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Date: 3/9/2021

Event: Managed Long-Term Services and Supports Meeting

StreamBox

>> Test test test test test test test test.
>> This is a sound check.
>> Test test test.
>> Test test test.
>> Hello, everyone. Welcome to the managed subcommittee meeting. I will start the meeting with taking member attendance.
Alley, are you on the call?
>> Here, good morning.
Cindy?
>> Yes, I'm here.
>> And new Brady.
>> Yes, good morning. I am here.
>> Thank you. David Johnson?
>> Hi, good morning.
>> Thank you. And good morning. Denise?
Denise curry?
>> I don't see Denise.
>> Gail Weidman?
>> Good morning.
>> Good morning, Gail.
>> Herrmann?
>> I don't see Herrmann, either.
>> Hashy has been excused from our meeting today, just fyi. Juanita gray?
>> I don't see Juanita.
>> Lloyd?
>> Present and accounted for.
>> Hello. Good morning.
>> Matthew Sele?
>> Hi, this is Jeff Iseman, he asked me to sit in for him today. He is not able to make it.
>> All right. Thank you and welcome. Mark? Mark Gussic?
>> And I don't see mark.
>> Mike Grier?
>> Good morning.
>> Good morning.

>> And Monica Vaccaro?
>> Yes, I'm here.
>> Richard wellens ?
>> I'm here, good morning.
>> Thank you, good morning.
>> Sarah?
>> Hold on one second, Luba. We have to switch her over.
Sarah, I think you should be unmuted.
Sarah, are you there?
Sarah, you're showing that you're unmuted. I don't know if you have your volume turned down on your computer.
Okay, Sarah is here.
>> Okay.
>> We will just move on with membership. Sister Katherine Higgins?
>> I do not see sister Katherine.
>> Okay and next is Steve gamble. He has been excused from today's meeting. Tanya? Tanya Teglo.
>> And I don't see Tanya.
>> All righty. And William bucks.
William?
>> I don't see William.
>> I don't think I missed anyone on the list.
>> I hi rich, Shelly Welsh, for Rich.
>> Yes, I'm here.
>> All right, thank you.
Good. We will move along to housekeeping talking points.
The committee rules. Please keep your language professional.
Point of order, this meeting is being conducted as a webinar with remote streaming. All webinar participants except for committee members and presenters will be in listen-only mode during the webinar. Welcome any members and presenters will be able to speak during the webinar. We ask that you use the mute button or feature on your phone when not speaking. This will help to minimize background noise and improv the sound quality of the webinar.
We ask participants to please submit your questions and comments into the chat box located in the go-to webinar pop-up window on the right side of your computer screen. To enter a question or comment, type into the text box under questions and press send. Please hold all questions and comments until the end of each presentation as your question may be answered during the presentation. Please keep your questions and comments concise, clear and to the point.
On the meeting minutes, transcripts and meeting documents are posted on the list serve under MLTSS meeting minutes. These documents are normally posted within a few days of receiving the transcript. In regard to captioning and audio reporting, the captionist has documented the discussion remotely so it is very important for people to state their name or include their name in the chat box and speak slowly and clearly. Otherwise the captionist may not be able to

capture the conversation.
This meeting is also audio recorded. The meeting is scheduled until 1:00 p.m. And to comply with logistical agreements, we will end promptly at that time. If you have questions or comments that weren't heard, please send your comments or questions in. For your reference the account is also listed on the agenda. Public comments will be taken at end of each presentation instead of during the presentation. There will be an additional period at the end of the meeting for any additional public comments to be entered into the chat box. The 2021MLTSS subcommittee meeting dates are available on department of human services website. Thank you.
Next, we will have OLTL updates from Jamie.
>> Good morning, everybody. There are some challenges getting myself off mute. You would think after year now I would have that one down. So I hope everybody is enjoying this beautiful March 9 morning, least outside my window it is sunny, it hopes to be warm today and it seems like we are turning the corner on winter, which is always uplifting. I hope it is uplifting for the audience members as well. So today I will give anup date when some COVID-19 work that the office of doing, and the department and when we have time we will have monitoring report updates for this group. So moving along to our co-side 19 updates, this is a COVID-19 update. I was just looking, next slide, sorry. So this one actually pertains to this subcommittee. So we got a request from stakeholders and this is obviously really important. The managed long-term services support subcommittee meetings scheduled for Thursday April 9 will be a listening session focused on the experience of participants during COVID-19 public health emergency. So we got a request from some of the members and other stake holders that they really wanted to share their experiences or what it was like for our C hmpleghts C participants and waiver participants during public health emergency and what they experienced. And it doesn't have to pertain to a certain I want to say one aspect of what they experienced. We are just looking for comments and overall what their experiences were.
The feedback this we got is obviously this type of meeting that we are having webinars, sometimes it is really hard for participants to participate and share their experiences. It is very hard to type their questions into the chat. So we wanted to give the opportunity for them to share their experiences in a more open format. So if a participant wants to share their experiences, we are asking them o register so we know to turn it over to them at a certain part of the meeting next month and we provide the link there as well. I think that we have also sent this out to the MLTSS list serve and couple of other list serves so please, if you know of a participant who would like to speak during the meeting, encourage them to register so they are able to do so.
So I wanted to make that announcement first thing.
So the next slide is really giving an update on our different items that we have, an issue we are working on, as a department and as office of long-term living. First and foremost, obviously, is our vaccination strategy. I think this is first and foremost on everyone's mind especially if you are trying to schedule a vaccine. So we are going to be setting up home and community-based clinics for home and community-based population in the community health services.
In community health and in community health -- you can tell this is my Monday, definitely. For home and community-based population in the CHC program and our life program. So we have

