January 4, 2017

MLTSS SubMAAC
Honor's Suite
333 Market St
Harrisburg, PA

Transcript

>> **FRED:** Good morning, everyone. It's time to get started.
Meeting minutes, transcripts, documents are posted on listservs MLTSS meeting minutes.
Documents are usually posted within a few days of the meeting.
Captionst is documenting proceedings, so speak clearly and slowly.
Turn off cell phones and mute them.
Throw away all of your stuff, bottles, clean up around yourselves.
Public comments will be heard at the end. Hopefully, we have enough time this time.
Court and jury rining about if Katherine is present may she say things about herself and Veronica does present at the meeting introduce herself and ask her to say a few things about her several.
Emergency evacuation preers in the event of emergency evacuation we will proceed to the Zion church on the corner of fowrnlg and market. If you require assistance go to safe area located right outside of the main doors of the honor suite.
OLTL staff will stay with you until you are evacuated or able to go back into the honor suites.
Take your belongings with you. Don't operate cell phones or use elevators we will use stair 1 and 2 exit honor suites on left side near elevator turn right down the hallway, for stair 2 exit honor suite on side doors right side of of the room.
For those exiting side doors stair 2 is directly in front of you.
For those exiting back doors exit turn left and turn left again and stair well is directly ahead.
Merge to the outside of stairwell.
Turn left and go to corner of fourth blackberry Street and go to strain station.
Katherine, would you introduce yourself, please?
>> **JEN:** I don't think she is here.
>> She might be on the webinar.
>> Hi, I am Veronica cost cam.
I am a nurse. (Comfort pl.
I did work for Philadelphia Corporation for Aging for 15 years as director of quality.
I look forward to serving on this committee.
>> **FRED:** Glad to have you.
>> **Veronica:** Thank you.
>> **FRED:** Barbara we will start with you as always.
>> Bash liberty community connections.
>> Tan teg la.
>> Blare, united health scare.
>> Russ McDade Pennsylvania healthcare association representing Dr. Scott rip kin who couldn't join us today.
>> Joan filling in for Pam who is joining us on the phone today.

>> Jenn office of long-term living.
>> Fred Hess, advocate work for disability options network Center for Independent Living.
>> Drew Nagele brain injury association of Pennsylvania.
>> Pam awer, subbing for Theo Braddy, Center for Independent Living of central PA.
Good morning, Ray, UPMC health plan.
>> Jesse Wilderman SCIU healthcare of Pennsylvania.
>> FRED: Who do we have on the phone?
>> We have [inaudible] she is make copy.
[LAUGHTER]
>> [inaudible] from man or care.
>> Pam is on the phone also.
>> JEN: Pam we heard you
>> Jennifer Howell
>>: Jenn: Anyone else on the phone. Get names from Joan.)
>> JEN: Good morning, everyone. Happy new year!
Welcome to the Office of Long-Term Livings LTSS managed long-term services support committee. I hope everybody had a nice holiday.
This is our first full week back. Lots of things going on.
I'm sure you heard about the delay of the implementation of Community HealthChoices. We pushed back the implementation on December 15th we announced we would being delaying both the first and second phases by six months; that means the southwest will be starting January omp 2018, southeast July of 2018 and remainder of the state in January of 2019.
I wanted to share with you a few reasons why we made this decision and first and foremost is the fact that there has been a procurement of stay. We have a few of the disappointed offers have filed with the Commonwealth for a stay; so that stay has not allowed us to communicate with the selected MCOs.
It doesn't allow -- it doesn't give us enough time to really conduct a thorough readiness review. Something we learned from the other states that have gone through implementation of long-certainly services and supports as well as partners here in Pennsylvania at office of medical assistance program and CHIP, both of which operate managed care for physical health and managed care for the CHIP program have told us readiness review takes a solid six months.
The other problem that we were running into is because we had not been able to negotiate with managed care organizations, with the selected offerers on their agreement they do not have adequate time to build their network and will not be able to demonstrate -- we are worry the they will not be able to bill provider networkings that would meet our standards and the standards that the Department of Health -- therefore, not meet the needs of participants.
Because we haven't been able to negotiate with managed care organizations, we haven't -- we also haven't been able to begin effective communication with participants or providers.
We have held a meeting with some of the provider associations to discuss how to best reach providers, and that was held in December. We really can't effectively do anything because of this challenge in the Commonwealth court. We received notice from Commonwealth court on Friday that the stay asked of us was not granted.
However there is another challenge in Commonwealth court by another MCOs so we are under stay effectively.

There gives us an opportunity to have the MCOs, participants be better prepared to give the time we need to conduct readiness review and have a smooth transition too Community HealthChoices.
>> **PAM:** I just was wondering, since this is being delayed, we previously heard there was the possibility of a emergency procurement for the IEB now being pushed back.
Can there be a full implementation of IRFP and not full procurement to maximus ?
>> **JEN:** No we need to transition between the existing IEB to potential new IEB or the next one.
We need that time, that transition time, which takes about six months.
So we are still going forward with the emergency procurement, but we are also going forward with a full-blown RFP sometime -- we are hoping to do it sometime in January/February; that will give us more time.
That was a good segue to next topic which is update on IEB.
Does anybody else have any questions about the delay?
[NO RESPONSE]
No?
Okay. We are currently working with maximus our IE blp provider, independent enrollment broker provider on improved customer service for the call cente staff.
We escalated customer service staff to use for their use for questions out of the norm; that's something we have really been working closely with them on improving customer service.
Referrals are now being made by the call center staff to ADRC, information is provided on all denial letters from the.
We continue to see record enrollment in the aging waiver, which on the other hand a good thing but on the other hand, a potential issue, because we have the constraints of our budget.
The enrollments -- I will just give you information about the enrollments in the aging waiver in particular, they have grown by 144% since August.
In August we were enrolling 495 minimum. It grew to 867 in November and 1207 enrollments in the aging waiver in December; there's been alarming growth in that waiver. But it also speaks the story that the IEB is doing its job appropriately.
The December -- the jump from November/December of over 300 more enrollments really was a surprise to us. We didn't expect that. Winter months as we move into inter enrollments slow down; that's been the tripped historically; so that really did surprise us.
But it potentially speaks to the growing popularity of the aging waiver that people knowing about the aging waiver but it also speaks to the fact that the IEB is making those enrollments happen.
>> You asked about the procurement, Pam, with the delay S we want to make sure it's happening as we speak but all of the -- I think what you were alluding to all of the Community HealthChoices requirements are removed I think that's what you were alluding to in terms will of the delay.
But the goal is to have that emergency procurement for the IEB in place by the end of the month.
In terms of the new ich EB procurement, as you know we did public comment period for that procurement. There were 1,000 comments we are reviewing them with subject matter experts with OLTL and in the Department of Aging and other departments of Department of Human Services with familiarity with enrollment broker activities so that people at the office of medical assistance programs.

We are receiving feedback to make the procurement better. Once again speak speaking to the idea of being transparent about procurements gets you in a better place to what the final product ends up being.
The RFP is currently scheduled to be released next month.
Jennifer Howell brought up home modifications last month.
I did discussions with her. One thing we can't do with our home modification program is add rooms, you know, make a new room or space, unless there's a strong justification for it.
So we do have a service definition and I have that available but I don't want too -- in the interest of time, I don't want to take up time reading it to you and Jennifer, I can send our definitions to you, which have really strong details about that.
If you would like me to do that, I would go ahead and get that emailed to you; so that is the information on home modifications.
I don't think I have anything else on that.
>> **PAM:** I wanted to ask one more thing on IEB and ADRCs, when you talk about referrals to ADRCs is that when someone says hey, I 23450ED help filling out the paperwork?
>> **JEN:** Yes.
>> **PAM:** Is there anything else going out saying, if you have difficulty -- when we called yesterday to make a referral for an individual, there was nothing stated that, if you have difficulty filling out any of o the paperwork let us know, we will make a referral we will connect you.
How are people learning about that?
>> **JEN:** There is -- it is part of the script that IEB has.
Repeating her question, Pam awer asked if there is any information going out from OLTL regards to receiving help from the link program. We added a couple sentences or a sentence in the IEB call center script that gives them the 800-number if they need help, we make that referral to the 800-number.
>> **PAM:** Can something be added sintd into the individual to read it.
You get a whole lot of information when you call IEB right up front to -- it's a new process for a I lot of people. You get a lot of information not that they might be even able to remember part of the script.
If they can include something like that. Maybe they already are. I don't know.
>> **JEN:** I will look into T. I don't know if they are or not
Did somebody on the phone have a question? No? Okay.
All right.
>> **FRED:** Okay. Is there any further questions?
[NO RESPONSE] [NO RESPONSE]
>> **JEN:** I have a question on the phone. Is that Jennifer?
>> The numbers I just reported on the IEB, is that from start to finish or is it in some inter knit ent time during it? Is it is from the time a person presents to the actual enrollment into the waiver.
>> **JENNIFER:** Thank you.
>> **Jesse:** Maybe slightly off topic and bigger question. Thinking about the future the slight delay in MLTSS implementation and on the federal level the block granting which has some serious, you know, serious talk of it.
Nil thought yet? I know it's early but is there any thinking of how that impacts MLTSS transition, does it or is there anything we should be thinking about in that regard?

>> **JOAN:** Just to repeat the question from Jesse asking about the discussions federally around block grants and if we expect at the state level for that to have some sort of impact as we move forward with community health choices?
>> **JEN:** I don't think it will have any impact moving forward with Community HealthChoices. It may impact our budget. I am not sure what is going to -- how that is going to fall out. We are moving forward with managed care.
Managed care -- especially managed long-term services and supports is something that states across the country in neither party are doing, moving to managed care. We will just continue down our path. Thank you.
>>: Fred. R. Drew, do you have a question?
>> **Drew:** Yes. It was a follow-up question to one that the brain injury association raised at last month's meeting using CAHPS survey as a program evaluation tool/quality tool.
Jenn, you directed us back to your consultants on the use of this tool indicating that the -- their experience with the brain injury population was that there was no significant difference between the response rate of that group compared to the response rate in general when this tool was used. It's not really the response rate that we are concerned about, it's really the accuracy and validity of the responses that are obtained by this telephone interview.
I did speak with Lorraine Margot, who was the member of that group that first studied that tool for use with brain injury she is executive director of the national association of state head injury administrators.
Lorraine said that her recommendation to that group was that four people with brain injury there be reasonable act dailings when this tool is used. Such reasonable accommodation (accommodation) my provide proxy person to help them understand the nature of the questions and also possibly face-to-face instead of telephone interview.
The reasonable accommodations that she recommended were a proxy person be made available, somebody else who would help the person to understand and answer the questions to the best of their ability and also face-to-face interviews as opposed to telephone surveys.
>> **JEN:** Yeah, we are going to be using face-to-face and the telephone we will use both.
As far as proxy goes I have to go back to the folks who work who do this to get their seal of approval on this and get their stamp on it because it's part of a larger suite of tools.
My understanding is that proxies are not allowed for these tools. Let me find out what they did with Lorraine's recommendations, how they handled it and how did they test it and look at validity.
Did you speak to anybody at Truvent analytics.
>> **DREW:** No, I only spoke with Lorraine.
>> **JEN:** May have been we can set up a call between the folks that really have been she shepherding this since 2009 to the finallability to get the CAHPS approval. They shepherded it for serial years. Let's industry to get a call to continue this conversation.
>> **Driewl:** It doesn't only apply to cognitive brain injury but those with dementia and people who cannot answer the questions accurately.
>> **JEN:** Let me look another that and see if we can pull together a consultation with them.
>> Thank you I had a second follow-up question having to do with the five new services offered under indispense and com care. These services went into effect October 6th. CMS approved waivers posted on the internet site. They say there is an 18-month period whereby people can get the newly-required certifications in order to provide those services.

