of health , look at remote technology and how they can support individuals with remote technology, develop provided training on infection control practices , purchase or invent new software technology maybe for electronic health records, quality or risk management or enable provider to contract with health information order they can exchange real-time information. An implement provider could be eligible and interested in applying for a grant under that portion of our plan. Regarding your MAT question Jeff, I will have to get past back to you. I know you asked a couple of meetings ago and I reached out to the office that oversees the MATP program. I asked if any parts of their plan , I want to say was providing funding for MATP. They did provide me a response, I will have to send a response to you. I cannot find it in my email in order to respond but maybe I can put it in the chat and you can see the response .
>> SPEAKER: Great, thank you.
>> SELLERS DORSEY: Any other committee member questions : Jamie, I got one from the question from the audience . The question is has a rate increase affected now or is it's still in the approval process?
>> JAMIE BUCHENAUER: That's a great question. The rate increase will be effective January 1, 2022. It is technically still in the approval process. I think technically only because we are going through the approval process for the rate increase now with CMS . We suspect obviously , separate and apart from the CMS approval we needed for our American rescue plan act funds, we also needed CMS approval on our rate increase. We have submitted the rate increase to CMS for approval. They pretty much know what is coming so we think is going to be approved and like I said, the CHC MCO will be required to pay those rates starting January 1, 2022.
>> SPEAKER: - - ADP, the officer film until scheduled yesterday?
>> JAMIE BUCHENAUER: Yesterday the office of governmental programs released a letter and I believe an attestation today providers letting them know that they are eligible for

supplemental payments so providers who are eligible for supplemental payments head to the test they want to use those funds as prescribed by the office of developmental programs in their plan. ODP deletes information cycle out Ottawa as well. The office of the long-term living is working on a letter to our providers along with an attestation for strengthening the workforce payments. It's not quite ready yet, ODP is always the first and good for them . Look at the information available for our providers very soon.
>> SELLERS DORSEY: That is all the question I had Linda, if you want to move on .
>> LINDA LITTON: Okay, we can do that.
>> SELLERS DORSEY: This meeting we will start with America health so Jan, - - and Melissa .
>> JENN ROGERS: I'm here to present today on - - community resources. Next slide please. To state the obvious, we know that texting to community resources is integral to successful independent living but also the Covid 19 pandemic is highlighted some vast inequalities and inequities in the community. There is no better time to discuss ways that our AmeriHealth community choices service coordinators work to connect our participants with resources available to them in their communities. Next slide please. Talking about food insecurity, food insecurity has always been a top of mind area considering the population that we serve in Community Health Systems. One in three people who are food insecure are unlikely to qualify for federal nutrition program. We are grateful that home delivered meals is an included benefit in the MLTSS benefit package. We have service coordinators ask questions to our participants. Do you have enough food to eat today? Over the past year or specific timeframe, have you had trouble getting access to food or items need average to healthy? These are the types of questions that are service coordinators ask the participants during the assessment or competency need assessment . This information forms what services and support we offer to the participant based on how they're answering those questions. So home delivered meals and also help in rolling and snap benefits such as supplemental assistant nutrition programs offers through our Department of human services, those areas of focus that we try to close the gap on any food insecurity issues that our participants may face. Next slide please. Also important to whole person care and community resources that are available , our internal collaboratives came focuses on educating our service coordinators and also dispense on topics such as budgeting, knowledge of utility programs and tapping into assistance programs , understanding tenants rights and eviction processes and the laws article 2 eviction . Information is available on our website for participants to access and also for service corners to tap into regarding emergency rental assistance , Covid 19 related resources , County listings or vouchers and public assistance programs for housing related resources . Our service corners are trained for participants with unique and specific housing needs to our internal housing resources teams so they can support the participant and now meeting with community resources that are available in the local area. Next slide please. Another area that is important to discuss and address is , I'm having a hard time sorry. Social isolation. Our service coordinators are trained to assess the psychosocial well-being. They

also administer the - - assessment and is appropriate response to behavioral health services or coordination team are made in the important - - available to the service coordinators to pursue paints with available resources and behavioral - - behavioral health providers in the community. Our service coordinators are also training to discuss benefits that address help with the feelings of isolation which include nonmedical presentation, getting out, going to community events , seeing family as appropriate gatherings with friends , adult day programs , also combat social isolation. Community integration and appointment services are all benefits offering - - authorized by the service coordinator to engage pursue paints in the community related events. Next slide please. When talking about caregiver support , I presented on this in the past - - in the digital health engagement coordination. It offers organize an actual information to support our caregivers through their specific journey. We are expanding the offering for the AmeriHealth zone coming in early 2022. Right now it's available in a southeast zone suffer caregivers that reside in Philadelphia, Montgomery, - - Chester County. We are working behind the scenes - - Commonwealth in 2022. Next slide please. The assistant test analogy, I want to touch on this . It's definitely top of mind in 2022 to deal with important things in this area. One is returning our service coordinators . There are folks in the audience are subject matter experts who we are looking to lean on and learn from regarding what is this technology, how is it were, and how to talk about participants to perhaps increase their knowledge and ultimately access to technology. Our aim is to increase utilization of the benefit . We think that their approach to that - - is welcome our patient therapist - - appropriate analogy can bolster their independence. Next slide please. We talked about whole person care and everything I discussed this morning at about how do we make sure that we are addressing not just the daily services that dispense my knee but also talk about housing, talk about social engagement, talk about what is important to participants and keeping service coordinators informed, trained and supported throughout team of subject matter experts and folks that are on our teams that support us with housing, employment and clinical areas of care . As a managed care organization, we the benefit of having the subject matter experts available to us and our service coordinators. The Commissioner service corners have access to those folks so they can talk about how to best support or best interest. The piston on her caseload might be experiencing. Also, our wellness centers. We see them as opportunities for participants to engage in activities , 10 education events and are hopeful in 2022 we are able to reopen the locations and they can resume seeing our participants face-to-face in the communities where they live. We are presented previously on the survey and how we use those results . That's an opportunity for the plans to get feedback and what we are doing and what is working . - - Based on the results we get from our surveys. Our find help formerly known - - community resource outperform to make available the resources information to our service coordinator . Anybody can search and now find - - to connect with community resources available in the local area. Next slide please. We have a specific URL from our service coordinators are trained to go there and use our URL so we

can close the loop. So we can get data back to what exactly are our service corners using the platform for . Are those referrals being made ? Closing that loop substance are connecting with the services available to them . Again, we are excited to say that - - is an industry leader in being able to quickly that resources and add them to the service offering in the platform. As things pop up, so food trucks or farmers markets or co-tribes if you will . If that information is referred to it as quickly them listed as an available service offering and a specific ZIP Code or location. Pretty cool stuff available on the platform. Next slide please. I wanted to share success stories of illustrating what the Brisbane in-service correlator is in community health choices with AmeriHealth and Keystone community health choices. One story I wanted to highlight was Sam's story. It illustrates that advertisement was feeling overwhelmed and he was having issues with his housing. He was having issues with this behavioral health . We talked about this with the service coordinator. The service coordinator did not address those two areas but are looking at the physical health and engage with their complex chief management team - - navigate the fiscal health if they are not able to meet going independently. Sam agreed to case management services are also working with the service coordinator in the housing team for a better place to live. We are able to report back progress and that is what this is about. How to change and adjust your goals and the services perhaps perceiving the community health choices program to best support the areas of need that one might have. Sam was successful in case management and decided to - - still receiving services and supports their benefits and connect to the service coordinator. Next slide please. We also wanted to highlight a housing success where we had a participant who we helped engage on section 11 with Luke and housing coordinator nature that opportunity was matched to upper dispense . We work with the Brisbane to find that location that met his needs best and he was able to move into new subsidized housing. The net feedback is always important. He was sure to tell us this coordination housing team , he was happy that everything fell into place . He was grateful for the service and support he got from our team. Just wanted to share that , a small win for one of our participants in the housing stage. Happy to answer any questions but that was all I had today for our presentation. Thank you Pat .
>> SELLERS DORSEY: Sure. Do any committee members have questions for Jan?
>> SPEAKER: Hi gentlemen this is Dave Johnson. I wonder if you could expand upon - - expanding to the other zones in 2022 , could you give some examples of the hopper dispense or caregivers may use this app and give any idea that utilization rate by caregivers currently using - -?
>> JENN ROGERS: David, I was having a little bit of a hard time hearing you. There was a little bit of an echo but I think you are asking about - - and that so sorry, I was missing - - I do not the current status of my fingertips but I'm happy to provide you that off-line. I will say, if there any ideas for engagement or opportunities to engage our caregivers over dispense to direct them to the app, we are constantly looking for ideas to increase the use of the resource . We've done so far as trainer service coordinators on how to present the