set up clinics in March. We will be conducting outreach to participants who have been prioritized for a vaccine. We have the opportunity through these clinics to vaccinate about 10,000 participants, which is great. Obviously we know we have many more participants that we would like to prioritize to get a vaccine but we were able to, working with Rite-Aid and partnering with Rite-Aid, we are able to make 10,000 appointments available to get our populations vaccinated. Just so everyone understands, we will not be releasing the place that these vaccine clinics will be held at or obviously the dates. We really want these vaccine opportunities to be for our most at-risk home and community based participants. And Rite-Aid has let us know that if others show up at these vaccination clinics that they will vaccinate anybody who show is up, meaning the general public. So that obviously would take spots away for most at-risk home and community-based participants. Service coordinators will be reaching out to the CHC participants and life programs will be reaching out to their participants in order it schedule them for these opportunities. Please Don encourage people to call their CHC or life program about an appointment. Like I said, we are prioritizing and vaccinating our most at-risk populations and so I just wanted everybody to have that information and to know that work was going on.

We also is obviously prioritized in priority 1A group home and community based services direct care workers. We sent out information on our list serve. I think I might have shared this at the last meeting. That not only did we let our agency based home and community based services staff, we let them know they were in the priority 1a group and they should get vaccinated if they are able to get an appointment. We also did in the participant directed model and so we gave, I want to say, ppl a letter for direct care workers and participant directed model to download as proof. Obviously they wouldn't have badges to show that they were health care workers so they would need these letters to show that they were health care workers and to be vaccinated as part of that priority 1a group.

We also recognize family caregivers for older adults and others that receive services under department programs and more specifically our CHC program and our life programs. Or our overwaiver programs and act 150 programs. If they have family unpaid caregivers they are part of the 1a priority group and they go to the DHS website to attest they are an unpaid care giver and download a letter that they can use as proof if they need an appointment and are making an appointment and are asked for proof that they are in that priority 1a group.

If anyone knows that a family care giver was trying to use that letter and experience difficulty, you can let the office of long-term living know. We will be working with the Department of Health, outreach to that vaccinator and let them educate them that it is an unpaid care giver and they are part of that priority 1a group and they should be vaccinated and given an appointment. Obviously if an appointment is available.

So we have been spending a lot of time on vaccines, just for this group. It is not on this vaccine strategy list here but we have also been working on getting our populations that are in personal care homes and assisted living residences that are licensed under the office of long-term living vaccinated. Many were part of the federal pharmacy partnership program and so those facilities were able to be vaccinated through h program. We also did partner with Rite-Aid. Another opportunity to partner with Rite-Aid to get those facilities that weren't part of federal pharmacy partnership program vaccinated through Rite-Aid. Rite-Aid on-site at those facilities and able to

vaccinate both residents and staff that were willing to get vaccinated.
We know there are a very small handful of facilities in the office of long-term living and assisted living residents who were able to get vaccinated through the two opportunities. Though we are continuing to work on an opportunity with another vaccinator to get those remaining facilities, residents and staff vaccinated. We are continuing to work on getting vaccine for that priority 1a group population as well.
So I will pause there. I'm not sure if anybody has any questions regarding regarding vaccination. I think the overwhelming struggle for the state of Pennsylvania and a lot of states is obviously supply. We are very interested in getting additional supply for everybody that is in that priority 1a group in order to get people and keep them as safe as possible from COVID.
>> Jamie, if no committee members have questions, I do have some from the audience and I have a few comments and questioned related to the listening session first.
>> Oh, sure. Absolutely.
>> So Brenda is there, and this is more after request, would like to see the registration deadline extended by a week to let folks know about it and have time to register.
And then, Jamie had several question. First question is, is it open to family participants as well?
>> So I will answer the first question. I think we can extend the registration deadline by a week and we will let those know who are controlling that registration deadline. That is agreeable to me. The other question, Amy, you asked if family members can participate as well.
I believe that they can, yes. Obviously hearing from participants is our priority but obviously we recognize and want it hear from those family caregivers as well.
>> Okay, great. And then, how long will each participant be given to share their experiences?
>> So obviously we have the length of the MLTSS meeting, so we would have to look at how many participant that we have register and determine how long we can give each participant to share their experiences.
I'm not quite sure yet, I haven't seen the registration list.
>> Okay.
>> And then, will they be able to call in?
>> Yes.
>> Is it the normal?
>> I assume.
>> Okay.
>> And then, she was just saying thank you for opening it for participants. So that is all of the, we just double-check here and make sure no one else -- okay. So then, I think the next questions are related to the vaccine if committee members have questions.
The first question, are there any statistics on the effect of the vaccine or people with disabilities and so where can we find it?
>> So I don't have any of that information on the affects of the vaccine on people with disabilities. I'm not sure if people from health has information on air that website or the CDC does. Or the vaccine manufacturers if they have conducted any studies and they would have any of that information available on their website.
I have not heard they have done specific studies on people with disabilities. So I can't really speak to that.