I am concerned that some of these services are not being made available because people don't yet have those certifications. It clearly says that there will be 18-month period to -- for providers to get those certifications.
>> **JEN:** Right.
I don't know. I don't have data yet on those services. I will take a look at it.
>> I would appreciate that. It really is an access to service issue. if there are new services being offered under the waivers currently, that people can't access because people cannot become approved providers.
>> **JEN:** At this point we are doing a lot of work with RCPA to get access to those providers. Some of them have been providing the same services that are the new services for years. Those providers are very interested and we are working to get them onboarded as OLTL providers. They are working with our bureau of provider support to actually become OLTL providers.
We are also doing webinars with those providers to give them information on how OLTL's system works and then vice versa, we will work with our service coordination entities and other providers on the flip side, giverring them information on all of of the providers that are out there that are providing trif these services.
Those are benefits T counseling career assessment, employment skills development which provide job Schoching replacing supporting employment and job finding.
We are really working to bring those two communities together. The providers that actually have those services available, as well as the service coordination entities so that they know they are available.
>> **DREW:** That's good. The two in particular that are the new ones for these waivers are career assessments and job finding. So, you know, I understand this it says in bloaj waivers that if a provider does not have the necessary service; however, since the waiver went into effect in October the supervisor would not have had the stunt to get that certification.
It was our understanding from previous discussions here, that everyone would have 18 months to be able to get those certifications in place and in the meantime, we thought the services would be available to people. It turns out they are not.
>> **JEN:** They are available we just have not connected you with the providers that can do it.
>> **DREW:** I don't know there are providers in the brain injury community that have those certifications. We --
>> **JEN:** I think there are. We really looked into it.
Regardless, let me go back and find out exactly how we have set it up. I can do a follow-up phone call with you.
>> **DREW:** Okay.
>> **JEN:** Ed butler who has been here to talk about employment, is working on making -- getting training here T.
>> **DREW:** Two new trainings have been added in Wyoming and Holly, which is good. I'm sure brain injury providers are signing up for that. In the meantime the services are not available through brain injury provider ors.
>>: Jenn: They are available through alternate providers if you had somebody who needed them you could get access to it.
>> I I am not sure it's an effective solution to go to another system of priors to get career assessment and job finding. Trim (Drew) it's not integrated service if you have to do that. Those providers would not have brain injury training. That doesn't make sense.

>> **JEN:** We can have a sidebar on this. I think it makes a lot of sense because these are people who are experts in job finding. Let's talk about it: We can talk about it later
>> **DREW:** I don't think this is a solution to it. I am asking that the -- what is written in the waivers and what was approved by CMS be honored. I don't think it is.
>> **JEN:** I don't have an answer for you now but I have to do some research. I will go back to my office and talk with the folks in policy and learn more about it.
>> **Descry:** I had one more question with regard to those five vocational services. I am just a little confused because in the OBRA waiver that is currently posted on the website, none of those services are I listed; is that accurate that they are not available to people under OBRA. I thought they were listed in OBRA. Aren't they? I am looking over to a Patty over here.
>> **PATTY:** They should be. I am not sure why it's not showing up on the website.
>> **DREW:** All three waivers should have the identical services maybe I can connect with you about where I am looking on the web and maybe it's the wrong site or something.
When I just looked yesterday, the old services were listed for OBRA.
>> **JEN:** We definitely updated them in what we put into CMS. Thank you.
>> **Joan:** We have a question from committee member Jim.
>> **JIM:** Jenn, I just wanted to point out that I was doing some unless on the published data you have been putting out as it relates to aging waiver enrollment. Between two sets of the data I found a pretty large discrepancy in reported numbers. It's too detailed to go over. I wanted to know if I could email to look at it. It may be a timing thing but I wanted to bring it to your attention.
>> **JEN:** All right. Send me that email. We will see if we can get it reconciled.
>> **FRED:** We also have a question from Tanya.
>> **Tanya:** In follow-up to the question about numbers with people enrolling into the aging waiver, it brought something else into my head. Is -- what is being done to ensure that when a person wants to get out of a nursing home and back into the community, what is being done to make sure that they have the proper resources in place to be able to do so?
A lot of times -- I am not trying to scare you, but a lots of times when somebody is placed in a nurse being home and older, it's because their family didn't have either the resources or the capability to be able to take care of them correctly in the first place.
What safe guards has the state put in place when they want to get them out to make sure, they are safe; B, they are getting what they need?
They are not -- again, if I am stereotyping at all, I apologize, but just from looking at it from an outside perspective, you would think that that same person maybe won't have the cognitive abilities to make share own calls on their services so how is the state going to handle that influx?
>> **JEN:** Well, we do have -- I am repeat the question, Tanya asked what the state does if somebody, especially somebody older, if they transition from a nursing home into the community, what kind of safe guards get put into place to ensure that they are able to get the kinds of services that they need to be able to remain safe in the community. Does that capture your question correctly?
>>: Tanya: Yes.
>> We are doing renovations to it. We have a nursing home transition program. Through nursing home transition, first of all, let me just say, many people enter nursing facilities they are there for a short-term stay. They are there for a rehab stay, they are there to get stablized. The nursing home is required to work with them to safely discharge them.

They can't discharge them unless it's considered a safe discharge. The nursing home has staff that works with people all of the time, in particular, people who come in on a Medicare stay and then are there for a short period of time; so that's a common thing; that's one thing that happens.
In some cases, we never hear of those people. They simply return home and they are safely served at home. I happen to know somebody who is in that category who went in with a stroke. He was in the nursing home for about eight weeks. He discharged with his wife and they -- he had some services at home, which was mainly therapy to teach him how to do his physical therapy, which he continues to do to this day; so that happens.
Another category of people who are people who enter a nursing facility but for some reason there is a barrier; that's when nursing home transition gets involved. The barrier makes it very difficult for the nursing home discharge staff to have enough time to really work with the person; that's when nursing home transition comes into play.
In that case -- for example, say the barrier is, they need ramps to get into the house because the house has steps and they are now a wheelchair user and need personal assistance services.
In that case, NHT team may come in and help them navigate to get on the waiver, to navigate and get the home modifications put into place.
So we do a lot. We do not -- one of the things they do go into a waiver, any of these waivers, one of the waiver assurances that CMS requires us to measure and report on is the health and welfare assurance; that assurance means that we have to, when people return home, we have to assure that their health and safety is appropriate and they are placed appropriately in a home.
So it's through the waivers that we have available.
Some people are in nursing facilities and they are not qualified for long-term services and supports. They may not be financially qualified for -- in that case, they may go out into Act 150 program, if they are a younger person with a disability; there's a lot of ways in nursing home transition -- a lot of things in nursing home transition since 1995-2000 when Pennsylvania started working on it; is that it is an extra amount of help and exper sees that is not seen with plain old service coordinators or nursing home staff discharge planning staff.
>> **Tanya:** Good. The major concern I had going on in my head asterisks is if the movement is to give people a choice of whether they want to stay in a nursing home facility or go back out in the community, I just wanted to be sure that there is, like, something implemented in place to make sure that that transitioning goes as smoothly as possible; and that the person doesn't end up in worse circumstances than what they were when they started out.
> **Jenn:** Nursing home transition is described in the agreement we will have with managed care organizations. The managed care organizations, their proposals demonstrated that they are ready to do nursing home transition.
They also have financial incentive and quality incentive to make sure that people are safely discharged. They will not want to see somebody go home and have that fail because it's going -- they will end up back in the emergency room or back in the hospital. That's not showing good quality of life.
>> **Tanya:** I know when somebody enters nursings home financially they take over assets or Social Security payments or something. All of that is set up so that the person can get that back if they needed, like, their financial way of life; so that the nursing home doesn't have control over it anymore. Correct?
>> **JEN:** That's correct.
>> **Tanya:** Good.

>> Pam. Real quick question. We got the information before on the numbers of aging waiver. Do we have any other numbers? How is enrollment going for the other OLTL waivers?
>> JEN: The trend we have seen in the past continues to be the trend.
>> PAM: Is there any way we can see that.
>> JEN: I can bring a report on that.
>> PAM: That would be great. I have to leave at noon. I would like to make a recommendation that we could public comment in middle I have a heard that there isn't time for public comment. I don't know if that's why a lot of people haven't been showing up. I just want to make a recommendation that somewhere it is adjusted so there is an opportunity.
>> FRED: I have heard the same complaints, Pam.
>> JEN: Duly noted.
>> Dpred: Fred: Any other questions?
[NO RESPONSE]
Let's move on we have LGBT elder initiative with Heshie Zinman.
>> HESHIE: How do I do this? Is it good morning, everyone. I am Heshie Zinman. I am Chair of LGBT elder initiative, something that was established in 2010 -- today I need to present. What I wanted to do is give you some background on the elder initiative and the work that we have been doing in the Delaware valley --
>> FRED: Excuse people. Could you come up here and sit so that they can hear you on the phone?
>> HESHIE: Sure.
I wanted to give you a brief background on the work we have been doing in the Delaware valley area and will lead into my presentation on how it helps health disparities and closing the gaps for LGBT older adults.
2010, there were a group of members of the LGBT community. The AAA's PCA, COSA, Bucks County, Montgomery County and CARY, aging services organizations, we started talking about the fact that baby boomers would begin to turn 65 in 2011. Many of them would be LGB&T -- (commercial on the phone line).
>> Joan: I think somebody put us on hold on the call.
>> PAT: I will mute everyone.
>> JOAN: Pat is muting everyone on the phone.
>> Do we know who this is?
[LAUGHTER]
>> HESHIE: So many 2011 baby boomers would begin to turn 65. Many of them would be LGB&T. We took a look at, basically, aging services and the aging services network and had a discussion about how, culturally competent, how culturally adept would that network and system be at addressing the needs of LGBT older adults?
Pretty much the consensus was, it would not be very competent. There was not only a lack of information about LGBT aging but there was a lack of information about resources for people who are LGBT and so we took that during this conversation. We did some work in the Philadelphia area, a group of us conducted a survey that was distributed through survey monkey and really concerted outreach of people of color communities.
What we found after about two months we closed the survey off. We had about 360 people who responded to the survey.
What we found is that there was this profound sense on the part of the people who participated in the survey, there was a palpable fear at the point they needed to access aging services, that there