act to pursue pins and their caregivers. It's really easy, everyone is able to do it. Downloading the app on the smart phone and also contact subscribers have access to full content which is super exciting. We trainer service corners to do is a little demo with participants and show them the library of resources that are available and truly, it does not have to be an informal or caregiver that benefits from the materials available, it could be anybody. We could have anything to have them prepare for doctors exhibit visit to caregiver burnout, mitigation strategies, all of those things are resources available , all topics that are discussed in that resources attached to them and are available in the app. I do not want to take away to be that it is limited to informal support. It is anyone that is caring for someone that is quite a bit going on in their lives is a way to organize and navigate through the programming and the physical health and community resources available to caregivers and dispense alike. I hope that answers your question.
>> SPEAKER: It does, thank you very much .
>> I worked as a community resource page , I would invite you to check it out .
>> SPEAKER: Perfect, thank you.
>> SELLERS DORSEY: Any other committee member questions? No? Okay. Jan, I have several free from the audience. The first is from - -, she was wondering if there's any data available on the number of people assessed using the PHQ nine and the number of referrals made?
>> JENN ROGERS: Two things I like to say to Lynn and this is a follow-up to the previous discussion. Just to illustrate the flexibility , Lynn and Lloyd met with our team off-line to try to figure out a way to have a behavioral health resource domain added to the platform. That conversation happened several weeks ago and we are still in conversation and how to avail that. I think it's super cool that we were able to have that conversation, bring the stakeholders together with the tech team and figure out a path forward to make sure that behavioral health is its own separate category and own separate topic area available . More to come on that but it's a good opportunity and a good reminder . The questions about the PHQ nine. Yes, we absolutely have data available to us in terms of a plan on the scoring of the PHQ nine that is administered. Our service coordinators are trained as to what to happen next regarding referrals or other interventions is appropriate as a result of how a person is responding to the effect . - - The Realty was making to the managed care organization .
>> SELLERS DORSEY: I guess the question then is can you share that information?
>> JENN ROGERS: The referrals we do, yes. I do not have it available right now in front of me but I - - as part of our quality services committee report . Every monthly report out that data. It's available and I can certainly share as appropriate.
>> SELLERS DORSEY: The next question is from Pam - - service Quinn Nader believes her modification but the occupational therapy or physical therapist disagrees or if someone higher up disagrees.
>> JENN ROGERS: If I'm understanding the question correctly, only to go to bat the question

is through the evaluation process if the result a DME is not approved. That the day - - and a policy and procedures in the agreement. If advertisement is requesting a service and is evaluated and gone to the prior approval process, that is exactly the service coordinator what they are trained to do and follow. The other opportunity Pam into the service corners again has access to - -. If they want to present the spit information there whether it's a home modification or behavioral health need or anything they can take to case terms and present to our subject matter experts in all areas to talk about what makes sense and what a good action plan to address the need going forward is. That's an available opportunity for all of our service coordinators. To be very clear , the assessment and request process is what service coordinators - - benefit .
>> SELLERS DORSEY: Next question is also from Lynn Cooper. To the service corners have a good working relationship with the area agency on aging ?
>> JENN ROGERS: There's always opportunity to meet reeducating our service coordinators through the network but to answer your question Lynn, from a plan perspective we do have a good relationship with the aging network and tried to work look for ways to keep that relationship fostered if you will through continuous conversations and engagements. I know it very the service offerings are so we are anxious at our plan to find opportunities to engage or collaborate as appropriate with the aging network. So absolutely. I would put this plug-in, from a training perspective always looking for subject matter experts to train and educate our service coordinators .
>> SELLERS DORSEY: Goes to the specific questions I have for you Jan on the audience. Next up is Pennsylvania health and wellness . Olivia Martin and Bailey Carey will be presenting for pH W .
>> BAILEY CAREY: Can you hear me?
>> SELLERS DORSEY: Yes, thank you Bailey .
>> BAILEY CAREY: Of course. I see Olivia is on as well. She is trying to connect to audio. Good morning everyone
>> SPEAKER: Good morning everyone, my name is Olivia Martin. Also for today is Bailey Carey. Daily the executive VP of PA health management. She is here with her team to highlight success stories and also provide additional information that service coordination and the role of the service corner with accessing community resources. Thanks for having me, happy to be today speak and how they access - -, Bailey, feel free to chime in whenever you feel you can add to the content.
>> BAILEY CAREY: Absolutely .
>> OLIVIA MARTIN: Awesome.
Please . Most of you are familiar with the person centered planning process . Community resources can be requested through the same process as any other service. Also it's really important to keep that service coordinator in the loop of your specific needs. They can be requested to service coordinator and to the person centered service plan process. The service plan include appropriate services to help maintain health . For our waiver

participants , it ensures the provide support individual needs are likely needs to avoid hospitalization. The big role of the SC is to help avoid risk. We want to keep up dispense in the home and community is much as possible and avoid any kind of risk that would result - -. The service corner along with the person centered planning team will utilize the assessments to the content of need assessment as Janet was talking about and also documentation of paying for meetings and discussions with the individual . To secure information of business needs including healthcare needs, physical health needs , preferences, goals to help develop this person centered service plan. The service corner data update information on ongoing - - current needs . Just because needs change over time. We have all seen that happen with our current state of Covid and how things are really evolved and changed throughout participants, our own lives in our community lives. The service corner talk to any potential revision with the present and the individuals important to the present. This outreach done on a monthly basis and as needed to keep the sessions going and to ensure their meeting individual needs. When building the service plan that often used community connect. This is specific to CHW and access from a Pennsylvania health and wellness website. Community connect is a wealth of resources organized at the fingers of the service Quinn Nader went creating the service plan. It's also available to other staff and also dispense to help them see with available to them. If you would go to that pH W PA health and wellness.com, you would see it available in the community tab at the top there , it's called community connect. Through this service you can have reduced costs of select medical care , job training , food resources from those information related to transportation. Financial assistance , legal assistance and info on skills and training effect of the judgment is interested in . Next slide. This is also the link to community connect that you see on the PA health wellness.com under the community tab like a spoke about before. It's available for community partners and our participants. It's organized the local . Skip the
quickly , you will be able to input your ZIP Code and search for services that are local to you. You can access things like the local food banks , food drives and places where food trucks . I would - - to our pH W website.
>> BAILEY CAREY: You have said already there tons of resources on it and as we go through - - highlight a lot of the main areas it covers. Isearching several cities across the state that there are thousands of resources when it comes to food, housing , goods, any kind of assistance a person might need living in the community. I think as we go through, we can add more of the slides .
>> OLIVIA MARTIN: Absolutely. Next slide. Addressing things like food security during this time with the challenge that Covid is posing, food insecurity is top of the list and a big concern for all of us. The SC also has questions during the company to needs assessment to help us determine if food insecurity is the challenge for each participant. If this barrier or challenge is discovered, they can access resources along with the benefit and also to community connect like a spoke about in the previous slide. RCC benefit does offer