>> The next question is from many -- was someone to ask something --
>> Sorry to interrupt. This is rich Rollins. We called our PCP and endocrinologist.
So that would be that point if anyone has any concerns. I looked and did not see any long-term --
[Inaudible]
>> Okay. Thank you, Rich.
So then Pam was asking, what is the plan for people that physically cannot meet their plan, are in their bed a majority of the time. Will they go to the clinic or will nurses come to them?
>> Great question, Pam. Thank you for asking.
So for the community health choices and life clinics that we're holding, transportation is going to be arranged if needed obviously by the CHCMCO or life program.
And you know, I understand that in some cases people can be transported via ambulance if that's necessary and needed to attend a vk seen clinic. The Rite-Aid pharmacists that are actually doing the vaccinating are very flexible. If someone shows up at the clinic and cannot leave their vehicle, they will make accommodations and go out to a vehicle to vaccinate a person. Obviously that's one option. We recognize though that not everybody is going to be able to leave their house.
So we don't have a definite strategy yet. One of the founding factors on that is vaccine supply. We are looking at couple of options. One is that obviously providing vaccine to the person's PCP we know some of those PCPs for obviously a truly home bound population do house calls. So ideally that PCP office could obviously vaccinate their population. Another option is allocating vaccine supply to home health agencies that have nurses that could provide vaccination and go into people's homes and provide vaccination. Obviously we need additional supply to be able to do that. The other discussions we have been having is with some of our pharmacy partners on, you know, if they had capacity, could they make house calls and go to people's homes and give vaccine. Like I said, one of the factors there is vaccine supply and so we needed to show supply to be able to do either of those strategies. It is definitely something we are working on, though.
>> And then, what percentage of TCH and staff has been vaccinated and what percentage of residents.
>> I don't have the specific percentages. I can look into see. I know we have sent a survey out to all personal care homes and assisted personal care residences. They are reporting that information back to the department. So I don't think that we have really good data yet. Hopefully we will have that soon.
What we are hearing anecdotally is the vaccination rate for actual residents is pretty high. Many residents are being vaccinated. Staff on the other hand is not as high as residents and so I think, you know, anecdotally we have heard that it is about 50%, which I'm wishing that this would be higher. I think as time goes on, the vaccination percentages are climbing as more people realize and see their friends or coworkers are vaccinated or the residents are vaccinated. They are more willing to be vaccinated.
But we don't have the exact percentages yet to share. Only anecdotal from what I'm hearing.
>> Okay.
>> And then there was a question, Jamie, about knowing where the clinics are located and clinics in rule areas living on the community health choices website. The VHS website.

>> Sorry, I was on mute. So we will not be listing where these clinics are being held. Like I said, these clinics are not open to the general public. We want to ensure that our home and community based populations are being vaccinated. Those that are most at risk. So we are not publicizing the locations for these clinics. It is going to be obviously by a service coordinator reaching out. If we put them on the website, I'm afraid that people would, members of the general public and maybe they would be in the priority 1a group would show up but you know, like I said, Rite-Aid would vaccinate them. Not in the position to turn anyone away. And we really want to make sure that our most at-risk populations are vaccinated through clinics.
So I'm not going to disclose any information about where they are. I will tell you afterwards, though. I'm happy to provide that information.
>> So just be careful, you may have people showing up at your house trying to get that information.
Just kidding.
>> I hope everybody understands. So Rite-Aid shared with us that in New Jersey they attempted the same strategy and they did publicize the eks whos where these clinics were going to be held. And they were descended upon in mass. So the people with the appointments didn't get vaccinated. It was first come first serve so they vaccinated members of the public that showed up. They didn't even prioritize who they were vaccinating. They just didn't have any ability to weed out who was who. So the people that were probably targeted for that clinic never got vaccinated. That would be a shame in these cases.
>> So just to summarize what you are saying, participants, service coordinator should work with them to schedule the visit and also to make arrangements for transportation if necessary.
>> Absolutely.
Yes, Pat.
>> Okay, great.
>> So there was a comment I would just pass along from warren that the Lehigh Valley area, she hears this meals on wheels will be giving vaccines at home. There hasn't been any discussion or consideration of that type of arrangement statewide.
>> So what was that? Meals on wheels?
>> Meals on wheels, yes. Home delivery meal entity.
>> So we haven't had conversation with meals on wheels providers. I want aware that meals on wheels providers could be vaccinators. Meaning they were employing nurses or pharmacists or physicians or people that were able to give the vaccination.
It is an interesting idea but you need to have someone authorized to give vaccination and trained to do it.
I just wasn'tware that meals on wheels providers could do that service. Interesting.
>> I have a question. Is there any special consideration given through the NCOs provide for additional counsel for folks with mental health issues. Including deep depression. To encourage participants to accept the vaccine?
>> Yeah, so that's a really good question, Lloyd. I'm hoping that MCOs can talk more about that as their service coordinators reach out it participants an what types of education they are doing with participants in order to encourage some or educate them about getting vaccinated.
>> Thank you.