would be discrimination, harassment and prejudice. They would be treated unfairly and unkindly.
We looked at what we needed to do. We held a summit in October of 2010 over 140 people from the aging services world, the LGBT community and government folk came to that summit. We waked away from that summit with a set of recommendations on what needed to occur in order to work to bring the aging services network up to speed about the unique needs of LGBT older adults and the organization that I chair, the LGBT elder initiative was the result of all of that work. Essentially, at the end of the summit, we had a set of recommendations and people were, like, who is going to implement those recommendations? We were, like -- Ehhhh! We don't know!
There was a group of us who got together and created an organization to advocate specifically for LGBT elder adults.
With that, I will show you the slides. I am not sure how I will do this.
Will this work for the folks on the phone?
So today we will look at improving health outcomes and quality of care for LGBT older adults. We will look at some of the causes for health disparities, some of the outcomes, some of the effects that the LGBT older adult community experiences because of those disparities.
So there are approximately 2.4 million LGBT Americans over 50 years of age. By 2030 that number will grow to almost 5 million. This is an approximate number, which is difficult to take in.
In this country, sexual orientation and gender identity are not questions that are asked on census data. We really have no way of capturing LGBT, who is LGBT in census data?
There is in terms of state services, the California health interview survey, which is the only survey that I know of in this country that includes questions of sexual orientation on the survey. A lot of the information is gleaned from the survey and we figure it out for general population.
I heard by 23030 that number will grow to almost 8 million.
There are cultural shifts towards greater acceptance for LGBT identities.
P lesbian, gay, bisexual, people have made significant progress in securing long-awaited civil rights.
HHS continues to ensure that across the lifespan, all LGBT individuals, including people living with HIV and AIDS. There are approximately 675 anti-gay pieces of legislation on the books.
So what we know, you know, that we have seen a lot of push back after the marriage. Sometimes that push back is vicious and extreme. We continue to march forward.
The Department of Health and human services continues to ensure that across the lifespan, all LGBT individuals, including people living with HIV AIDS have the best possible hope to age healthfully. Why it's important is that it's the government agency that is recognizing LGBT older adults.
Just to throw out something, when you're not counted, you don't count. Okay?
Just think about that. When you are not counted, you don't count. What is the message that that sends to populations who are not counted?
The fact that health and human services has been working in this area is quite significant.
So some landmark accomplishments within the Department of Health and human services:
In May, the Affordable Care Act section 1657 the office of civil rights was implemented within the Affordable Care Act protecting against discrimination on the basis of sex. Do you know what sex stereotyping is?
>> **FRED:** Not really?

>> **HESHIE:** Sex stereotyping is, if a women comes to work wearing pant suit and she is not dressing feminine enough because pant superintendents are masculine and not feminine, she has cause to sue if she is let go.
It is how one acts, not how one is but how one may act.
In June, there was a new position for a senior adviser for LGBT health within the office of assistance secretary of health; this is really significant, because this is, clearly, you know, a significant population that has significant health disparities and so to be able to have somebody who is dedicated to LGBT health really means that a lot more can get done that has gotten done in the past.
In October, the national institutes of health, officially designated sexual and gender minorities as a health disparity population for research, which is significant in terms of data collection. You know, I don't know -- I am a policy wonk. For those of you like me in the room, data drives policy. Policy drives programs. Programs drives funding.
When you don't have adequate data, it's significant in terms of your ability to make an argument for public policies that would improve the lives of LGBT older adults.
We are beginning to make headway in terms of designating us as a health disparity population.
So some of the causes of health disparities for LGBT people, the first being low rates of health insurance. Specifically, employer health insurance. You could look at why it is that LGBT people don't have health coverage.
One of the reasons may be that they never got the job to have the health coverage. They were discriminated against within the workplace.
They work in areas where there is no health insurance coverage, like the service industry. Not having access to health insurance is very significant in terms of your ability to get healthcare.
The social stigma of being gay, the years of discrimination and marginalization and criminalization and victimization that LGBT people experienced over lifespan and impact that has had on their emotional and it physical health.
The third is a lack of cultural competency within the healthcare system. It's not just the aging services world but it's also the healthcare system. So you can imagine somebody who is LGBT but now add on to that somebody who is a person of color who is LGBT. A person with a disability who is LGBT and a person of color. It goes on and on in terms of disparities and how they build one on to the other.
So I want to talk a little bit about the unique circumstances of LGBT older ad
You have a list of health disparities between LGBT older adults versus non-LGBT people this is from SAGE. I will touch on this a little. This as a companion piece gives you a whole bunch more information.
Caregiving in the United States occurs 80% of caregiving within the United States occurs within the family. So LGBT people generally refer top families of choice versus biological family or logical families versus biological families.
Essentially, what we are talking about is, many of us, when we come out, are are thrown out of our families.
Many of us who come out move across the country to get away from our families. We have been separated from our buy logical families through circumstances or geography or both.
Our friends are our family. Imagine growing older with your friends who are the same age as you are.

Essentially, I get out of bed in the morning and I have an ache in my back and kink in my shoulder. I call up a friend who I consider my family. I tell them about my ache and they tell me about their knee or hip; this is just what happens when people age together.
What I want to say is, with 80% of care giving happening within the family you have kind of hierarchy of families. LGBT's familiar are horizontal T. 75% live alone; 90% are childless as compared to 20% in general population; 80% of LGBT people don't have a partner versus 40%. This is a staggering number; 20% of LGBT people cannot identify an emergency contact compared to 2% in the overall population.
So if you look at these figures, and you understand the the structure of caregiving in this country you will understand that LGBT people will have a much greater alliance of forthal systems of care and support.
So it is for that reason that we look at the cultural competency of the aging services network. We look at the cultural competency of the healthcare delivery system in terms of their ability or its ability to meet our needs.
So some of the physical health, there is a disproportionate rate of high blood pressure, cholesterol, diabetes, heart disease, HIV/AIDS and certain types of cancer within LGBT communities.
With regards to emotional health and well-being, LGBT people display elevated rates of anxiety, loneliness and hopelessness; 31% of the people surveyed reported incidents of depression; 39% have seriously thought about suicide; and there are much higher rates of smoking, alcohol use and it drug use within the LGBT community.
So social connectedness, which you know as we get older, our ability to stay connected is so critical in terms of issues of social isolation. When you look at social connectedness, 27% of LGBT older people feel that working or volunteering would not be an option that would be available to him/her or them because of their sexual orientation. It's really a sense of being welcomed in organizations. Being welcomed in institutions because of sexual identity because of workplace discrimination or just actual discrimination between people.
Faith-based support networks are often not affirming to LGBT identities and interestingly, there is a struggle to fit into LGBT spaces because of age and a struggle to fit into LGBT spaces because of being LGBT. Maybe I didn't get that right.
A struggle to fit into aging services because of being LGBT and a struggle to fit into LGBT services because of your age.
LGBT populations experience a high degree of ageism within the community, much like mainstream populations where fitness and youth is really the thing to aspire to -- although it's not -- it's also experienced by LGBT people. The ability to fit into these spaces sometimes is challenging.
With regards to healthcare environments being Hoss I will, often hostile and discriminatetory, 80% of LG imp T older adults fear nursing homes and similar care provider rs because of the expectation of discrimination.
Going back to the survey we did in 2010, although a large percentage of the people who took the survey were not -- did not qualify for aging services, there was this palpable perception at the point they need to access services, they would not be friendly.
It's really about perception. It's really about perception. Because we don't collect data on gender identity or sexual orientation, it's very hard to document actual experiences of discrimination within the system.

39% of LGBT people have had at least one of a series of lifetime discriminatetory experiences at a healthcare provider.
40% of LGB older people in their 60s and 70s say that their healthcare providers don't know about their sexual orientations.
I think this is really, when you are looking at stages of aging, you have old-old, who are generally more reluctant to come out of the closet. They feel safer, obviously, staying in the closet. Staying in the closet, you are not able to communicate effectively with your provider; that puts you at a disadvantage.
Older LGBT adults in long-term care facilities, may face discrimination from staff and other residents.
The interesting thing here, in terms of training, which is something I will get to, you can do staff trainings but the issue is, in a residential facility, how do you train other residents to be accepting and tolerant of LGBT people? There are ways, which I won't get into now. There are ways but I will pause that it's a paradigm shift that needs to occur within society. When you are dealing with older folks and ones that don't feel well for a whole host of circumstances it makes it tough.
So you may not know, HIV/AIDS -- by 2015, as of 25015, 1.2 Americans will be living with HIV and half of them will be 50 plus.
What we know is that half of the people in this country in over the age of 50; that's a startling statistic, when you think of the comorbidities that people with HIV will experience and the comorbidities that they will experience because of aging and what's the implications of that on society and within the healthcare network.
There have been tremendous advances made in the treatment regimens of HIV/AIDS but 17% of all new infections are occurring in people over 50, yet there are few prevention programs that target this demographic.
My sister lives in Florida in a place called the villages.
I don't know if any of you have heard of it it's a golfing community. It's a lovely place. I think the last count there were 210,000 people. They, actually, have two nights during the week where there are social nights for singles. Just to say I have read about them multiple times in articles about the increases prevalence of STDs in the villages itself. The number of people who are presenting.
Essentially, this is because, while you have 17% of no infections, there is literally -- there is no prevention messages or campaign that is targeting older adults around prevention and safer sex. There is, actually, a campaign I've seen that says -- it's a picture of older adults it says, age is not a condom, which I thought was a pretty effective campaign.
[LAUGHTER]
There are increased rates of cardiovascular disease. Again, with HIV comes increased rates of cardiovascular disease, hypertension, diabetes, osteoporosis, on top of the comorbidities of aging. You have a lot of things happening here.
As well as older adults living with HIV/AIDS are more likely to experience depression and social isolation.
So now, let's move forward to data collection.
As I said before, surveys typically do not collect information on sexual orientation and gender identity, which is a major obstacle in studying the realities of LGBT old e adults and health disparities. How can you capture the true realities of any population, if you don't ask questions about gender identity and sexual orientation?

Collecting this data at an organizational and institutional level would also improve the ability to track the needs of LGBT older adults, such as on assessment forms, you know, asking the question about orientation and identity.
To better track the needs of the people in your facility.
You know, not asking this information hinders the development of public policies and programs that seek to improve the well-being and health of the people that you are looking to serve.
So it just makes sense to really look at data collection. Data, policy, programs, funding.
Next slide.
So improving the quality of care, LGBT cultural competent. LGBT older adults deserve to access medical social services that are culturally sensitive and affirming of LGBT identities. It's just a basic. Opinion I have often said too people in aging services that it's the responsibility of everyone working in this field too do the absolute best they can for their clients, regardless of their color, the color of their skin, of their identities. You want to do the best.
So you need to be affirming. How you can do that is, agencies can put in place policies and protocols and programs that account for the unique needs of LGBT older adults.
LGBT older adults need to be recognized by the older Americans act as "graft e greatest social need" group, which opens funding avenues and service opportunities; that would be great because it would match up with NIH recognizing sexual minorities as a population of greatest need.
Only about one-third of senior service agencies have offered staff trainings on LGBT cultural competent.
Because of gender and race are included, you've all been mandated to do training around gender and race, but because LGBT populations are not protected nationally, there has not been a mandate for training around LGBT, but you can either wait to be mandated or you could simply do the right thing because there are a lot of LGBT people who are going to be passing through and you might want to capture that market.
I always say it's a business imperative. It's a business imperative. There's a profit motive here. You want to get people who are LGBT into your services. If you want to do that, you better train your staff and do what is necessary to capture them and keep them in your service.
Next slide, please.
Ask the right questions. Questions regarding sexual orientation and gender identity should be integrated into clinical settings so that medical professionals can capture the demographic data during an in-take.
Add the question on an in-take form.
There are organizations like SAGE, services in advocacy for LGBT elders. If you go online, there are at least eye dozen resources you can refer to on how to ask culturally-appropriate questions in your assessments, in your agency's in-take forms. Okay?
So it's really not excuse to say, quality We can't ask that".
What we often hear is when talking to AAAs we can't include that information because it gets sent to Harrisburg and Harrisburg doesn't require that information so what are they going to do with it until we need to say to the folks in power "just add the questions in data collection" I believer we have done it in New York and California. We have done it. Just include the questions in your data collection set and we will be able to gather this information. I don't know if it's -- I don't know how much longer it will be an excuse that we cannot do it.
Not asking the questions limits the chances that an LGBT person might withhold this information for fear of being judged.