specialized meals . There are a lot of resources tailored to the needs of the present. They can offer a cultural meal, kosher meal, meals that address special health needs such as diabetic needs . Low sodium diet and heart healthy options. There really is a lot out there that is being offered. I try some of these meals and they are not bad at all. We do encourage and are trained to assess for any kind of food insecurity. There is also on this community connect temporary assistance for needy family benefits. Some of the temporary assistance that is available to help people through a tough spot if that is the case. There are a list of farmers markets and that is also tailored according to ZIP Code. Resources for adult learners can provide - -. I just encourage you to take a look at that.
>> BAILEY CAREY: When it comes to using community connect online, we can effectively for food anyone can search - - is missing the community. They can find resources on food delivery , food pantries nearby . Participants typically in the program are approved for home delivered meals but said they have individuals who are not, there are resources to help pay for food . Meals and also nutritional education. There is a lot included in this site and we use those resources every single day.
>> Absolutely, thanks Bailey. Next slide. Housing that housing is great opportunity research with community connect. We do have a housing specialist on staff that works on housing specifically. Housing applications, hide applications, whatever the case may be , that is their specialty and that is what they do. We are able to pull in housing specialist only do it then if I needs to the company to needs assessment and also challenges with nursing home transition and finding housing. On the community connect there is a link to the 811 program . Obviously United Way , though 211 utility assistance and community resources are available and you can find more information on that. Next slide.
>> BAILEY CAREY: We have quite a few success stories. A pathetic couple to share today but especially regarding topics. Service coordinators help individuals in the community every single day . I have met many people personally and down to the service plan as part of the different types of care they can receive technology but think that will help them from day-to-day. We see this on a daily basis. One story I can speak first on, if someone needed help with additional assistance . We work with an individual, they were having a difficult time with some of the providers not necessarily their fault, they were trying but the home delivered meals provider suspended the service because they were having a hard time getting a hold of the client , the individual present . In addition the first provider, the need to replace the device that person was using. The service coordinator also found when they first started working with them they did they do not have a concrete backup plan in case any emergencies are going to happen . The service according to the present , with health and wellness in the service providers and individuals choosing . We did internal meetings with health and wellness, the providers and placement all in one call. They discuss areas of concerns regarding the best care the basement and in the end the service coordinator was able to link the percipient with companies that have a new device and a new home delivered meals providers and have a level backup plan . The new service providers helping

to ensure their safety while in the community . This has been established since this are working to the coordinator, then I had a problem since and maintain fluid communications. In the story we have with housing assistance , this was a big one. We had an individual we were working with still do - - at the time of the story they live in their home for 10 years . The service corridor was alerted by the participant that their caregiver through the caregiver the basement will have to start paying that market rate for his apartment because he missed the deadline for the apartment complex. This would increase their ranks dramatically compared to what they were paying and they would have become homeless if they did not find another option. The come to the building manager and was informed there was nothing they could do because the update was sent to hide to increase the present rent. The service corridor contacted the Philadelphia hide office requesting assistance to help them remain in their apartment and they were given the opportunity to complete their overdue paperwork. In the end, there was a slight increase in rent nothing compared to what it could have been an advertisement was truly happy to continue living in their home . They argue that there 10 years and since the story, it has been some more time. Those are just a couple of stories on these topics.

>> OLIVIA MARTIN: Thanks Bailey. Next slide? Along the lines of social isolation, the SC does work with in a fight if you have any social isolation needs or any risk for social isolation . In addition to other standardized assessments incorporated into our health risk assessment, our SEs will ask questions to get the conversation. A lot of times - - making sure that person is comfortable with you because there are times where our members don't want to share the intimate feelings with someone on a much lesser service coordinator. Just by asking those questions become identify and find those at risk of social isolation. There are a lot of research to consider in addition to community connect find those resources at the tip of the fingers and employment opportunities. It also might be as simple as advertisement is likely to go to the local church or community center once a week or whatever the case may be. Something as simple as setting up additional presentation can go a long way with social isolation especially during Covid. We all feel a little bit sheltered and it would be nice to be able to meet on occasion face-to-face more often than we can now. As the holidays come around, I think you all feel that a little bit more and is really important for service corridor to be trained on this and identify this when it is a risk .

>> BAILEY CAREY: To add to that, be of service coordinators reaching out more often than when Covid hit specifically for this reason. I know many officers including ours has someone dedicated to reaching out and doing spot checks. Service corridors do have , you post the questions here. They ask specifically these things. They track depression, loneliness, how the person feels . Many Christians do not have family or friends nearby an individual from the office calls and spot checks on those that are highlighted as having the need for the service coordinator. In addition, social isolation the ensemble is alone, we will forked individuals who live with their family but they likely more independent and don't like being stuck at home . People of all ages , we visited homes for someone says look, I know

I'm in a wheelchair but I really want to work and I want to be out of this house, I just want to do something with my life. It's like to see how it would help people find employment . Typically our service correlator has their assessments and the competency needs assessment , notes and the paperwork for their work a lot with individuals on the personal unique needs. Everyone has one. The just a few examples of how business corneas can help with this .
>> OLIVIA MARTIN: Caregiver support. Even potent informal support my family members, whatever the case may be is always good to check on the well-being of those providing care. Community connect has a great section for caregiver support and provider support. They can address burnout and even offer support groups, Christ hotlines , training resources . That's really important to keep match the expense well-being in mind but also those providing care. It does affect our participants indirectly. They do assist with connecting caregivers . Mentors providing additional path, there is respite in the form of other place the person can go. It's always good to keep the care of our caregivers in mind also spotlighting the PA Department of aging does offer that PA caregiver support program. As a huge resource and provides individuals for that relationship. And to keep their relationship strong never spent . We focus on the well-being of their caregiver and aim to alleviate the stresses associated with caregiving . As we all know, that can be stressful for the participants and the caregivers.
>> BAILEY CAREY: A no on this is that caregiver burnout is very real and it is something we have seen many times have in the past we have an open line with service coordination even if individuals who assist or dispense call in but anything they say, especially regarding the care of a participant has to be confirmed with a person first. If someone reaches out saying that I need more support , checks and balances, service coronation has in place . We don't like to let a caregiver work 90 hours a week. Even 60 hours a week is pushing it. Maintaining normal working hours of participants is important not just for the caregivers mental health and well-being but also the participants. That is one check that is in place and there is also open hotlines of agencies that they can call him. If they address or bring up any needs they may have , that means the person may have the same. Everything is to be confirmed with dispense. They are allowed to invite anyone they would like to those calls. It really providers and family members and talk about the care. That's all for this one.
- - Communication sensors , mobility aids such as walkers , wheelchairs , voice aids, vehicle modification and home modification. Also assistive technology can be sort of in the form of telehealth appointments and assisting dispense with setting up appointments if a special permit is needed . During Covid it's always good to keep that option in mind that that is something that our members are interested in. Moving to 2022, we do have a lot of upcoming training plan for service correlator's. We would like to increase utilization in the lives of our members and service plan. We have training to client regarding what is available and can options they have and how to best partner and access these benefits.
>> BAILEY CAREY: - - Which type of technology might need or benefit from that they are not