>> Leicester Bennett add qui on how are they told about the clinic and maybe it is something that we can be do you want to speak to or hold that for when MCOs do their portion of how to contact their MCO and service coordinator.
>> Yeah, so that might be a good question for them. I know is probably not service coordinator estate wide. We have a limited amount of clinics taking place and so if a service entity doesn't have a clinic close to them, it is likely that they are not being asked by the CHCMCO to reach out and to start scheduling people for a clinic. We only have 10,000 opportunities and so we are targeting certain areas. So it is not available statewide.
>> Okay.
>> And is there, do you know, or can you share, is there access in rural areas?
>> There may be.
I was being cagey a little bit, not talking about the location of the clinics. I'm not sure how far out from the clinic location that the CHC, MCO, or life program would be looking to, I want to say, transport population.
But there may be opportunities for rural as well as urban and suburban vaccinations.
>> Okay.
>> And also, working with transportation authorities to provide vaccine appointments to talk about doing that in other areas.
We saw a flyer and I can't remember who the transportation provide are was but they were offering free trips for any person that needed a ride to get a vaccine.
So that was excellent news. It wasn't just reserved for one type of person but anybody who needed transportation to get a vaccine.
>> Jamie, this is Mike Grier speaking. Are you guys considering working with PAS providers to possibly get vaccines in rural communities?
>> So that might be an opportunity, my only caution on the PAS providers is, like I talked about with meals on wheels, you have to have the right persons giving the vaccine. Meaning someone approved by the department of state to give a vaccine. So pharmacist, nurse, physician's assistant, I don't know the complete list, but you have to make sure that you have an approved vaccinator going out and giving the vaccine.
>> Yeah. We understand that. We do know that they employ nurses at some point.
>> Thank you.
>> Yeah.
>> I think that's primarily why we were looking at home health providers knowing they have nurses on staff that would be able to give vaccine.
>> Bennett was asking about service coordinators, consumers and nonTHC waivers.
>> Yeah. So not as of yet. We hope to be able to include them at some point when we have more vaccine available and can set up clinics for those populations as well.
>> Okay, thank you. And Pam hour asking, is there a second round for consumers not chosen to get their vaccine in the go-around.
>> Pam, we are hopeful. It all depends on vaccine supply and hopefully these clinics go well and they can allocate vaccine to vaccinate our locations. I'm hopeful, just not definite yet.
>> And the last question I have is from Debbie Robinson and you may not be able to answer this. What areas are being targeted? I know you said, areas.

>> Yeah. So I'm going to respectfully decline to answer this question.
And I'm happy to release that information after the clinics and hopefully by that time, as I spoke to a little bit earlier, to Pam's question, we will have the opportunity for additional clinics.
>> Okay.
>> Thanks, Jamie.
>> Yeah.
So I'm not sure how I'm doing on time here.
Oh, I'm got 3 minutes left. So I will speed through other updates. I really obviously want to make sure we have enough time to get to our MRC report and evaluation of CHC. I know everyone will be interested in that. And our cap survey results, we want to provide enough time for our staff to provide those results to this committee. Just a couple of updates. So our 1915 waiver appendix k extension. CMS provided guidance to state, I want to say very late in 20, very early 2021, that we could apply for an extension for our appendix K waiver flexibility to be good for six months after the end of the federal public health emergency time period. So we did submit an application to allow our appendix K waiver flexibilities to be good for six months after the end of the federal public health emergency. Many may know that our appendix K was due to expire March 5, 2021. It was only good for a year.
But the states were provide he the opportunity to apply and be grapted the extensions. We are still waiting for formal CMS approval on that extension. However, CMS assured us that extensions will be provided that we should continue to apply and allow those appendix K waiver flexibilities. We did send out information to providers and participants on our list serve on Friday about that. And that those waiver flexibilities did not end on Friday. They will continue. We expect to receive CMS approval and it will be back dated until March 5 to allow seamless waiver flexibility. So just giving everybody an update on that.
The other update is that regional care assistance teams, the RCATs, they have been extended through may 31, 2021. Originally the RCATs we found some limited state funding and they were approved to provide outbreak assistance to nursing facilities, personal care homes and assisted living residents as well as other care facilities. Just January and February of 2021, we recognize that some facilities continue to have outbreaks and we will extend those RCATs through may 31, 2021. Just to ensure that those facilities have as much support as they need if they do experience an outbreak situation.
The other update and it is not on my slide and I apologize is that this is an update for direct care workers in the participants directed model. PPL, who is the financial management service agency applied and was granted funding through federal cares act relief funds.
It was an award made available through HHS. Health care providers had to apply and then they were granted funds directly from the Federal Government for COVID relief and PPL was granted an award, I'm not exactly sure what the award was. Now I'm blanking on the amount.
But they applied across multiple states and provide financial management services for multiple states. So for those direct care workers in the participant directed model, PPL is making available awards for direct care workers for PPE reimbursement. The direct care workers needs to apply to PPL to receive funds from this award.
The direct care workers have to apply soon or PPL will have to return any unused money back to the Federal Government. So I just want to make a distinct, with the act 24 funds we received,