So this, essentially, is if you don't ask the question, I am not going to disclose. It's that simple. If you don't ask the -- you know, use coded language to ask me my sexual orientation or gender identity, I am not going to tell you.
So what agencies need to do is, they need to expand definitions of family and next of kin to include friends, caregivers and alternative kinship structures to let others know who my next of kin is. It's my husband, significant other but we have to stop asking about husband and wife. We have to stop.
Binary in the choices we provide people!
Next.
So creating safe spaces, you know, it's simple. Create an environment where LGBT people can feel most comfortable asking candid questions about their health needs.
Use LGBT affirming language on your forms and your assessments.
Create a physical space in your office, agency, your practice that is LGBT affirming.
I often say, you know, that can be, one, having language on your assessment forms that reflect a non-binary model, using languages like next of kin. Do you have meaningful relationships? Do you have a significant other? Do you have a partner?
Putting a rainbow flag on your desk. Putting photos in your office, I mean if you have photos of people who you serve, put in some pictures of non-traditional families so that people can see this in your office and begin to feel that, you know what, maybe I can feel safe in this space to disclose my identity/orientation.
So there are a bunch of things -- again, one of the things that you have in your packet of information or on the desk is information from SAGE.
Again, SAGE is seniors advocating in an LGBT environment. It's an organization that is national. There are two SAGE affiliates in Pennsylvania. One in Pittsburgh and one in Philadelphia. SAGE is the organization that you could call upon to do cultural competence training in your organization.
I would urge you to look at this piece of paper. There is a number on here for SAGE. Use it!
I think -- again, the organization that I represent is the LGBT elder initiative and, again, we add voact for LGBT older adults to age successfully and everything that needs to occur in other words for that to happen and to age successfully at every age, which is important. Thank you.
>> **JEN:** Than you
[APPLAUSE]
>> **FRED:** Anyone here have any questions for him? Anyone on the phone?
>> **Russ:** Thank you if the Court please the presentation. I was with you 2010 at the summit. It was a moving experience I will tell everyone here.
The poster child for non-inclusion the straight white guy in the room at the time.
I hope people are not offended that's how we took role that day. I was one of two straight white guys my prior board chair fill formed a bond.
I would encourage you, Heshie, we had a webinar last June our analysissal association has award wing presentation our physician general here in Pennsylvania and I believe the highest ranking public LGBT official in the nation helped host that for us.
So the opportunities do not have to -- you don't have to stay at retail level you can go wholesale. I think you can reach united to folks and do the training.
I agree with you. This is about culture. It's not about training. I can go to training. I bring by asses with me to every environment. Everyone does. Over time changes the biases will be what helps you move the ball forward.

I am sure many associations in the room would be happy -- if you have something like that that is canned to help you get the message out.
>> **HESHIE:** Thank you.
>> **JOAN:** Thanks, Russ.
We have a question on the phone. Brenda?
>> **BRENDA:**
>> **HESHIE:** Give Brenda my information. I would be happy to answer anyone's questions.
>> **RALPH:** Thank you. Next is readiness review by Randy Nolan.
>> **RANDY:** Good morning, everyone. I am Randy Nolan. I am the person in Office of Long-Term Living overseeing readiness review.
I came a couple months ago and gave presentation I want to give updates on where we are at in readiness review.
Presentation up on the screen and it should be in the packet of the handouts.
I just wanted to give you a further update of where we are at. Obviously we can't tell you a lot of information because of where we are at in the process itself with CHC.
I wanted to give you an update irregardless.
Give me a second to catch my breath. Hopping around on one leg is tiring.
Readiness reviews manages MCOs prior to going live: 1? 1/18 in southwest; 7/1/18 in southeast and 1/2019 in Lehigh/capital.
It is based on the requirements aligned in CHC-MCO agreement; that's the document that you have commented on for over -- well over a year. It's still a living/breathing document that will be further negotiated with MCOs, once we are allowed to move forward with that phase.
As things change with the document, we will be making adjustments to the readiness review tools to also adjust that.
When we do readiness review, it will be based on the full, executed CHC/MCO agreement.
So we will be growing along with the agreement also.
The readiness review team are ent tips that help us with the revie. It includes physical health and LTSS components. We will look at physical health sides of what they do and also the LTSS side.
Readiness review, we have actually had this scheduled three or four times as far as scheduling a room for it.
The plan is to have the readiness review kick-off with MCOs in the spring. The sooner the better. We hope February/March at the latest depending on how things play out. Once we have the okay to move forward we will have a kick-off meeting with them.
At that meeting we will go over readiness review, what the tools are, answering any questions that the MCOs have and get them to start moving forward on presenting information to start reviewing it.
The readiness review teams will review all documents submitted by MCOs. Through the process, we have set up criteria and benchmarks that the MCOs must meet and the readiness review is either completed through desk review or onsite there is a combination of both. Policies and procedures will be looked another on desk review. They will submit it to us and review them.
We will also go onsite and do interviews with staff, testing IT systems. Running scenarios through them, checking call centers, a lot of onsite stuff also we will spend time-out with the MCOs.
Provider network adequacy component is primarily Department of Health gives blessing on that.
Between MCOs, readiness review teams and Department of Health we will make sure that all of that information is in.

The Department of Health has the final say on whether the networks are adequate but as they have questions, they will work back and forth with the readiness review times and MCOs. The assurance between the teams for adequate provider networks; that's one of the key things we are looking at when writing the review between adequacy and network piece carrying out the work that needs to be done is what we will be looking at.
Readiness review teams will provide technical assistance to MCOs, probably daily phone calls and weekly conferences with them. We will be in constant contact with them as we walk through the process.
This slide shows the readiness review roster and some of the things we focus on.
A lot of the offices involved are within the Office of Long-Term Living. There are entities from office office medical assistance programs that help us -- data management collecting system we have financial stuff, bureau of finance to help out.
It's a whole office-wide/department-wide look at making sure the sentities and MC Os are ready to provide services.
The key at bottom shows you the departments that are involved with readiness review.
All right. Some of the readiness review criteria we look at, MCOs must demonstrate that they have compliance with specified policies and procedures as outlined in the CHC agreement and CMS recommendations. This is a list of things they need to comply with and do. We will look at administrative functions, enrollment-related functions, member services, member handbook call centers and things like that, service provider and network adequacy, which go hand in hand to provide services that are required and having adequate network to provide them; continuity of care, as you know we have 180-day continuity care period in CHC agreements; so we will look at that part of the process.
J. grieve pance, appeal and fair hearing process. We are looking at this internally and making sure our process works with the final role fro CMS so grievance, hearing and appeal process is a process that will be fairly new and rewritten. We are working with legal on that to ensure that we have the appropriate process in place for individuals.
Credit coal incident monitoring and reporting. Quality assurances. We will look at quality related items.
Systems testing; this is something we will do on site to make sure they can build, download care plans and do whatever is necessary from the system's perspective.
Program integrity and also looking at encounter data and financial functioning.
There are a lot of components within these things that we will be looking at; that's why we will have a team dedicated per MCO but also have the subject matter experts as we need them. We will be able to pull people in from our pharmacy area, financial areas and look at all of these things because we have the internal staff to do that.
It's a large process. People may say, do you have four people? No. At any one time we have twenty people in the room looking at something, depending on what needs done.
The readiness review criteria. MCOs must demonstrate coordination with various entities including: Behavioral health MCOs. The collaborative worth we do with behavioral health is very important. They have to coordinate with independent enrollment broker to work on enrollment-related issues and also with the financial management service entity.
There has to be coordination across the board, here. This is just not the CHC we are looking at. We look at making sure all of the services are available and they are being done smoothly and relationship between MCOs and other entities, which is very important. It's one thing to try to get them services but if we cannot get them paid for or money through the system or link them up to

a behavioral health service or mental health service they will need, it's defeating some of the purpose we want CHC to do.
All right. What happens as we are done rig readiness review:
Once readiness review has been completed the teams will assume responsibility for day-to-day monitoring MCO. As Jenn probably mentioned we are going through reorganization we are looking at staching on managed care and balancing fee-for-service side. How the teams play out and get staff involved in it will be independent. Once review is done it will slide over to monitoring responsibilities.
>> **FRED:** I have a question.
Are they in different regions that this is going on? In southwest is it review you had there and continue on?
>> **RANDY:** The question was, will the staff be regionalized or justurallized? A lot are centralized in Harrisburg. I have regional staff? Field operations in seven different regions in Pennsylvania. We will be utilizing some of that staff. Most is nursing but we will utilize some of the staff to assist with the review of readiness revie but then we will also utilize the staff to do other thingings out there we continue to need to do outside of managed care.
There are areas in nursing home side and home and community side outside of CHC we need to continue to monitor. On nursing facility side things like pre-admission screening process still needs to be done and overseen by our staff.
There will be some ability to do that.
There will also be ability to use regional staff to go out and do spot checking and monitoring. Popping in on a provider and saying, hey, have you heard from MCO? Making sure the provider is available and providing services. Maybe going out and meeting with a consumer that has an issue. We will have an ability.
>> Who will be trining contract monitoring teams to make sure that they are consistent you will have several teams apparently (Veronica comfort) to make sure there is consistency.
>> **RANDY:** We are patterning this on health choices and what other states have done Texas, Tennessee we have looked at some of their models, which we will continue to do as we develop things.
As far as training staff, a lot of the responsibility will be mine as overseeing readiness review.
I have a group right now of about seven individuals that have worked on the tool and put it into place that know the tool inside and out because they created it. They will help training also.
>> **Veronica:** Thank up.
>> **RANDY:** Uh-huh.
All right. Issues identified is looking at readiness review. If there are issues we don't think the MCOs are meeting and we have a go/no-go date in place, which we keep adjusting. If we are back to January of '18 the no-go date will probably be end of September.
I will show you a little bit later, we have a set list of tasks that need to be done by that date. If we look at that MCO and maybe their provider network is only 25% built by that date, obviously we don't think they will be ready to go. If they don't have an IT system in place that will be able to handle the billing and coordination with FMS entity and other coordination with promise obviously they will not get a system in place by January 1st.
We will be looking at that stuff. We are going to work closely with MCOs to ensure this stuff is in place.
It's a benefit for the department to make sure that everything is in place because we want to make sure that the services are appropriately provided for consumers. It's also a benefit for MCOs.