aware of - - connect website with health and wellness. You can search for ZIP Code - - covered many times a lot of these technology needs . Service correlator they don't just focus on Medicaid. We know Medicaid is the funding of last resort. When you log into a poorly considered dispense Medicare and Medicaid cover and if Medicare were to have a Medicare. Today traditional or federal Medicare? A Medicare advantage plan? Those types of things service corridors are here to help with . I can go into more detail but I don't know how much I should . I will answer questions if you have them.
>> OLIVIA MARTIN: Awesome, thank you. Let's talk about whole person care. Recently here at PSW, we did structure our teams to continue to address needs with more of a whole person care focus. This is our approach for integrated care but does encompass all the person's needs. We involve many departments to take a look at each person to create an individualized plan specific to their needs. For example, our behavioral health program offers - - program. This aggressive dispense may be at risk have expressed the need to - - pain management or non-opiate options. Our behavioral healthcare managers partner with the SC to assist with meeting any unmet behavior health needs. It's a bridge or liaison between - -. That partnership remains strong and that multidisc Larry approach is the best way to really make sure that there are no care gaps. Our special needs unit help service correlator with more complex barriers. Oftentimes the partner without conditions care teams. Our conditions of care team supports our members through complex discharge barriers when returning home from the hospital or shirt nursing facility stays or long-term nursing facilities days. This seems as if we focus on trying to anticipate any potential risk that can result in a readmission. Just keep in mind that whole person care is so important to be able to address all the needs, not just long-term for services. Next slide please. Through these integrated care services, that approach that I just spoke about, there are couple of options here . We have regular meetings which are into this plenary care team meetings. Our teams work really closely with all members of the Pistons care team whether it's physical, behavioral health, pharmacy, the medical directors, individuals families, the dispense and their care team. ICT meetings are regular scheduled meetings. They are down around every six months. They are scheduled in a clippers bent and anyone the present would want to include plus anyone involved in the care. Case confidence can be initiated anytime. That's the difference between the two. They can be initiate by family, by the participant , a team member at the plan, PCP. Anyone seeking support to help provide care or address any barriers that are identified. Next slide. So this whole person care and integrated care services , participation in this is voluntary. This isn't anything that is force, is obviously a voluntary program and participants need to express that they want to include all these folks. Wherever the person chooses to be included in that plan of care and help them plan their service plan , I want to be clear that it is a volunteer program. We also continuously assessing the quality of the services being provided to our members and Dennis Booker previously about the Survey. In addition with looking at the satisfaction of our members looking at the quality of care being provided, we want to know where we can

improve and where we can help improve the care being provided. Today we have added a few ways to tailor our approach to address individual care needs especially with community resources . I really want to stress that whole person care approach is really the focus here at pH W. Keeping the individual needs of the focus, we are able to work together to renew those barriers for artisans to get well, stay well and live well. Any questions?
>> SELLERS DORSEY: Any committee member questions? For Olivia and Bailey .
>> SPEAKER: Hi Olivia, this is David Johnson. He said case counsel can be initiated by anyone , how the initiated and by whom?
>> OLIVIA MARTIN: There more of a regularly occurring meeting. It initiated generally by any kind of partnering Medicare plan. Whether it's an aligned Medicare plan there is more on regular basis. Their accidental and topic and addressing concerns but there are formal ICP meetings generally with a Medicare plan initiated unless the need is identified by the service coordinator or the piston expresses they want a formal ICP, they can always be requested.
>> SPEAKER: Thank you for that. We work with consumers navigating housing issues which we recognize that a pumpkin for a number of reasons. We cater is a typical example - - housing specialist you have on staff. What kind of follow-up is the consumer gets? Is there a call of service correlator? I wondered if you could expand upon how this relationship works .
>> OLIVIA MARTIN: The SC has a resource of the housing to find the kind has an individual needs. The follow-up is done in an as needed basis as always but it's frequent. They can retain info from the Housing Authority and help with the application process . Any kind of low income housing the content and availability . Utilize the housing specialist to help with those behind-the-scenes type of resources. All of this is pretty individualized depending on what the specific recipient needs .
>> SPEAKER: Is December the housing specialist or the service coordinator? What is the scope of assistance who may not be able to quickly application on their own?
>> OLIVIA MARTIN: The SC's were instrumental, the housing specialist is a huge resource but the SC sort of is the closer to the president. But nobody's been to the entire application process. They drive that hands-on support.
>> BAILEY CAREY: David, one on that the service Grenada will visit the prison in their home to sit with a mental paperwork if they need it. If not online through email but most often it is sitting next to the present.
>> SELLERS DORSEY: Any other committee member questions? I have several from the audience ? To start with , can you talk about your , are you using the - - to identify - - assessing your products - -.
>> OLIVIA MARTIN: Absolutely. The conference needs assessment, generally the way we view it , it's, you have a couple of things. The MRI is our primary needs assessment . That assesses for needs - - we do that in collaboration with as well. It focuses on physical health needs , some of the social isolation. People's feelings towards her own health . Yes, we do

use the and RI as a primary needs assessment from a series of other assessments as well.
>> BAILEY CAREY: Service coordinators really try to cover physical, mental, social aspects of a person's life. The legacy mind, body and spirit plus cultural concerns. We use the company to needs assessment the - - health risk assessment . People additional notes for example . And you dispense think of his other services and very specific questions which help target their specific needs without them saying it so is encouraged to the questions that are asked . I think that covers it .
>> SELLERS DORSEY: Do you have data available on the number of people who identified as neat meeting a need and the referrals that were made ?
>> OLIVIA MARTIN: We are always tracking and pulling data according to a couple different things. Obviously it spoke about you want to find out - - trends in different needs and areas. We know how to address and improve our services on a daily basis . Anything specific you want to know about, I'll have any numbers at the tip of my fingers but it will be more than happy to get it off-line .
>> SELLERS DORSEY: The specific request Linda was looking for relates to any type of behavioral health disorders. Related to that was a request from Janice minor . She was asking for pH W but probably for all the NCOs, would you be able to provide data on the number of people we have identified as needing assistance with use problems?
>> OLIVIA MARTIN: Absolutely. That program is just starting up. I'll be more than happy to work with our department to pull some of those numbers . We do have that liaison the referral specialist the work hand-in-hand and they are very involved in this program. We are excited to see what the numbers look like and get some results.
>> SELLERS DORSEY: Thanks Olivia. The next question is also the time that - - asked , how does the service corner go to bat pushing on behalf on the service but it's been believes - - medical equipment or a home modification with the occupational or physical therapist disagrees or someone higher up disagrees?
>> OLIVIA MARTIN: It's pretty similar across the board to what Jen had responded to that question . It's laid out in exactly the process for even grieving the complaint and grievance process is very specific . We do our best to assess the best we can for any type of - - but for some reason - - there's always a substitute offered or other ways to look at things and follow the defined complaints.
>> BAILEY CAREY: If there's a situation in this case they're requesting for a piece of equipment is I don't see the need , if this is related to the service coordinator, they are able to work hand-in-hand with the MCO without doing the meeting if they will include the service corner percent occupational therapist . In addition you will have nursing staff and medical director . Everyone will discuss the need and will be determined if needed . It is not needed, maybe will have more understanding of why it's not needed an alternative services can be provided or given as an option. This happens as well.
>> SELLERS DORSEY: The next question from Lynn Cooper . How would you characterize your working relationship with the local area agency on aging?