especially for participant direct care workers, that money flowed out right through PPL. People received checks. There was nothing that the worker had to do to receive funds. This situation is different. The worker has to submit information to PPL in order to receive an award or I believe they are going out through gift cards. So please, if you are a participant directed direct care worker check the PPL website. You could be eligible for a funding award. There may be an application to submit.
But if you do so and you worked during the public health emergency time period, you are eligible for an award. Please check out that opportunity.
So the only other update I want to provide is on the act 24 cost reporting. For providers receiving act 24 funds, act 24 was passed at the end of May 2020. Funds went out early July 2020. I want to say. And they continued going out. Direct care workers receiving in participant directed model receiving their funding a little later.
But now it is time to file reports on how providers used those act 24 funds. You had to use the funds on COVID related expenses and the office of long-term living as well as department provided information to providers who receive funds on those approved expenditures. We have also done a lot of messaging for providers who received funds about how they had to submit to reports in order to let us know how they have used those funds. So on March 4, an e-mail sent to OLTL providers who had not yet submitted act 24 cost reports. Please note that failure to submit the necessary information through the web-based reporting tool by March 22 may result in DHS recouping funds. This is not really what we want to do. We want providers to have used those funds. We know they had COVID related expenses and we don't want to recoup the funds but if you don't tell us how you use those funds for COVID-related expenses, we may have to recoup them. So please, please, please, if you haven't already, and if you have received act 24 funds, submit a report on the web-based portal per instructions we are sending out.
And let us know how you have used those funds.
And can you see there, obviously there's where you can submit the report at the first web link and if you have any questions, please use that act 24 reporting at pa.gov to submit any questions that you have.
>> So finally, I think, and the last slide and then the other, the monitoring or report information I will let committee members and look at the ledger and feel free to forward me any questions that have you on it. And just know that persevere pa is a COVID-19 crisis counseling program. It is available to all Pennsylvanians. And if you or someone you know is feeling stressed, overwhelmed, alone, afraid, please feel free to reach out and use this number for any support or resources that this line can link you up to in order to receive the help that you need. So we are publicizing it as well as others just to know, just so people know there is somewhere they can call if they need help. A COVID-19 crisis counseling program.
And for you and the committee, I won't go through the next couple of slides due to time, but if you click through them, we have shared this information at the consumer subcommittee at the MAC. We will make this available to this committee and send it out on the list serve. As we pledge to do, we continue to share the number of person centered service plan changes that were made as a result of lifting the moratorium that we had on making any changes during the COVID public health emergency time period. We lifted the moratorium in late June and then obviously the phase 3 participants, their continuity of care period ended July 1. So CHCMCOs

had a lot of assessments and reassessments to be conducted. We continue to share information on the number of assessments and reassessments that resulted in a reduction in services.
So please look at this information at your leisure. Let us know if you have questions or concerns. We're happy to take those questions and concerns and answer them.
Like I said, I want to reserve time for those on the agenda from the office of long-term living and obviously CHCMCOs.
>> Thanks, Jamie.
And there are several questions about information regarding direct care worker PPL. I put the link in the chat box and sent it out to everyone. That takes you to the information on the website. That has information about how to apply and timing.
>> Thank you so much, Pat.
>> Yes.
>> And Linda has now joined us.
>> Thank you.
>> Yes, I'm here. I've been on for quite a while now, just on mute. So hello, everybody.
So now questions ?
Now we will move on to Dr. Harold Degenhohtz. I hope I pronounced that properly.
>> Hi, this is Dr. Howard Degenhohtz. Hold on. This is showing the wrong screen. Okay, great. My pleasure to be here this morning.
I'm going to present jointly with John Yauch from our Medicaid research center. I will turn it over it John when we get to his part of the present taition. So as people on the committee and regular attendees where we have presented in the past, progress on our long time method of the CHC program. This is an evaluation that got started, oh, boy, in the planning process back in 2016 and some preliminary work and baseline interviews in 2017. We have been conducting this evaluation and reporting back to this committee about once a year since then. I'm going to share with you findings from multiple parts of our study today.
But the committee should know and audience should know that we report on a regular basis with OLTL. We share data with OLTL leadership and THS and they have been relying on data and findings over the past few years as they have continued to manage and improv the program.
Quick highlight of some of the findings that I will be sharing today. In terms of findings related to participant experience, we have some data on the enrollment experience, on participants self reports of activities and subjective well-being. And some recent findings from the 2020 rollout in what we call phase 3 implementation. We have data from interviews with providers. That's wh John is going to share. And then we will provide some findings from our analysis of administrative data from Medicaid program and then the last will be some recent data on the impact of COVID-19 participants and providers. People are probably familiar with this slide, which shows different methodologies that we use and I have annotated it with information about which data will be presenting today. It is a bit nitty-gritty to get into and I will highlight it as we get into each section of the presentation.
But it is available on the slide deck. So you can look at it later for your reference.
Turning to the first chunk of information I'm going to report on telephone interviews with CHC program participants conducted from 2017 to 2020.
Now, our approach is to interview program participants and selecting program participants. This