If we have 3 manyCOs or more if one is not up and ready they just put themselves behind the eightball and will never catch up as far as frying to provide services out there.
We will work with MCOs to make sure that everything is in place.
Then once we go through that phase of readiness review and start moon toring, we will also do early implementation and evaluation we will take a look at the things that are happening. Lessons learned, things we need to do better and change, as we move forward we will do that part of the eye valuation to have lessons learned as we move on to southeast and Lehigh/Cap area. We will look into the outcomes.
>> **JOAN:** Pam, you had a question before Randy moves on to the next session.
>> **PAM:** The Department of Health has a final say on network adequacy but both Department of Health doesn't deal with non-medical services like our long-term services and supports to providers like CILs or MCOs.
There is regulation for the home care but there's not -- they don't deal with the consumer employed part of it.
I am wondering, with the department of health -- licenses to provide long-term services and supports, who will determine network adequacy for long-term services and supports providers; that's one question.
The other one is: Who is training your nurses in the different regions to deal with long-term services and supports? Nursing is completely different than our services. We hear nursing and alarms go off in head if you have nurses monitor our services; those are a couple questions I have.
>> **RANDY:** The first question Pam had with Department of Health being responsible for overseeing adequacy piece they have experience on medical side but not LTSS side who will make sure they are adequately looking at things.
When we work with Department of Health they work with department of insurance to make sure that everything is approvable.
We worked with Department of Health. Once we get rolfing with CHC we will work with them weekly and provide them input and training and guidelines that we look at on the LTSS side; that's one of the things they asked us also.
So we are going to be providing some information for them. We will be working together with the Department of Health to ensure that they understand the LTSS needs; that it's not just necessarily, all right, you need to have one provider every 300 yards. We need to have other things in place. We will work with the Department of Health to assist with that part of the process.
The second question she asked was: If I utilize nurses out in the field to help out with review and Monday dooring of the process who will train nurses since it falls on physical health side versus the other side.
We will only use nurses to review policy and procedures a lot on the healthcare side but we also have staff out there in our quality management teams our QMET teams dealing with home and community-based providers as well. We will utilize that staff out there.
It will not be nurses that currently do nursing facility stuff but QMET staff that work with LTSS side we utilize combination of those staff.
>> **PAM:** Thank you. I just want too say one more thing I stead it before and Jenn talked about it last time. You talk a lot about the experts. I don't hear consumers being part of this. We are experts in our services.

I really, strongly, recommend that you get participants involved in the readiness review process. You are talking about creating a appeals process or grieve enance process. It's huge for consumers. We go through it and experience it.
I understand there is a question about conflict let us find people who don't work for a CIL and receive services. Let us help you find people who, genuinely have an interest and really want to be part of this process.
>> **RANDY:** Thank you.
So I will show you a couple screens on the readiness review tool. The first screen we have up is the table of Don tents. As you can see, if you go down the left side where it says "tabs" these are the different tabs listed.
This information is taken directly from the agreement. All of the tabs are things we will look for and have tools set up to collect it.
Up at the top table of con ent feds the circled area is responsible party. As you can see, we have a color-coded chart on there. This is a color coded chart that allows people that have to review this information to go into their area and review it.
For instance, we have quality is yellow; program integrity is blue -- there are different collars as you go through there.
The way we have the tool set up is you can click on your area. It will take you into the part of the tool that is responsible for you. Manage if you are reviewing quality measures throughout this tool, instead of searching through the whole tool to see where the quality information is at, you click on the tab and it takes you to that information in each tool. It's more user-friendly for Is and reviewers and also user friendly for plp C Os because they will see the information and where they need to go; so that's the color coding we have there.
Across the bottom is the table of contents that we have listed all of our tools. So this is the basic table of contents, it is the front participate of the tool that is the driver. It allows us to find stuff. If you want to say, what are we looking at in quality stuff? We need to check on the yellow tab/box which takes us to the quality stuff. In each tool we will monitor it as we go along. It makes it user friendly as we move forward.
Now, as far as the content of the tabs, which is down the left side, basically, it spells out -- like the examples we show you here are materials. Underneath there is outreach and education and looking at participant handbook.
Under participant services we look at hotline outreach, complaints and grievances.
Throughout the tabs it sheas you if you go to tab of participant services we will look at stuff on the hotline, outreach. This will show you what is under each one of those tabs we will look at. It will help the MCO because they will know what material they need to provide us for review; that's within that content of the tabs.
The next sheet is a summary of progress. It allows the tool to automatically calculate, once we a approve stuff how the MCs are doing as far as meeting criteria it gives us a snapshot and we can see where they are at different points. It allows us to go back to the MCOs and say, your 30 days before go/no-go date you are at 50%. You have a lot of work too do. It's a great snapshot by category of what they already presented to us and what we have already approved.
It will give us that ability to do that.
Part of that measuring we use for the go/no-go date; that's a big piece of why we look at this.
The next sheet is the core readiness review and benchmarks. This is -- it's not just one sheet --
>> **RALPH:** We have a question from Tanya.

>> **Tanya:** In terms of the go/no-go date, with that example you just gave about, okay, you are only 15% ready. You have to get to X before we let you do this.
What happens if you agreed to a contract with an MCO but they are not ready but that go/no-go date? Will you still give them a chance to get ready or will they be automatically withdrawn from the process and then the consumers are only left with maybe one or two choices instead of three?
>> **RANDY:** The question was, what happens if we get to the go/no-go date what happens if MCO is not ready do we disqualify them or continue to work with them.
We continue to work with them. In the southwest the actual start date is January ' 18 if we get to the date and they are not ready, their start date may be pushed back it may be March of ' dwlt 18. We will continue to work with them to get them up up to be a viable provider.
>> **Tanya:** I have a bit of a follow-up question. You said you will continue to work with the MCO to get them ready. What happens to the consumer while they are waiting for the MCO to get ready? How quick with the transition process be able to be from one MCO to the other so -- and without interrupting the consumer's services?
>> **RANDY:** The follow-up question was, if we have an MCO that's not going live and they are pushed a couple months back, what is our process that will be in place to ensure the consumers get services; if they want to transition MCOs how quickly can that be done?
As far as transitioning that it's a decision a consumer can make every month and thrans ition happens from there.
MCOs are responsible to work with each ear to make sure that services transition, et cetera; that's part of the agreement we have in place; so that safe guard is already there to make sure you have that.
What happens is, hopefully, we have at least 3MCOs, if one is not ready, then we have 2 options for you until the third one comes up.
What happens if two of MCs are not ready and one is, I think we are all running scared at that point in time.
I think that is why we work hard in upfront phase in writing agreements to make sure that we get the MCOs up and running by go/no-go date.
>> Tan ya. One last question: What if certain providers will only work with certain MCs and one is not up and ready to go but that p person's doctors are under all under that MCO? What happens too that person continuity of medical care during that time should they need it?
>> **RANDY:** Her follow-up question was: What happens if the provider that the consumer has doesn't want to participate in the two MCOs that are ready they won want to participate in the one that isn't ready how do we share continuity of care with medical care.
We have providers in place providers can be served out of network we work with MCOs to possibly do that.
We will work with providers and MCOs to try to get them enrolled; that's part of the ongoing process that we will put in place to ensure continuity of care.
One of the big efforts pushes we have is allow for out of network providers and MCOs have to honor that.
Are we, as a subcommittee going to get more information on this as it comes into being so we could go and help people in our own communities, in our own backyards to understand this?
See, to me, what we are doing as a subcommittee, part of my job is to not only ask you these questions on behalf of myself and some other people I know, but there is a whole other population out there that will have a hard time knowing how to work within these systems are we

given as much of that information as possible in advance to help people get ready, regardless of whatever level it may come to?
>> **RANDY:** Yeah.
The question was: As far as information with education on how to work the system, how to survive in the system is there a mechanism to provide information to help population and consumers?
The answer is, Yes, there are outreach components with contracts that is part of the IEB and some other contracts to provide education and outreach.
I'm sure that through the Office of Long-Term Living we will continue to provide you all the information to have to work with the consumers also.
>> **Tanya:** Thank you.
>> **RANDY:** Thank you.
The next chart up here is core readiness review. This is the benchmark sheet. It's not just one page. This is just a screen shot. It's multiple pages. This is the tool that we will be utilizing to ensure that they are ready to go to by go/no-go date.
Everything in the core readiness benchmark is the stuff that needs to be met prior to us allowing the MCOs to move forward.
If you look at it there are certain things the MIS system, being able to integrate the system so that they meet righter requirements to do the care plan and provider payment to ensure that providers are enrolled.
Provider met work is the next one. Staff training. Those types of things are the integral things that we have identified in the agreement that must be done prior to the go/no-go date.
This is the big thing we will look at. It's not the only thing important to us but all of the stuff under core readiness review benchmark simple be the things MCOs will be required to work on and ensure that they have it in place before we will allow them to go forward.
We have that set up as part of the tool.
The next sheet is just the tool itself. It pretty much goes line by line with what is in the agreement. We have a lot of hyper links into the tool so that if we click on certain sections of the tool it takes back to the agreement, the exhibit, it takes us to an appendices and other things we need to ensure and MCO needs to ensure is there.
When MCO clicks on this it takes them back to hyper link for the agreement and they will see all of the language necessary there.
Our tool is set up to do that. It's set up to be user friendly and go back and forth between the tool itself and the agreement.
We have kind of coordinated that whole thing to make it easier for everybody to use and also ensure that we will not miss any information. We will have all of the stuff we need and all of the stuff that is required.
The worst thing you can do is come to the 11th hour and figure out we forgot to ask for something.
We integrated this whole thing to go back and forth between the tool, CHC agreement, so that everybody has it in place.
Like I said earlier, as we negotiate the agreement with the MCs, obviously, there will probably be changes I don't think anything major but slight changes. We will address that in the tool also.
We have addressed every time we made a change in the agreement we addressed it in the tool.
We have even, the work the department has done, working with the final rule in how it affects

our agreement. We have that down as a pretty good many draft. Of everything that was incorporated in the final rule.
We have now incorporated that into the agreement.
The next step we will take one the agreement is negotiated, the stuff that has change willed we will bring it back into the tool itself.
One of the big sectionings that we need to pull back into the tool is the grievance hearings appeals an fair hearings section; the stuff that our legal department is working on right now. Once that is finalized we will create a separate tool for that also. A little overview before the fool there is an agreement section, it's based on the agreement.
The stuff in the tool is direct language from the agreement.
Deliverables we are telling the MCOs to provide, they have to deliver everything.
We have talked about the review types we will do as far as desk, desk and site reviews, common strayingses. We will be asking them to run things with the system when we go out to see them. We will be working on them taking calls to see how they are handling their call center, one of the things we may work with you on is developing scripts or assisting us in testing call center. Maybe there are areas we can work together on that also.
This provides a whole list of what is deliverable and what the review status is. We have a category where we reviewed things and the department will determine whether it's been completed, whether it's still under review by the department or whether pending further information from MCO.
There's a section on there that will document our findings when we review stuff. Like I said before, there are hyperlinks found on each tool allowing us to navigate between the agreement, tool, exhibits, the checklist. It will help us navigate everything back and forth.
The next sheet is the checklist itself. We develop willed checklists for every area regarding as it comes back to to the agreement itself the one we are showing you here talks about provider networks. It's the same language as in the agreement. The language in the agreement is a little bit more specific than here, but we relate all of this stuff back to the agreement and to the exhibits in the agreement.
The hyper links allow us to go back to the agreements in the exhibit which provide more detail than what we have in the tool itself, but it gives us the ability to go quickly back and forth.
The way it was set up before we put the hyperlinks in, if we wanted to look at the agreement we had to page through a 300-page agreement to figure out where it was at.
This way we can hyperlink, pull the agreement up, it will help the MCOs to do that to to go back and forth and look at stuff. It's a benefit for everybody involved.
The mechanism that we are using, that all of this information will be on is called doublingushare a tool we use to share documents back and forth.
We will have access for themselves but not other MCOs just themselves they are responsible for scanning, downloading however they get the information in doublingushare and readiness review teams will pull it up and review it through Docushare. It is a management content system which will be utilized as the main source of communication and exchanging information between department and MCOs that way everything will be in writing. There will be no verbal stuff. We will have phone calls back and forth but all of the information is put into docushare.
Each MCO will have access to only their folder. No access to others. We don't want anybody stealing somebody's paroleses and procedures to make it easy for themselves; not that that would happen.
Subfolders will house the materials for specific tools and checklists.