>> We have a strong relationship. There is always room to improve contracting these relationships but there are plenty of resources out there available through the aging network and also . There he reaches every day with start bolstering and remembering about. We do me with the leadership on a regular basis . I know Anna Keith is involved in that and she has an established relationship as well. But as with any relationship, there is always room to make it stronger . - - Is one of our senior directors in pH W. He also meets regularly with the aging network leadership as well.
>> SELLERS DORSEY: The next question is from Kate, what about - -? Is there a plan for them ?
>> SPEAKER: Four begins? There is a vegetarian option. As far as vegan, I know I did speak to Cindy the other day and she said they are investigating and trying to develop vegan option. Hopefully more to come on that.
>> BAILEY CAREY: And no service corners can help you find provided has vegan options. I have several that have the only vegan the ones that are culturally appropriate . If we population, could be anything. Service corners help with that .
>> SELLERS DORSEY: Rich, do you have a question?
>> SPEAKER: No .
>> SELLERS DORSEY: The next question is from Lucienne Newman. How do you measure the effectiveness of the referrals? Do you know how long - - and what extent the needs were met?
>> OLIVIA MARTIN: The service correlator works to - - needs that have been identified. Along with tracking dissipation in the program, we can always do that. But the constant back and forth, the check ins just to see how they're progressing to meet those goals they have and bridge the gaps with the identified needs is constantly being touched on by the service coordinator.
>> BAILEY CAREY: To highlight that, but dispense are approved for service providers receive authorizations. They do keep track of them , how long it lasts and which authorizations , if the authorizations are being utilized or not. For example if they are approved for service but it is never used or always used to the max . In addition to meet the goals the present that is listed in the - -. They documented every time a piece ESP is complete. For example, I work with the participants. A very wonderful person. I met her myself in a nursing home. She says several goals for herself and set my goal is to not only be back home, but I want to walk the neighborhood again. I like to go out and be with my neighbors and I like to make candles and the candles which do not burn but to have it sent . I have a lot of goals, we put this in the piece ESP. She providers to help her come home and she needed transportation initially. She needed a wheelchair initially. Some time passed and she finally met her goals. I have a candle in my windowsill right now. I think she gave a candle to everything a person in her office at some point many years ago. So yes, the authorizations are tracked and meeting goals is also connected to the providers in the organizations and the services are being utilized or not.

>> LUBA SOMITS: Think that's a good observation Bailey, we have monthly - - we submit to all LTL and all that is the report . We do monitor missed visits . If there are any kind of gaps notified , we are notified of the missed visits . We have a service corner to reach out to make sure that the policeman is safe and try to mitigate that risk and why is this therapist being missed? We are constantly in touch with what is being provided , why it's being provided .
>> SELLERS DORSEY: Those are all the questions that I have unless the committee member has another question. No? Okay. So thank you Olivia and Bailey . Next up will be UPMC with Kim Maddox and Lincoln .
>> SPEAKER: Just so you know bits April Soriano if you can argue her .
>> SELLERS DORSEY: Sure, let me find your microphone .
>> SPEAKER: Unfortunately and had an emergent so April is filling in .
>> SPEAKER: Thank you so much for the time to be with you all this morning. We are glad to present on the CAC service corner role in accessing community resources . Like Mike Simmon's April Soriano, I'm a training ritualist and you also be hearing this morning from Kim Maddox, our senior manager for community relations . Next slide please. As we know, but dispense in the community health oftentimes experience the greatest hardships and barriers for accessing resources. Because of this, the goal of service corners to assist our dispense in overcoming these barriers. Similar topics have - - social isolation , caregiver support Mr. technology and whole person care.
Please . The time service corners hire they receive prescheduled calendar - - statewide and regional training sessions. That's not politically across the state as well as code geographic specific updates. The on the Pennsylvania is a diverse region whether the culturally , urban versus rural and just the size of the state as a whole. Therefore, having both statewide and regional meetings allow for tailored information and resources to be discussed. When it comes to statewide trainings, you can see at the bottom half of this slide these trainings are recorded so the information can be viewed if the meeting is missed or for service correlator ever wants to return back to a specific topic and have a refresher course of knowledge. My PC cover is community resource guide . It's one of the first ways that our new service coordinators have the means of learning about local community resources and additional information for our participants. At this time, Ken is going to present a little bit more in depth on our resource guide so can if you are available next slide please .
>> SELLERS DORSEY: April, I am not seeing Kim Stephen okay, I can continue, that is no problem at all , thank you . Wonderful. But you can see in this slide is on the right-hand side , this is our right and for the community resource side . As I noted when the service coordinators, when they are first going through our orientation and then in post orientation as well , they are made aware that this is a platform that is always updated in real time and both on the left and right hand side there specific search options that are coordinators can access to delve a little deeper into any resources that are needed by our participants. In this swing chair on the right-hand side, what you will also see is there is

almost like a rectangular box to submit a resource. This is really valuable for our service coordinators. If they are ever aware of a local resource that is currently not listed in the guide , and they are able in my time to go ahead and submit the resource and we have a team that almost screen that resource to make sure that the phone number, the addresses, the contact information and everything is accurate related to that specific need. It's a really great live time, always updated tool that coordinators have the fingertips to search more in depth. Next slide please. Just to focus a little bit on those topics. When a coordinators selects a specific category or resource that they are looking to be more knowledgeable or connectivity to, what they will do is they will click on the specific symbol indicating what that need is. The needs available that more information and resources are available include housing, employment , food and pantry. Behavioral health, utility, cognitive disorders , home repair , adult education, public legal assistance and support , faith and recreation. Was really nice about the resource guide is a coordinators able to search private participants and residential counties. Not only is it specific to the geographical location of the participant but it offers a wide variety of locally based resources that we then have the information such as the contact phone number, the best contact person and we are able to provide to participants in several times we offer three-way calls. That way for dispense not feel comfortable making those calls or connections themselves , our coordinator able to almost act as a liaison to be able to connect up to spin to available additional support. In our new hire service coordinator on boarding which is basically our orientation once a corner obtained as a caseload , it is reiterated that our assessment is almost a foundation or - - holistic needs of the individual. The MRI is more to the beginning platform or tool used to identify what it is our dispense needs or barriers are. Because of that, they very pointed questions which address several barriers our needs. Our first focus point is on food security . As you can see, the assessment is asked specific questions related to accessibility and availability and even along the lines of has advertisement never had to barter or trade off something they had in order to obtain a resource or something they don't have at their discretion. Then the question becomes once these questions are answered, what resources do our coordinators have been noted to have a participants overcome these barriers. Next slide please. As we just covered a little bit ago, one of the tools that are corners have greater discretion is the community resource guide with the food and pantry option. Again, they are able to review by geographical location of the participant as well as the food security that food and pantry target or issue . They're able to gain the contact phone numbers, resource locations and further assistance with food needs. In the discussion over dispense, we are also able to provide accessible food bank information that whether a participant , an informal caregiver or support or even a caregiver or an aide may be able to make a trip to a local food bank in order to obtain some of the food staples. Coordinators are also made avail of region specific distribution events for they are able to share information with our participants. Again, more so locally based one time distribution sites and centers. That way we are not just