is primarily covering all three phases. We interviewed people in the earliest part of the implementation in each region of the state.
So basically before the community health choices program was fully active either in late December before the actual program rollout in phase 1, phase 2 and phase 3, those early interviews continued into January and March and capture people's experience, basically before any service plan changes or changes can be put into effect during continuity of care period. So what I'm going to share with you now is some information about the enrollment process and I'm going to share enrollment from all three phases, southwest, southeast and the northwest northeast. I will refer to that as central part of the state.
The chart on left showes a basic question of did you receive information about community health choices? And you can see the blue bar, that is the S. And then you can see improvement. So phase 1, 58% of people reported receiving information. Phase 2, up to 67% and phase 3, 72%. That shows improvement over time with information receiving as part of the enrollment process. The chart on the right asks people how satisfied were you with the information. And generally speaking, that was about, you know, above 70% to 75%. And fairly consistent between the 3 different implementation rounds.
We ask people, so now here is one of the questions. This is limited to the phase 1 implementation and southwest and here we are focused on one particular outcome of interest. Which is for people who are HCBS and nonHCBS users. We wanted to know an important quality of life to the extent of which people are preferred to do their activities. Social engagement and social activities is are a big part of the service plans and that was a critical outcome that we were monitoring as part of the evaluation. So what I want to show you is data from people who are part of the southwest, implementation from the southwest, and sorry, I think there is an error on the date. We interviewed them before any changes from service plans went into place. As we call baselines. Actually January of 2018, into March of 2018. And then we follow them up again about 18 months later, which is July of 2019. Those interviews extended through October. So that was approximately one full year after any changes to service plans could have been implemented by the MCLs. We ask people about four different categories of activities. Did you have a chance to visit with friends and family in the last two weeks. Did you attend religious services? Participated in clubs, classes or other organized activityes.
Have you gone out for entertainment. And this is very important. Not everything is relevant to everybody. So we weighted these activities on how important people considered them. This is arbitrary here but it makes the point that we put more value on activities that people report as being important. As you can see, in the HCBS group from baseline follow-up period, he see modest improvements in which the rate people are getting into their activities. This is also what is referred to as NFI group, people without LTSS. There is slight improvement. Though not significant.
The next set of findings are around participant health status, psychological well-being and depression. This is limited to people in the southwest, that same time period from before full implementation to 18 months after the implementation. Here we are reporting on a general health status question. Psychological well-being, higher scores are better. And depressive symptoms using PHQ-9 where higher scores indicate high are symptoms. For that measure, that is a clinically validated measure, we are looking at percentage of people with probable

depression on a clinical screen. So if you just look at the preto post for each of the bars, health status basically unchanged, psychological well-being, this is in the HCBS group going up slightly and depressive symptoms goes down slightly. And in the nonLTSS group we see the same pattern. Slight improvement of status. Slight improvement in psychological well-being and decline in depressive symptoms or percentage of people with probable depression.
Now turning to findings with focus groups and this is from phase 3 implementation in the central part of the state. These are focus groups we conducted right before everything shut down with COVID.
We conducted 22 sessions in eight counties.
They were held in January and February of 2020. And we asked people a range of different questions, asking them about their experience with enrolling and getting into community health choices and we found patterns that were fairly similar from previous rounds of implementation. People reported that the paperwork was confusing, there were some misinformation that people experienced, public meetings, about enrollment, interestingly when we asked people how they sorted out their problems, they got help from their enrollment plan.
We also asked them about service coordination. And people said they like their new service coordinator but that they didn't know everything that is consistently previous years. And also that medical providers were not aware of community health choices and again, that is consistent over across other rounds of implementation. And again, there is confusion over interactions with Medicare and the need to choose CP and that's a problem around how the program is implemented. One report is they had no problem with medications or copays. That's also been a consistent positive finding. And some people were reported having -- I will turn to qualitative interviews with key informants. I will invite John Yauch to lead this part. John, just tell me when to turn the slides.
>> Will do. Thank you, Howard. You can hear me, right?
>> Yes.
>> Perfect.
>> Hopefully everyone else can too.
>> Thank you. My name is John Ya uch. I'm a qualitative research assistant at Pittsburgh graduate school of health working under Howard. I am responsible for most of the interviews we conduct. Most of this summary is going to be based on interviews that I have conducted from late June 2020 through December of 2020. There are going to be a few included, January 2021. First of interview projects that I'm going to discuss or is in service coordination. So we have a service coordination sub study that we are still continuing. This will continue through March. However, this is a preliminary analysis here.
But within this service coordination subcommittee we have interviewed CHC-MCOs as well as formerly conducted SCE entities. Some findings are that the MCOs are implementing a hybrid model of service coordination meaning they have some -- they employ some internal service coordinators as well as have partner SCEs or service coordination entities. And they are administrative function of the MCOs as well. And they post continuity of care, the CHC-MCOs can continue or discontinue contracting with those partner agencies. We have seen a decrease over time and number of contracted partner service coordination entities. To the point of the end of 2020Q4 there are about 35 distinct partner service coordination entities and then moving