We will show you a couple screen shots of what it looks like. The circled area sheas we have a separate section for MCO-a, b and c.
The only people that can get into all three is review team as we monitor stuff.
DocuShare. We will update policies, to have ongoing communication; that's what the last section shows the communication so it's back and forth.
It's very important for us to have the open communication with MCs but also have it documented so that will if a month later we need to say to the MCO, hey, we haven't received this. The MC oop says, we submitted it to you.
Look based on our communication this is what we requested from you. You have not submitted these pieces. We will have it in writing. It will be a good log of what is happening between the department and MCOs.
In a brief overview it's what we are looking at in readiness review. We are moving forward with it. We are very comfortable with where we are at with the tool knowing we have to make minor adjustments as we go through the negotiations of the agreement with the MCOs, knowing that we still have one piece to put in there regarding the hearing, appeals and grievance section.
Everything in this document, everything in this writing review tool we have in there is based on the agreement.
I mean, if you have questions on what we are looking at and what we are looking at in each section you have access to the agreement; that's where we are getting everything from.
There is nothing outside of the agreement that is in the readiness review tool. This is what we are requiring from the MCOs; this is what they will be signing off on when they sign off on the agreement.
It will all be vicinity.
>> **FRED:** Any questions?
>> **JOAN:** Pam, did you have a question?
>> **PAM:** Yeah, but I think I know the answer is based on your last comment. I was wondering how we could see it, DocuShare. To find what you are monitoring the benchmarkings and things use the hyperlink and look where it goes into the agreement and all of that. We don't need to see providers just a generic one. At one point somebody said we would be able to look and review the readiness review tools but then we were told not -- asterisks there a way we can access that is there a link on the website to see tools.
>> **RANDY:** The question was, is there a way for consumers to access the readiness review tool. At this point in time there is not. There is not a plan for the department to do that at this point in time.
>> **PAM:** Okay. Just a recommendation. It would be great to have.
>> **RANDY:** Okay.
>> **JOAN:** Any questions for Randy on the phone?
>> **Blare:** Thank um st. you have mentioned you are working to create adequacy standards for home and community-based providers. How close are you to those -- do you anticipate they will be published, available for MCOs or this committee to review what those network adequacy standards will be?
>> **RANDY:** We have not done a lot of work on this because of the pushback in time frame. As we get the tool done it will be on the calendar probably within the next month.
Once we have the okay to start moving forward we will start meeting on a regular basis and get input from the SubMAAC will get information from other providers as we work with DOH.
>> **BLAIR:** That makes sense.

>> **Russ is:** A followive up on blare's question. The rules as far as network adequacy for facility's act licensed provider it gets grayer as it goes through; that's base-level have authority to operate in counties.
Will the department be putting an additional layer on top to have it to see networks that exceed the minimums, which is kind of what they are, that the Department of Health has to see to grant certificate of authority in a county?
>> **RANDY:** The question was, the Department of Health has a basic flat-line to where they need to be at for network adequacy.
We will look at where their standards are at and look at what we feel the needs are throw CHC. If we need additional or need to require additional providers in the network, yes, we will certainly do that.
>> **JESSE:** I apologize if this is answered I am not clear on it.
As you go through the process, how transparent will it be, you know, if you encounter problems or MCO has already gone through the process and met benchmarks, who will have access, as we are going through the process? Will it be at the end of the process to see what the progress is? The second question is, if there is a dispute about one of the benchmarks or criteria, is there a dispute resolution process or what about that?
>> **RANDY:** Two questions: First is how trance parent will we let consumers/public know where we are at? I don't knee if we have you know discussed that at this point in time. I'm sure we will come to the committee and give updates on where we are at. As far as the specifics, I am not sure on that yet. Ppg the second question was,.
>> **JESSE:** About if there is a dispute about use criteria and someone meeting or not meeting that criteria, how do you resolve those challenges?
>> **RANDY:** The second question was whether the MC oop has a dispute on criteria or benchmarks how do we resolve that.
Since he is not here I will throw him to the wolves here.
I will sa sick Kevin Hancock on you.
>> **JESSE:** The question, if you say, well, not just using one example there are probably millions, if you say this network is not adequate if there was a smaller one you say it is not adequate and MCO says we think it is and this is our evidence at the end of the day, the department makes a call --
>> **RANDY:** The department has ultimate decisionmaking but it is a negotiation process we go through with the MCOs, the main focus both for -- both for MCOs in the department to make sure that they should have access.
>> We have to wrap up because of our other presentations.
I need to say something in response to Jesse's question about how transparent this process will be. We will use the health choices model and, so, this is the first time I've been asked this question, but we will go back and talk with our partners at OMAAC to is find out what they do.
>> **FRED:** Next is Charles talking about my come pass demo -- I'm sorry, long-term care council.
>> **JOAN:** While switching chairs I want to share a it comment from Terry Clark regarding Heshi fixnum ['] presentation. First she says thank you! Great information. Folks can reach out to SAGE affiliates in our state and nationally. They have engaginged in our state and continue to provide resources. Folks can reach out directly for more information and make sure that her contact information gets on the record for everyone to reach other directly as well.
Change.

>> **CHUCK:** Executive director of Pennsylvania long-term care council. It came to the department of aging the end of August. I will give you quick background previously work willed for the General Assembly, from there I went on to serve with Pennsylvania home care association and joined woferl administration of all administration Department of Agriculture and found my way back to aging issues joining the council.
The council was established last year, actually -- 2015 by General Assembly housed within the Department of Aging. It replaces -- some of you may be familiar with the former inter government council on long-term care. That council was created in the late 1980s specifically to focus on personal care home licensing and regulation.
The focus over the years expanded beyond that, the statute was never updated. Then there were periods of inactivity. That council had ceased meeting, I believe, around 2008.
Looking at the multiple demographic challenges confronting the state, legislature decided to bring back to council, kind of reconstitute it and here we are.
Council is comprised of 35 members representing diverse array of stakeholders with long-term care services and support system, legislative members cabinet secretaries from different departments who all expect with long-term services and supports are on there as well.
Providers, consumers, caregivers, representatives of the medical, legal, insurance communities and academia.
With that said, you could go on to the next slide.
Powers and duties of the council are to make recommendations on regulations, line lins licensure, financing and anything else related to long-term services and supports systems as well as perform any other duties assigned by the Governor.
We are tasked with establishing committees to study, make recommendations on different issues. We have to point committee members and Chairs of those committees as well.
Within those committees, the statute itself -- I don't know if you have an electronic link. I provided a hyperlink in the first slide to the statute. The statute givens direction. Regulatory revie and access to dwawlt care; community access and public education, long-term care services models and delivery systems; workforce, housing and behavioral health issues of seniors.
Frism.
>> **FRED:** Who is going to be involved in these committees? Are consumers involved or just PHS or what?
>> **Charles:** We haven't, actually, established the meeting yet. We held a meeting at the end of November which I will explain in a few minutes and answer the question then, if that's okay.
The statute is very clear that the scope is to address all areas of long-term care, the full spectrum from home and community-based services all of the way to skilled nursing care.
Going to the next slide.
As I mentioned, we held our first meeting November 30th of last year. It was really a meeting to bring everyone together for the first time. A lot of the meeting was taken up with housekeeping matters.
The various designees I should mention, deputy secretary Burnett is designee for secretary balance e Dallas, Joan Bradbury. Heshie is also on council filling an advocacy role.
So at our meeting various departments on the council gave presentations on hour their departments intersect, their roles and responsibilities as it pertains to long-term services and supports.

The afternoon part was reserved to begin a discussion about what the priorities of the council should be. At that point we haven't established priorities. We started a dialogue with members too make sure that we are as deliberate as possible.
With that said, the committees are not restricted to merely those who serve on the council. As we establish committees, other folks who are not on the council who are interested and may be subject matter experts in the areas we examine are more than welcome to be on the committee; that's information I could share with deputy secretary Burnett once we get to that point.
In terms of 2017 meeting dates these are the dates -- I should note there is one caveat. We have a 35-member council which is a pretty large group. When you consider staff involved, it makes it difficult or first meeting was at the department of aging. We are looking for a more accommodating place to meet to hold that size of a group; so that everyone can see each other and have a good debate.
We are talking about moving the meeting location, still in the Harrisburg area. If that happens; the February 9th date may need pushed back a week or so. Again, it's something once that decision is made, I will share with deputy secretary Burnett as well.
All of the meetings begin at 10:00 a.m. We don't specify an end time because it is contingent on the agenda. We have people traveling from all over the state. We have robust agendas.
That's where we are at at this point. We are excited to be on the council and get to work with all of the stakeholders on -- some I see in this room, I worked with in my past life and aging committee.
If anyone has any questions, I hope I was brief enough.
[LAUGHTER]
>> **FRED:** Any questions?
[NO RESPONSE]
What is your contact?
>> **Charles:** Next slide.
>>: Fred: Anybody?
[NO RESPONSE]
Okay.
My S Terry. If I can introduce myself I am Patricia Allen bureau of director at office of income maintenance I see a familiar face. Hi.
Is that better? Thank you. Sorry about that.
>> Thank you.
>> Patricia Allen program of support office of income maintenance.
I am really pleased to talk with you today about the very first mobile app that the Department of Human Services has built. We launched it November 28th of last year. What we are hooking up right now is a very brief PowerPoint. I wanted to share with you the journey that the office of income maintenance has undertaken to build this mobile app, how we did it.
Then I want to show you a brief demo of the actual app and go through what we built and went live in November.
As of November you can download the app on Google Play and Apple store. Are we up yet?
>> One moment.
>> **P**Patricia: 72% of citizens have a smart phone andize it as sole access to interest irnet. Most people don't have broad band at home or internet. We wanted to improve our services; that's why we built the app. We wanted to save clients time and improved customer service.
Our mobile app I apologize about the delay in PowerPoint.