discussing what is available statewide but we are making it very participant centered to their needs. One such example is the senior farmers market voucher program where participants and/or service coordinators are aware of when this event takes place. Basically what it is, the persons go to oftentimes decentralize location . We are able to receive , I believe it's for vouchers. Each of them have a specific price affiliated with the voucher . The Pistons are able to obtain those vouchers free of charge and there are local farmers who accept those vouchers in exchange for fresh fruits and vegetables. Our coordinators as they are made aware of these one-time distributed events , they are able to relay the information to dispense and make sure they have been means to be able to go there whether or not it's through our nonmedical transportation or other alternatives to making sure they are aware of what is offered in the community. Coordinators are also aware of the USDA website that is offer resources for accessing food and whether or not there are food insecurity concerns or issues. Next slide please. Often times we often find that Pistons are not aware of the government resources that are available to them . One such example is the availability of snap benefits . They are pointed to the County assistance office. Our coordinators will hold these persons under discussions and will educate our participants on government benefits such as a snap and enforcement isn't really sure what is not know whether or not they qualify, we have our eligibility team who is able to provide further support to ensure that advertisements are connected to those benefits of which they are eligible. Again, many of his benefits and offerings are unbeknownst to our dispense. Our coordinators really do have that educational and advocacy role to make sure that our prisons are aware of everything that they are eligible to receive. Next slide please. Housing hardships is another barrier that up dispense may experience. Maybe they are unaware of where to turn or who to obtain further information from. Our coordinators are ready to be able to assist . UPMC get a housing strategy team that will oftentimes step into assisted service coordinators in working with her for dispense. Our housing team support the service corridors the offering information and guidance in order to topics such as eviction notices, housing options, resources related to local services and general information and even things along the lines of tenant education . Our service coordinators are aware that once the persons express housing concerns , our service coordinators have the ability and are aware to make referrals to our housing strategy team. I really nice perk and to me I will discuss a little bit later on is that UPMC CHC, we have a website that is dedicated to our participants , to caregivers and it also offers a specific section in our website related to housing information and resources. Not only our participants but informal caregivers , and mentors Internet capabilities. They able to log onto the website and delve a little deeper into all of our housing strategy team offers. Our housing strategy team also wanted to share some success stories . One such success is that they help to connect dispense the section 811 program. They assisted with navigating the waitlist and the application process to access the housing option . More recently our housing team identified housing option for participants with a housing choice voucher for the present and that family members.

This rate collaboration with not only the service coordinator, the participant and the specialized teams such as our housing strategy team make sure our prisons are being holistically tended to. Next slide please. Social isolation is going to impact the well-being and overall life satisfaction of our participants. Because of the goal of CHC is to ensure up dispense our thriving regardless of their location , we are always at our forefront of making sure that we have this discussion with a participants as far as the level of social connectedness. Again, we will delve a little deeper into how we go about having those conversations but on the opposite side of that we have coordinators ready to assist when these needs arrive . Next slide please. As mentioned earlier, our assessment is that foundation , that backup were starting point for having this conversation as far as Pistons needs or barriers. As you can see in the slide, we go to specific sections related to questions of social isolation . Section F target psychosocial well-being. Questions related to the ability to connect with others recent dialogue and interactions with family members and social supports . Social isolation is not just that connectivity to other person but it's more so on a grand scale as well as the connectivity feeling connected to the community and ensuring that if there are any struggles or concerns that we are ready to assist and help our needed . Next slide please. Similarly, what resources do our coordinators have when these needs arise? Our coordinators discuss the benefits offered through CHC including opportunities such as adult daily living and the nonmedical transportation to connect our participants to a greater social network . For a lot of individuals we serve , often times there is a desire to want to be connected and contribute in many times it does come down to not having the transportation . Whether it be handicap accessible or just the opportunity to get out and go complete point a to point B. If corneas are aware and attentive to our participants , do they have that piece that could connect with nonmedical transportation? We also have employment support team that provide counseling to our participants to identify if connections to employment or the workforce . That connection might alleviate some social isolation concerns as well . Our coordinators discuss natural supports and any barriers that may limit that connectivity as well . Is it a means of transportation? Is it assistive technology? Is it durable medical equipment? Those conversations will oftentimes arise on what we are having our monthly contacts or our assessments or the face-to-face interactions . Coordinators will discuss the local options - - offering senior centers to the awareness of what is available in the community and what is available through CHC and illustrating and stepping in to assist our participants with whatever level of kindness they desire. Next slide please. Again, with our nonmedical transportation - - January of this year but November , December did not make it at this point but UPMC has coordinated 127,000 one and 27,167 nonmedical trips across the state. Those include trips to senior centers, church groups, volunteer community events . It all stems from those conversations that are coordinators have a participants to really make sure that if they have a desire to connect to the community , to somebody else and the workforce that we are providing the tools and resources that can help them do so. Next

slide please. Another obstacle or situation that arises where feelings of social isolation are presented will occur sometimes when there are transitions from a nursing facility . When the person was in the facility they had day-to-day contact with others . Maybe over meals breakfast lunch and dinner ended up having support within a facility. Then as at present transitions to the community, suddenly they might be in an apartment complex but everyone is in you face to them . Maybe the transition back to their home or suddenly there's a dynamic change that level of social connectedness . A large piece of the nursing home transition team and nursing home condition coordinator is providing our ongoing follow-ups with check ins that assess the individual's assessment with the community. There is a screenshot of what some of these questions look like and are assessed in but more so, it's conversations related to feelings of loneliness , that connectivity to others , community safety and ensuring that once it is transitioned then that is not the endpoint of our care, it's more so the beginning conversation to make sure there is still that level of connection. After the assessment and the dialogue occurs , there is a great collaboration between the nursing home transition coordinator and the participant community service coordinator to make sure that there is more that interdisciplinary care team to ensure that the person's needs are being met. Caregiver support is another area reviewed and further addressed if the need arises. Subsection P is designated as social support. It has specific indicators related to caregiver availability, willingness to continue the caregiving role and the caregiver's ability to continue to serve as the caregiver of the participant. Again, as needs sort of arise , our service coordinators have resources to assist caregivers as well. Next slide please. A tool is extremely useful as I mentioned earlier and has been reviewed in depth from our new service coordinator hires ongoing and post on boarding is our UPMC CHC website. This screen highlights there's a definite area stiffly on our website for information for caregivers. It opposite page test data for all public resources that can be accessed by anyone who has Internet capabilities one such resource that is listed in that tool is the caregiver support program . The coordinates were participants, their caregivers and informal supports. They really make sure if there is a need and that the caregiver support program if it's enticing for more information is needed, are coordinator to make sure that we provide that additional contact and support. CHC offers the benefit of respite care as well. 1056 respite days were arranged by UPMC. Respite care is an offering to provide relief if the need arises. Our service correlator's are knowledgeable to other CHC benefits and Care Plus which I'll describe a little more in detail in the next slide. There is a wide range of support care that is available. We also offer 24 hour on-call service where after hours there are supervisors that are available to provide additional support and almost serve as a liaison if I caregiver overspent need to connect with our team after hours. Next slide please. This is a benefit that is wonderful and currently offered in southwestern central reasons. Care Plus is a benefit for participants who need assistance with daily living and they prefer it for the care to be provided for someone who lives in the home with them. Often times a loved one or a caregiver. The notion being the individual list of is