into 2021 there are 17 distinct partner agencies. That's from my count.
Some of the themes in this service coordination sub study, we have staff turnover communication and training. Decreased fraud overall improvement. Financial impact that is both positive and negative personal assistant hours being reduced participants with intellectual disabilities, transitioning to CHC and office hours. So staff turnover, this is one thing we did notice from many of the SCEs we interviewed. They did lose staff to MCOs. One quote is that what was challenging is the significant amount of turnover of staff because of the MCO hiring at all levels. That included servicer coordinators, other administrative staff as well. Communication and training we saw some positive feedback as well as some challenges. And one of the SCEs interviewed said they have dealt with, everybody we have dealt with as han very knowledgeable. Very easy to communicate with, very helpful. So I have seen that as a positive experience. However we did also give feedback on it, the challenge of learning three documentations systems for the three MCOs. One of the SC agencies said we can't get a lot of training as far as how to use documentation systems so we didn't know what to expect for documentation. We knew would different for all three and we knew it would be a challenge. One thing that was pretty consistent over these last several interviews with SC agencies was that MCOs did address concerns about some unethical service coordination entities. One of them interviews said we did see MCOs quickly identify an address some of the more unethical supports coordination agencies. On a positive note over all, it seems that issues that occurred in the beginning of CHC, so if you think back January of 2018 that launched in the southwest, and but over time, there have been some topic areas, issues, challenging that have improved. One of those main ones is billing. Another is a successful transition to CHC. So a couple of quotes here. We have one of them said it is fully implemented across the state. Referring to CHC and so far a seamless transition. And another saying billing occurring since the beginning, issues have been resolved. Other entities did permanently close during CHC. Not to say it is because of CHC, but during CHC, there have been many that did close permanently. COVID-19, of course, another topic area that could relate to some of those closures as well. With regard to COVID-19, as it has changed the lives of so many people and so many organizations, many of the organizations that I have interviewed had to change the way they operate, the way they deliver services. This goes from anywhere from working remotely to screening and temperature checks for employees to personal protective equipment. One of the entities did have this to say, saying two MCOs delivered PPE for the whole office. That is a positive aspect to MCOs about providing PPE. Another concern they had that was very consistent was really from the consumer perspective and it was social isolation. From the CHC participants.
And another positive note on COVID-19 communication was the communication plan from OLTL, one of the agencies did say that the office of long-term living put together a very comprehensive plan and their willingness to listen to SC agencies and associations giving input, they were phenomenal in listening us to. Financial impact, like I said, we did hear some positive and some negative. One of the more positive remarks is that it has been a positive if that's what you are looking for. We're not losing money. Personal assistant services hours have been reduced, that does seem to be somewhat of a trend in recently many of the SC agencies we interviewed did say that there has been a shift to a decrease in hours.
>> Another interesting find is that the agencies I've talked with did mention that intellectual