It is the Governor's initiative. We are tracking all of the savings as a result of this mobile app from day one of it going live. The savings will be in the areas of postage, mail, phone calls. There will be increased efficiencies for CAO workers, less time on paperwork and answering questions from our clients because now our clients will be self-serving commonly-used questions they does have.
So there will be efficiencies with staff and they will be able to focus on more high-profile clients. Here we go. PowerPoint!
I have with me Shawn, special assistant to the bureau. Thank you for helping and doing this AV support this morning.
I just talked about the introduction. Could you go to the next slide, please?
So you can see, here, the driving number one priority for our office is improving customer service and saving our clients time.
Let's go on to the next slide. And the office of income maintenance didn't develop the mobile app in isolation. We, actually, took our idea to the road. We invited 300 community partners to 3 listening sessions in January of 2016 we were in Harrisburg, Philadelphia and Pittsburgh.
We asked our community partners, What functions do you think we should put into this mobile app?
You can see, it's broken out by Philadelphia, Harrisburg, Pittsburgh what the top 5 functions were for each area.
The functions that community partners identified aligned with what the executive staff was thinking about. That validated what we were thinking. Next slide, please?
We also talked to our clients. We didn't just ask our community partners. We asked our clients. We went out to the lobby with survey monkey and aye pads. We surveyed 200 # clients. Do you have a smart phone? What kind? Moist of them had androids.
We asked them to rank about a dozen functions that we were considering building. You can see, here, the number one function that they wanted us to build was the ability to upload documents, which means the ability to use the smart phone in your camera to take a picture of verifications document and attach to application or benefit.
They also asked one of the number one things they wanted us to build is what is the status of my application? I applied. Where is it? Is it in process? Is it denied? Was it approved?
You can see the other functions that they asked us to look at.
Next slide, please? What we came up with were 10 monks functions we built that went live November 28th. The functions were validated by our community partners and our clients.
I will be giving you a quick demo of these when we get to the end of presentation on an actual smart phone.
Go to the next slide, please.
We also wanted to measure the success of our mobile app.
We had to do that it was a go-time project they wanted to know monthly what are your savings and expenses? We wanted to be able to report back to our executive staff, to the legislature, to the pret press and also to monitor the health of our mobile app by tracing key performance functions.
This is a description of the functions that we are tracking but let's go to the next slide. We developed a dashboard. This dashboard is live. We can check it any minute of the day and do throughout the day. We are so excited about the app.
Since day one, in less than six weeks, we have had 11,500 downloads of the mobile app.
We are really excited about that.

The clients look the at benefit status 47,000 times. We had 21,000 success Phil log-ins. We are almost close to 6,000 documents submitted through this mobile app.
The number one document submitted are paystubs we have it broken out to the number and the ranking of the documents that are being uploaded.
We have the star ratings as you know on app stores you can leave star ratings and also verbal ratings.
On glueing he will ratings we can respond, which we are where we find appropriate.
First week we were all 5 stars now they go up and down. We haven't hit 5 stars. We are doing fairly well. I understand these are good ratings for a mobile app.
We also track password resets, accounts created how long somebody is in the app.
1.83 minuteses.
We have mobile app hotline in the phone. This is updated realtime. Very popular at our department. What are the numbers today?
So it's -- I just highly recommend, if you are thinking about a mobile app, build yourself a key performance dashboard indicator as well. It's very interesting.
Go to next slide.
The other thing we did was develop marketing and communication plan. The way we approach that is we did an analysis. We interviewed 108 managers, CEO staff, dlients and asked them, what is best way to market a mobile app to you? How should we talk to you about this? They told us. We developed -- like a 20-page communication plan based on the feedback we got.
Some of the things they wanted -- one thing that was surprising we heard from our clients, they still wanted paper. They said, put paper in the notice you send us but make it look different.
I have some of these to hand out. We develop willed these inserts they are a different size than the documents they get, different color. You can download the app and snapshot after what it does. These inserts go in with every single renewal package in 2007. We mail a lot of them.
English on one side and Spanish on another. I will hand them out and you can pass them around.
We also developed smart cards. English/Spanish. This helps get the word out. We developed posters we gave up to community assistance office. These cards are also being provided to them.
We are doing the Department of Human Services. There is a link in the Facebook page that takes will you right to the play store or the app store to download the app.
We have press kits, press releases. Then we also have an internal communications plan. We provided webinars to every single one of our CAO staff. If they are approached by a client, they can explain what the mobile app is. They are familiar with it.
Next slide, please?
Okay. So now we are going to go to the demo. I have a short cord here that I am going to have to standby --
>> Can we turn the lights off in the front?
>> Patricia. This is a deactivate iPhone. It is in mock mode. You will see typos and crazy names but it demonstrates all of the functions we have today in the mobile app if you download it from the app store.
Those on the phone you are not able to see what I will be going through right now, but you can download myCOMPASS PA on your app store.
You can go through some of the functions you will not be able to get behind the fire well and look at benefits, but you will be able to see an app tour and frequently asked questions, which I will cover shortly.
If you download the app this is the icon that shows on your phone screen. I will open that.

That's your splash screen. You will always see that young woman. You will -- the first time you download the app you will see the three screens. We call it the first-time user experience. These screens just give you an idea of what you will see if you create a myCOMPASS app.
Take care of business while on the go. Ready to get started?
I will continue to log-in screen. This is what you will see if you download the app and don't have an account. Those on the phone you can see what we are looking at right now.
Along the top in pink; that's our public bulletin board. A broadcast message. If we were down, which it was a couple weekends ago for maintenance and people couldn't access the app.
We put a message on this. We opened it up and typed in a message explaining the app is down for maintenance try again later or other types.
We can put them in English and spanish
The next thing is you can open the drawer menu. You can see the lines in the upper left-hand corer. Frequently asked questions.
I will open the last tile. What if I need help with something not listed in the help center? This takes you to a dedicated toll-free number for the mobile app.
We hired a vendor in Speratech to answer technical calls.
You can download it from here. This is a dumby phone so I will close it.
The other thing you can see and those on the phone if they downloaded it, it's an app tour. These are just four screens to give the user an idea of what they will get if they actually log into the app. You can see details of benefits, status of application, upload, submit documents, let us know when you have had changes in your life.
This is something that is just available for people to get a flavor, a sense of what the app can do. These same screen shots are on the app store too. When you search myCOMPASS PA you will see a description of the app, what it can do and also the screen shots.
I will go back to the log-in page. From here one new function we added, if you forget your password you can reset it. You can do that today on COMPASS debt being top, which is nothing new.
User name retrieval is a new feature. We had one client that had 132 myCOMPASS accounts. The reason is, before this app, if a client forgot their user name we told them, create a new account. We could not retrieve their user name.
Now you can.
If you forget your user name, you put your first name, last name, your date of birth -- which we always cheat on that one -- add your email and you will have your user name e-mailed or enter MCI number, Medicaid, EDT, find user name. It actually shows up right on the screen of your smart phone.
This is new function at. We are really pleased to have that with the mobile app.
I will log in now.
Actually, before I log in, I would like to show you the flow to create an account. You can either use existing myCOMPASS account or create a brand new one on the mobile app.
So there are six steps to create a myCOMPASS account, the exact same as COMPASS desktop. We immediate it simpler on the mobile app, we improved it.
You need to -- there are six steps. Choose your county, case record, I am just making a fake one, here. MCI.
There is a helpful hint to find the information T. we have a card to find the information. If you don't know the numbers, you can add your social number. Apparently a lot of clients don't know the number and that's the number they use.

That's step 1.
Step 2 is putting your name, date of birth, email is optional. You don't have to put that. Would you like to get online notices? We will go to the next step, step 3. Here is where you need to create a user name
Then you need to create a password. We improved this by adding these little circles that identify their criteria you need to include in creating the password.
As you meet each criteria, that circle gets a little check in it.
You need to put your password in twice. Then just like COMPASS desktop you have three questions that you need to answer and give your unique answer and remember those.
So I am just going to go through this real quickly. They are not really good questions but we could not change the questions; because that's what we have on COMPASS desktop. It's bigger than the app. We are stuck with them.
>> **PAM:** While you are working on that, may I ask you a question?
>> **Patricia:** Of course. Please.
>> **PAM:** With mobile app you need a log-in. How could we -- we do nursing home transition and a lot of times we are right there with them in the nursing home to use their phones because they don't have the same technology in nursing homes.
Can we do more than one account for them on a mobile app? Right now currently --
>> **Patricia:** If you have unique account numbers --
>> **PAM:** We do it online first --
>> **SHAWN:** You can create an account for anybody on the phone. It doesn't save your data. Every time you shine off it logs you off. If you want to create the account and give the information, go to the next room. You can create an account and go on to the next one. It doesn't save your cry den shalls, it's a fresh app every time you go in.
>> **Patricia:** Thank you, Shawn.
>> **SEAN:** You can create multiple accounts on the app. You have to do them one at eye time. You have to create the account, give them the information, log off.
If there was another room, go there and create an account again. It's just a gateway to everything you would normally get on COMPASS: You can do as much as you want just log on/off.
>> **Patricia:** The last step in creating a myCOMPASS account. These are the displaimers, click yes.
I just wanted to point out, these six steps in COMPASS desktop you can go through all six steps before you learn you made a mistake.
We improved on mobile app that you can't go to the next step that there ising? Wrong. You will get an error message go back. Your password was wrong. We are hoping that is an improof.
Over desktop to make it imsimpler
I am going to go into the homepage to show you what that looks like.
This shows benefits you opened and status of any application you submitted.
I will goo to benefits and open that tile.
Three benefits: Medical assist, SNAP and lie heap. I will open the first tile medical assistance each one you will see start date semi annual renewal date. Their renewal date detail about their medical a sixtiance.
If I go to ?ap you will see the amount of money they are getting. LIHEAP you will see that there. The bar will actually match with the day that it is that day. That helps you know if you are coming to renewal dates.