spent. The Care Plus benefit offers very tailored and additional support to the caregiver in particular. Care Plus offers a care coach was assigned to the present and the role the care coach is really to assist and support the caregiver. So the care coach will work with the present but also provide education within caregivers on topics as how to manage challenges , how to manage stress and understanding the diagnosis of the - - making sure the caregiver has all the tools and support they need to provide optimal care to the recipient. Next slide please. Additionally, another barrier that might impact a person's well-being is not having the tools and technology to adapt to driving in the community. I have it out to the living environment and if there any barriers technology wise. For example, some success stories is that we had a participant who had - - in her hands it was difficult to use the standardized essentials that are clothing stores. This request for ergonomic - - ability and independence to be yourself. Another success story is that technology placement had a diagnosis of scoliosis and he had expressed that it was difficult for him and he was sleeping because his difficult pillow was not conducive to keeping his spine aligned . We were able through our assistive technology process to obtain a chiropractic grade pillow for him. Our coordinator is aware that we collaborate with the participant and advertisements PCP or specialist and our utilization management team to discuss this new for the assistive technology and how can we benefit our participants. Our coordinators are also aware of local community resources that offer durable medical equipment free of charge and often times to those in need. Specifically in Erie County there is a local research - - to the nation-based organization . They taken a lot of the durable medical equipment and make sure it's sufficient. They have the equipment that is available free of charge that Courtney is able to outreach and express concerns and make sure there is - - that way as well. Both access to community resources and collaborate with therapist and technology - - tools need to be successful. Next slide please. Lastly be a focus on whole person care. We have a special needs plan which offers a level of care coordination as well. What exactly does that mean? Our participants, because - - active with medical assistance oftentimes participant had a Medicare advantage plan that designates them as being either online or unaligned. Online simply means there with UPMC but they also carry our Medicare plan. All of the benefits and all of their care is aligned with UPMC. Unaligned is when a participants there with us UPMC for CHC. They might have another supplemental plan or Medicare advantage plan with other managed care organization or another insurance provider. Depending on whether a person is aligned or unaligned , we can also work with their Medicare plans to identify benefits offered through those plans in particular. Our corneas learn about the alignment status of our participants and they also work with UPMC or the other Medicare plan to identify if there are specific benefits . Some of which include over-the-counter wellness cards . There is medical transportation that can be arranged . Obtaining the durable medical equipment. More so a level of holistic care and ensuring that we are medical plans because CHC last resort. We want to make sure that we are looking at the person as a whole as well as their coverage and utilizing everything that had available to

them. Next slide please. When there is this collaboration as far as the coordinator working with a different advantage plan, whether it's working within UPMC if a participant is aligned, it's all about that level of collaboration. The placement is at the forefront , our service coordinator and the advocacy role and often times third level of collaboration between other managed care organizations , doctors and specialists through that person centered planning team . Many times my family members are included as well , loved ones that really have a passion to really assist their loved ones . We work with are provided the medical personnel. We offer concierge team that upper spends to call in and identify specific medical coverages benefits , dental care morsel along the lines of ensuring that upper spends had access to the medical care that they need . It's putting a person's first and allowing that supportive team to come in to assist our participants when needed. Next slide please. With that, I think we are available for questions if there are any. Thank you so much.
>> SELLERS DORSEY: Do any committee members have questions for April?
>> MIKE GRIER: This is Mike Grier. Thank you for your presentation April, that was great. You talking about non-Medicaid transportation like church groups and things like that. My question was , is the translation available for folks in wheelchairs or need to cut assistance? Is it accessible transportation to them? If you can clarify that I would greatly appreciate it, thank you.
>> SPEAKER: This is Mike Smith, I will tag team with April. I think the presentation as well. Not only is she a trainer with her, she's a former supervisor and did great work with us . Now she's helping us stay trained. Release the nonmedical transportation Mike is wheelchair accessible and fully accessible option for participants based on their needs. This is the service that is available in the plan but also we will connect them with specialized trepidation available through the Medicare benefits . When you coordinate those in the traditional MATP program .
>> MIKE GRIER: I appreciate that, thank you .
>> SPEAKER: No problem.
>> SELLERS DORSEY: Any other committee member questions?
>> SPEAKER: This is Jeff from Pennsylvania silk. This is a broader question. Would OLT I'll be able to provide us a list and I guess you have to get it from each MCO in terms of the CHC coverage for all city seven counties? Are we able to look at a list like for example going to Allegheny and see here is who UPMC has RPA health and wellness or who does AmeriHealth have. Would be able to see a copy of the list for all city seven counties? The issue has come up with the Pennsylvania transportation alliance and some of our calls on a statewide basis and having something like that to share and be aware of the gaps and we need to improve would be helpful. Thank you.
>> SELLERS DORSEY: Any other committee member questions or comments? No? Okay. April, just in question from the audience and some of those are the same as I asked the other two MCO's the first question committee of data available and the number of people

that were assessed using the tool that required community resources and a number of referrals made.
>> We do not have the easily available. At some point we can make is something we can collect but is not something we readily track . I appreciate the question. We are always adding resources to that and it's an exciting opportunity to grow that list. Our staff participated in the growth of that . It's a real benefit for our team . We don't have specific tracking on that just yet. There are some ideas at some point we would like to do that a little bit more.
>> SELLERS DORSEY: I think Lynn's question was specifically if you can identify those who were assessed for any type of behavioral health needs and also from Janice Minard , identifying assistance with opioid use problems.
>> SPEAKER: We definitely do that. In the last year we created 37,000 assistance for behavioral health and of those which are tracking the number. We do not have his number up until October this year it was. It was 2300 of those assessments resulted in behavioral health referrals that we tracked . We do not always get back. There was another follow-up question that opioids the only way we know about opioids substance use referrals is when we make them. If they are somehow a subset of what comes out of behavioral health referrals , we do not get that information back. That's the one area we have a hard time with this what is ultimately shared back from us for the referrals. To see the basement is actually utilized the resources that we provide with them when it comes to behavioral health. That is something we tracked very closely. We also have a process by which a person hit the threshold that we talk about an automatic referral we say to the precipitant , we really believe that you would benefit from a referral here versus at other levels in our assessment if they are lower level he will have a conversation but we will emphasize it if we see some really struggling. We have a way to look at that in our assessment.
>> SELLERS DORSEY: The next question is from Lucienne Newman around measuring effectiveness. How do you measure the effectiveness of the referrals to community resources? Do you know which members actually access to community service or how long they do it? To what extent will they need?
>> We follow-up with every participant in calls with them , and our meetings with them during the assessment process. Part of every plan's goals and were looking to see if those goals were met. Oftentimes it's a requirement we are connecting someone with community resource that we have those goals and activities in the plan itself. We will have it from that perspective, we don't have actual reporting on that. It is in our system and it is tracked from the standpoint of each individual and whether or not they are getting benefit from a particular activity which might be referral to other outside activity associated with a nonprofit or community resource or church . That is AN individual plan.
>> SELLERS DORSEY: The next question is from Lynn Cooper. How would you characterize your working relationship with the local area agency on aging .
>> We feel like we have a strong relationship with our area agency on aging. There are

times where we are not on the same page . We both have open lines of communications across the state to alleviate points of conflict. We have regular meetings with the Association of area agency and appreciate that relationship. We meet with them to build relationships and a meeting every other month. Other MCO's have done is because we have been in the calls with them and then training with them simultaneously specifically on older adult protective services , training supervisors and staff at the AAA level. I would characterize UPMC relationship as a close one.
>> Next question , how does the service coordinator go to bat and pushing the issue when necessary for a participant when they believe assisted needs ? Occupational therapist physical therapist degree or someone higher up in the MCO.
>> SPEAKER: I think the other two MCO's address this . There is always an ICD process available. What we are trying to do his work to make sure that we meet the person's needs . Sometimes with somebody requests when working with an occupational therapist, they may find that there something else that may be appropriate to meet that need. We strongly try to work together with the precipitant and the team to come to an understanding of how we can best address and need that is identified in the most effective and safest manner. ICT team meetings are always an option for any kind of situation as well as the robust hearings and appeals process . We hope it is not get to that but that is always an option.
>> Next question is from - -. It is UPMC funding the Care Plus benefit ? Why is only available to present in certain parts of Pennsylvania?
>> That is a UPMC specific benefit and we are rolling it out in parts of the state across the state. Right now it's available in the two regions and we are hoping to have it in the southeast shortly. It was a benefit health early on as part of our benefits grade. If you go out the precipitant manuals you will see the unique benefit to UPMC. Something weird to grow over time. It's not been a widely used benefit and is because it started clothes first started out it started out in the initial phase of the program and I think it was lost in the shuffle of growth and rolling out the different regions. We are in the process of felicity finishing the rollout to help people. Thank you for asking .
>> SELLERS DORSEY: The final question that we will move to additional public comment from Latoya Maddox, can UPMC dispense utilize nonmedical even if the utilize - - can't but that she was told.
>> SPEAKER: I'm to see if I can phone a friend. Is she saying the benefit is not available ? I cannot address MTM because we do not use MTM. We use CTS as our broker. I am not sure. We do allow for - - and provide those . It answers the question, I'm not quite sure I'm answering the question right that maybe she can circle back on the - -
>> That could be something we address.
>> SELLERS DORSEY: Let me move to almost any other committee members have additional questions ? No? Belinda, did you want to move to additional public comment then? Okay. He will do that . I am going to try to unmute Latoya so she can ask you directly.

Latoya, you should be unneeded .
>> SPEAKER: Yes, hello. Can you hear me?
>> Yes, thanks .
>> SPEAKER: So there is a big problem with cc to here in Philadelphia. I was asking for participant through UPMC has transportation allotment in their waiver even if they already use like they get the - - every month, if they call to ask for a ride because they having issue are you guys want to grant them? Is UPMC granting those?
>> SPEAKER: I'm not sure what the problem is with CCTV. Could you elaborate a little bit more?
>> There is an operator shortage. The drivers are in their late , there's a lot going on . So if a participant decided to see if I can call to get a ride to her friends house and ride back home , even if they have used CCD regularly for having so many issues now and they call and say I am having these issues, is it okay for me to get a ride ?
>> SPEAKER: I get you now, I apologize. I am familiar with what you are talking about. We are trying to accommodate those on a case-by-case basis the best that we can. We understand that is creating issues with CCT right now. That's an operator shortage in some part of the state are an issue in general.
>> SELLERS DORSEY: To any committee members have any questions or comments on any other topics?
>> SPEAKER: This is Jeff from Pennsylvania silk just to stay on the topic, I agree with what Mike is saying. We are hearing that central PA with rapid transit with their reducing hours although for folks that are on MATP the hours are not reduced. That said , the driver shortages seem to be impacting other programs too. It's not limited to the southeast . Something to keep our radar in terms of how it impacts any the temptation issues statewide, thank you.
>> SELLERS DORSEY: Any other committee members? No? Okay. I guess I will call the question but is actually a scenario I received . Kathy would like to ask all three MCO's that there is specific it's been impacted by this and I can send that information over to share with the MCO's. There is a participant and they can't - - skin breakdown obtained in the hospital gets worse . They're not bad enough. There are complications related to individuals having Covid and difficulties with being able to ambulate for the bedside commode. The caregiver is concerned about the breakdown. For each of the MCO's and Mike , since your last talking , and three different scenarios how the service coordinator assistance participant in obtaining airflow matters try and avoid additional medical complexities with the three scenarios . First if they are in line to spend with your MCO , if it is unaligned for service. Brisbane is - - different if it were a non-dual participant ? Let me know Mike if my question doesn't make sense .
>> SPEAKER: Now can you try to articulate what is a comforting factor of CHC. Your special needs plans that are Medicare plans aligned that we share. We have learned that are not under and some that have great fee-for-service with did not mention their . Very

complicating factor and folks are Medicaid only and don't have Medicare. I'll just handle the first two but before I do I want to say , it's hard these hypothetical kinds of circumstances to know all the details and the ins and outs of arsenic specifically will be handled. I will make some generalizations and I apologize for that but honestly, if this is the precipitant that is UPMC facing we will roll up our sleeves to address the issue. To say at the top , we would not want to see about his business potential for skin breakdown have to get to the level of skin breakdown in order to get treatment or services. That being said, I want to put that on the table . In our Medicaid only population and our online services we have Medicare and Medicaid , we have very close communications with our care managers. In fact, our care managers support for the CAC product because we have the full visibility of their medical needs as well as the supportive services needs and functional supports needs. That's a real nice caviar for us for clinical support for our teams . The beauty if that is that we are all in the same systems and all able to communicate with each other for a more discreet and aligned way . It is even maximum Medicare benefits first that is not determined how we might fit that benefit under the CAC umbrella is appropriate for as hypothetical as difficult to know whether or not we will be able to cover those for the unaligned, UPMC with the other Medicare managed care companies across the state and there are nine is out with the date of the now the approval snowing airflow matters. We certainly would be in conversation with them. We will be working with them to figure out the best way to move forward is . The last - - we are engaging network health plan or somebody actively engaged with PCP or the direct care provider associated with the person's medical needs and that can be a much more difficult relationship in the sense that we do not have a relationship with every doctor and practice across the state in the way that we might when we have nine other agencies that we have contact with. It's not that we don't have a relationship with them . Our network team is built a relationship of providers for the service coordinator may not know that Doctor and that they get to know each other and build that relationship for the participant. A little bit more heavier lift but definitely doable. I hope that answers your question .

>> Thank you Mike. Jen, how about for a mere health?

>> JENN ROGERS: So our process - - from what Mike outline. Hypothetical situations are difficult to respond to effectively here. Please , if a AmeriHealth present situation I would like to have addressed - - I don't is available but the escalation pathways are available to us whether the placement is managed internal or external service coordinators. If a participant is experiencing some delays or issues does not understand where the request is whether they are aligned or unaligned what have you, - - service coordinator in the service coordinator would know how to gain the information needed to establish next step. I think - - the action steps are specific to this precipitant situation of course , the service corners no good way to go to? What is the senior should require, my supervisor , the evening case manager , then how to connect and escalate appropriately to get the answers to the participants and the provider as applicable quickly.

>> SELLERS DORSEY: I'm not sure Olivia and Bailey if you want to answer and I want to answer.
>> OLIVIA MARTIN: I can chime in, it's Olivia. I echo with the other two have covered. Just saying, this is the prime example whether they are dual eligible or aligned or unaligned. What is Medicaid, primary. This is for the care conference and the importance of using the resources for that entire care team comes in. It is the precipitant , we are more than happy to take a look at that and get information over to me to look at that and call the care team need to figure out exactly how to approach it. I just want to say that this the opportunity for us to collaborate and get the PCP in the service coordinator and whatever part of the integrated care team would be helpful so we can troubleshoot and find the best option for the placement.
>> SELLERS DORSEY: I will send the kind of information over and asked him to send it out to the applicable - -. Let's see, let me see here if I have any other questions coming in . I get there just a request suggesting that they should make sure the service coordinators explain the availability of the resources they discussed today with the dispense . Linda, that's everyone that I have from the audience .
>> LINDA LITTON: I don't have anything further .
>> SELLERS DORSEY: Yes, Luba Somits is unneeded but she itself needed. She had difficulty speaking to laryngitis .
>> LINDA LITTON: Oh, okay.
>> LINDA LITTON: Has been very nice being on this committee having a voice in it. I will still be able to listen and right?
>> SELLERS DORSEY: Jamie, I do not know if you want to answer that the meetings are open to the public .
>> JAMIE BUCHENAUER: The only thing I want is to say in conclusion as I wish everyone a wonderful holiday season no matter what holiday you celebrate , I hope you enjoy the time with your family and friends . Happy new year also 2022 and we will talk very early in the new year.
>> LINDA LITTON: Everybody take care.
>> BAILEY CAREY: Thank you very much Linda and for all the meetings you have been hosting .
>> LINDA LITTON: Thank you.