Release 2, which we are working on right now going live in August, you will be able to renew your SAR on the phone as well.
From this page, you can report limited changes. You can change your address, I. mail, home phone, best time to call.
In release 2 in August we will expand it to update other personal information. We kept it small for release 1.
Just a flow through, if I am changing my address, this is just fake that I am doing. Nothing real. You can review the change before you submit it. I just wanted to show you this page. You am see a little button update voter registration information.
It recognizes that you are changing your address and says, Hey! Do you want to update your voter registration? Then it takes you right there.
I will go back to the benefit detail. I will demonstrate the upload document function. So this is where you can use the camera in your smart phone to attach verification documents. You can see that Andy uploaded personal information on criminal history. I will add another document.
You need to choose a category. I will add personal information next, ID, I can either take a photo with my camera or pull one from my photo gallery. I will take a photo to show you how that works.
I have a driver's license here. There is the driver's license. It looks good. I could retake it but I will use this one. It looks good.
If it's something like a pay stub, you could add more pages here before you put it into one PDF. I am doing. I only have one driver's license.
You can see here the history of what I uploaded. Now I will submit the document and there's a confirmation. It takes 7-10 days. This will show up on the caseworker's dashboard now.
Let me go down to the application status. You can see on the bottom, here, this individual applied for food stamps; that application is in process. The last function to show is a little clock-looking-thing the circle in the upper right-hand corner. Just to click on that it shows you a history of everything that you submitted.
That's it. That's what we built in release 1. We will be adding more functions in release 2, which go live in August.
>> **FRED:** I have a quick question for you: How do you continue to make sure that -- let me try that again.
How do you continue to make sure that you are meeting the needs of the people who don't have literacy or access to the mobile app? How are you keeping up with their needs?
>> **Patricia:** All of the other tools are still in place. You can still submit a paper application. You can call customer service center, the CAO, community partners. This is just an additional tool for our clients. Does that answer your question, sir?
>> **FRED:** Yes.
>> **Patricia:** Great question. Thank you.
>> **JOAN:** Do we have any questions from dmt members from the phone? Okay. Great.
>> Zachary Lewis, I have a question. When you were talking about the process as far as when someone is in the process of getting food stamps or any services, even with -- when it comes to, you know, getting approval from the state, et cetera, is there a timeline or bar graph that you would show you are at this point -- maybe where 80% complete whether we will give you a decision -- to help you get benefits, to help you do it -- any services the state needs to approve.

>> **Patricia:** What is we have in the mobile app is status of any application you have submitted. It does tell you if it's in process, if it's denied, if it's approved; that's the limited Finksality. It's one of the number-1 question that our customer service gets and CAO offices.
Now you can log in and check for yourself.
>> **ZACH:** The reason I asked, of course, we know it's in Spanish, at what point will you be able to help us with that part or if we had a request to give us a call to find out exactly where we are. Status is great but we wait -- as a consumer we wait endlessly. It's either yay or nay with a letter.
>> **Patricia:** At this point the only functionality is if I submit a application in process, approved or denied. You can still call the customer service center, CAO to get a more exact detail, I think is what you are asking.
>> **PAM:** Zach, this is Pam. I think there are time frames that people don't know about that the county assistance office has 45 days when somebody is applying for medical assistance or waiver, if there was a ticker. You have a clock but if there was something that could say, you applied on this date you should expect a response by this date or, you know, we requested this information from you on this date we need it by this date; something like that.
>> **Patricia:** They are functions we look willed at for release 2 we are calling them text message or push notification for an appointment, a reminder for renewal to be more interactive with clients. It's something we need to look at how much money we have to spend and pace ourselves. It's not included in release 2. There will be a release 3, I've leader. It's something we call the backlog of functions we like to add.
Shawn, did you have something else you qo add?
>> **SHAWN:** We are tracking what our qlients are saying through phone calls and messages on the app stores. We have heard, we want a little more information. As Patricia said, those are functions we have considered. They didn't make the first cut or second cut.
Again, balancing against everything else we have, we still have them though for future releases. As time goes on, we only had this for six weeks. As time goes on if we hear over and over we need this and this we know it will bubble up to the top.
>> **PAM:** It is really helpful for what we do going in to see consumers who voant don't have access.
The rights issue, making sure they know how long they have a right to be heard by this time that's another angle to take. People don't know their rights. This app is great. It's a great opportunity to have that.
>> **SHAWN:** Thank you.
>> **JOAN:** Brenda, did you have a question?
>> **PAT:** She is muted and I can't find her phone number.
She wants to know if it has voice capabilities for the app.
>> **Patricia:** I know we built the app to meet disability standards. We had to go through that whole exercise. I am not sure. I will check on that; that's a very good question.
>> **FRED:** That would be a great thing to do for people who are not articulate or cannot type.
>> **Patricia:** We tried to meet all of the standards we needed to meet. It may be included. I will find out -- is it VOIP?
>> **FRED:** Yeah.
>> **Patricia:** Thank you.
>> **JOAN:** Barbara, did you have a question?
>> Dash Barb.
>> **BARB:** Yes.

Am I understanding correctly if I have staff in consumer's home for renewal process and they forgot to send bank statement, my coordinator could create an account on mobile app, take a picture of the bank statement and send it in; is that correct or not?
>> **Patricia:** That's correct.
>> **BRENDA:** That's wonderful.
>> **JOAN:** The question Barbara had was, if you were a consumer in need of some assistance, that your assistant could log in and create log-in for you on app help you take a picture and submit bank statement. The answer to that question is, yes.
>> **SHAWN:** I need to caution. There is a processing time. If there was ever an emergency situation, it doesn't get it faster to them. It beats mail time but there is still processing. We don't want to give false impressions if you send the picture over the phone that it's taken care of within seconds. It's not instantaneous.
Overall it is quicker than mailing it.
>> **BARB:** It's just great to know that they wouldn't have to make arrangements for transportation to get to the office where this way it could be handled in their home.
>> **Patricia:** We heard from the clients if you build the app we won't come to the CAO. We loved hearing that.
[LAUGHTER]
Any other questions?
[NO RESPONSE]
Thank you for give us the opportunity to share the app.
>> **FRED:** We have time for people in the audience to make any comments or questions for a change.
>> Hi. Is it my name is Lester Bennett with supports coordination.
Let me make sure I got this right. I have been trying to use myCOMPASS. Number one I can't do application with myCOMPASS. Correct?
>> **Patricia:** We didn't do that. It is too long and difficult. You can do it on the desktop sit site.
>> **Lewis:** I got that part.
My thought process is, okay, I can check it. Right? But can other providers or let's say my supports coordinator can check that. Will they be able to check it basically? I put in an application me as a consumer, but I don't create it in myCOMPASS.
Can provider create myCOMPASS and say, I have all of these people that are applying for medical assistance, I need to be able to know where they are in the process? Can priors be able to do that?
>> **Patricia:** This was built for the client. We do want to broaden it to help partners. At this point the head of household has access to the data.
>> **Lewis:** Are you telling me that you are looking on the back burner to allow providers to have access?
>> **Patricia:** It's not on the back-log list but we have had the request to make app functional for them as well.
Infancy, baby steps first. It is part of our vision statement and goal to broaden this to help our community partners as well.
>> **Lewis:** I am kind of worried it will happen. I've seen it and actually done it. Consumers are et gooding letters. They are saying, you have to apply. They don't apply they run up to my office and go through the application process.

Whereas, though, I can basically, during my monitoring, can say, I know so-and-so is up. Let's see where they are at in the process without calling them. I could go on myCOMPASS to see where they are in the process and call them and say, you need to do A, B, C to continue to get as much ass in your home.
>> **Patricia:** Great feedback. I will make a note we need to go back to our community partners to ask for that function.
>> **Lewis:** Thank you.
>> **FRED:** Jeff? >> **JEFF:** It's actually not on this. It was a question for OLTL. There are two issues I have gotten calls on or had personal discussions on lately. One was about resources for folks, somebody under 60 contacted the SILC office, they are having trouble maintaining their property. They mentioned about finding direct care staff their attendant., of course, it's not within the attendant's job description. They are 55 with a physical disability. They contacted the CILs, they contacted UCP, they are from this area. I don't want to give clues out as to who it is.
There are other folks I would imagine with this issue.
Do you have any help where they can go, especially under 60. We ask them to go to their church or synagogue to get volunteer help. Are there resources you could suggest on that ?t.
>> **JEN:** I don't understand the question. You say people come into the SILC office and ask for resources?
>> **JEFF:** Basically, if somebody -- they are in their R50s with a physical disability, they have trouble maintaining their property. They need help attendant cannot do T. it's not within their job description.
>> Not part of service description.
>> **JEFF:** Are there resources you can suggest to folks when we get those types of calls?
>> **JEN:** I always suggest you call service organizations like your rotaries or VFW. I think faith-based organizations are a good resource. Centers for Independent Living, also.
>> **JEFF:** They did the latter.
The second question is something I have been hearing more and more about is the issue of hoarding. It becomes an issue folks try to stay in their home and it becomes overwhelming for people. Not just from the work I do but on a personal level and have talked to people staying in their homes they mentioned it with relatives. It's to the point it's not safe for them to stay in their homes. They are doing what they can. I don't know. I am just wondering if you have suggestions.
>> **JEN:** I am sometiming up here because one of my new year's resolutions was to get rid of the clutter in my attic. We cleaned out half of our attic this morning I wake willed through the porch all of the stuff we are throwing away there was a little aisle I thought, if people see this they will think I am a hoarder. It's going to the dump!
I would say in Community HealthChoices we will have the ability, MCOs will have the ability to support pest irradication and those types of hoarding behaviors.
When it becomes medically necessary, there is no doubt about it. Under Community HealthChoices we will have much more flexibility on what the MCOs will have providers do.
>> **JEFF:** Maybe something a value-added benefit something like that.
>> **PAM:** I just wanted to ask, so there is no seasonal -- the definition, no seasonal hours aids to be able to help with mowing or shoveling like they used to?
>> **JEN:** No. No.
Any other questions or comments?
>> **Lewis:** Yes. I am so nervous right now about these income block grants coming.

I understand that we have had the Governor's association write letters to Congress about, you know, this repealing of Obamacare.
I am just really nervous of what am happen. I have read -- we talked about it here and just talked about it again. I am just real nervous.
Is there any repercussions to our state forting medical -- for expanding medical -- for Medicaid expansion? Is there any -- if there is this appeal, repeal of this Obamacare -- my understanding was there was some portion of medical -- if you accept it Obamacare the states would get some extra money for expanding Medicaid. If there is an appeal, what is going to happen to that money?
>>: Jenn: I don't know.
>> **Lewis:** What are you suggesting we do as individuals who have seen a benefit of this expansion and how it's providing individuals a chance to live in the community?
The money is not going to waste. What are your suggesting we do as individuals who see this is a good thing?
>> **JEN:** Advocate with your elected officials.
>> **Lewis:** You know I am on that.
>> **JEN:** That's all I can say. We have over 600 #,000 people benefiting from Medicaid expansion in this state. They are at risk. The conversation has started in Washington today big-time!
>> **Lewis:** I know.
>> **JEN:** I don't think it's a bad thing for elected officials to hear from you, here in the state as well as our Congressional representatives.
>> **Lewis:** Got you. Thank you.
>> **FRED:** Any other questions or comments?
>> **Tanya:** Jenn, you are it. It's not a bad thing for your elected officials to hear from you, but I am going to say this from personal experience, there's got to be a technique that you use in order to get them to really is to hear you. A lot of times it is done with just an over-the-phone call to them. They get so many of them. They are less likely to listen to them.
I really advocate writing to them whenever you can and, actually, going down to their offices and asking for meetings.
Now, that does take a while longer to do but once you do it and if you stay consistent enough in doing it, they it will -- maybe if you are lucky and bend the right person's ear, they may listen just a little bit.
I am telling you, phone calls won't get it done.
>> **JEN:** And if you are interested in learning how to do advocacy effectively, please talk to Tanya.
[LAUGHTER]
Thank you, tan dwra.
>> **Tanya:** You are welcome.
>> **FRED:** Any other questions?
[NO RESPONSE]
Excellent. Meeting adjourned.
>> Thanks, everybody.
(Meeting adjourned at 12:57 p.m.)