disabilities waiver participants, some of them are transitioning to CHC and assessments and authorizations, this is the main point here is that they are still very lengthy. One of the agencies said their assessments and process and documentation and authorizations taking upwards of five hours per participant.
>> Okay, we also did a round of skilled nursing facilities, interviewing 21 of them, 7 in each phase. We tried to get focused on urban and rural facilities and we also looked at large, small facilities for profit, nonprofit and county-owned homes. So county-owned homes. We did get a nice mix of all of those. Topics of discussion were themes that were unkferred were financial impact. Again, we did hear some positive, some negative. They did say that as far as the rate setting, most were paid based on the floor rate and didn't have too much opportunity to negotiate that. Others, ones said that honestly, I think is better, we are getting payments quicker. Thinkty is coming in a better methods. Another said financial impact has been negative. Staffing issues, they have noticed the nursing facilities that were interviewed did notice that the workload, demand for their social services staff increased over time. And of course COVID-19 exacerbated that. Behavioral health coordination, another interesting topic. From what we could gather, most of the skilled nursing facilities have no knowledge of behavioral health care coordination. However, that does not mean it is not occurring. I think further analysis into this needs to occur.
COVID-19, of course, we have seen increased workload, increased cost, staffing issues, PPE, from the feedback that I got are many of the facilities was that PPE could even something as simple as gloves and masks were the price was increased five-fold, even ten-fold in some cases. Transportation, that's an area that I believe was really kind of resonating with the skilled nursing facilities. That message seems to be resonating. Transportation is included in their reimbursement rate. One of the facilities said, I think we have to pay, we have to absorb that in our budget. MCO communication and interaction, another one that says improved over time. One of them said we have a positive relationship with them. I think we get along with them well. Nursing home transition, this is an area where we haven't really seen much change if you compare prior to CHC to underCHC, one of them saying it was supposed to be one of the pushes but in all reality there is nowhere for the residents to go. So we haven't, based on the interviews done, we haven't seen much of a change as far as nursing home transition. Go ahead, Howard.
Adult day centers, we did interview several adult day centers. This occurred more recently in January/february of this year. Just within a couple of months. The adult day centers we interviewed had expressed that they believe adult day services are underutilized in CHC. Perhaps there is not enough education about the concept of adult day services. And they are getting pretty low volume of referrals to adult day. And one thing that they did express as well is their virtual services of course during COVID-19 many centers have closed their doors. So there is no person to person visit. Or no face-to-face visit.
But many of them are providing virtual services and they have all expressed that they would like official authorization from this CHCMCO for virtual services for their CHC participants. COVID-19 obviously extraordinarily impactful within adult day. Many centers have been closed for a year now. And have remained closed. Others have opened at various points. Many had to furlough staff. One positive that I did get, it seems like vaccinations for staff have begun and many of the

homes reported that staff have received least the first round of the vaccine.
Service coordination was another topic with adult day. They have expressed that service coordinators change frequently and there is not really a dedicated contact person for the adult day centers. And billing as well, there is some positive, some negative there. Different systems for billing can be challenging and cumbersome. However they are getting quicker payment. Some did report as well that they are still owed money for services provided.
Go ahead, Howard.
And lastly, we did interviews with home care as well. What we have noticed is that the volume of home care providers entering the market is still increasing. And that looks like that has been for a number of years now.
They have experienced staffing issues. COVID-19 exacerbated issues as well, really been magnified in the last year.
Some home care agencies are still reporting challenges with billing and authorizations and and again with COVID-19, PPE costs have risen. Just like within the nursing facility environment, in some cases, five-fold or ten-fold, as well as experiencing staff shortages too.
Okay, I think that's my last slide, Howard.
>> Thank you, John.
I appreciate your take the lead on that component of the study.
I'm going to turn now to quantitative analysis of Medicaid claims data. And I'm going to she a couple different findings here. Few different findings here based on our independent analysis of Medicaid claims that have been made available to the Medicaid research center by OLTL and Pennsylvania Medicaid.
First is overall rebalancing trend. And this is the percentage of people that are in each CBS versus nursing home among pement who are LTSS users. And I would show this trend going all the way back to 2013 on page groups from 21 to 60 plus. Consistent with the legacy aging waiver distinction. And there is a separate line for each region of the state. And so what you can see here is that over time there has been a long-term trend towards increasing HCBS participation. And in both age groups, the southeast region was always leading in terms of that percentage of HCBS. The blue line is the southwest region and gray line is the central part of the state.
So what you can see, it is a little bit difficult to see the transition to community health choices on this long-term trend. So I'm going to show you, we are going to zoom in and just look at 2017 to 2018 transition and then 2018 to 2019 transition so we can see what was going on during community health care period. We are getting very short on time, I realize. I will show you this and try to pick up the pace. So what I have done here is I've shaded the bars for the southwest transition in green. You can see that there's an increase in the percentage of people using HCBS in southwest between 2017 and 2018. That's the blue bar that is shaded in green. And then, I also want to point out that the increase, we do see increases across the state. That's that long-term trend.
But the increase in that first year of community health choices was larger than the increase in that central region. Now if we look at orange bars and now we have to look at shaded orange bar, because that is the 2018 to 2019 transition. So that is the first year.
Of community health choices in the southeast. Then can you see that there is a positive increase

in both age groups but not as big as other changes in other regions in the state. Particularly with the 21 to 59 population, that's due to a ceiling effect where that starting rate from that long-term trend is relatively high. So it is harder and harder to shift that needle.
Where as if you look on the right there is still a lot of room to grow the age over 60 plus population.
And can you see there is increases in the southwest in 2017 to 2018 and then also smaller increase in the 2018 to 2019 time period. Increase in the southeast and aged group is about comparable to the central part of the state.
But it does seem to be slightly slower than previous years increases. We haven't looked at 2020 trend yet of what is reported some of the numbers directly. . This is a very important finding.
This is where we look at hours of personal attendance services per person per day for the time period 2016 to 2018. The blue line again is the southwest and the trend here, if we look at bars on the left and lines on the right for both age groups, if you look at just the orange and gray lines, and all three lines really, from 2016 to 2017, it is on a steady increase. If you look at the difference between 2017 and 2018, the southeast and central part of the state continued on that historical trend in both age groups.
But in the southwest, during the first year of community health choices, what we see is that that rate of increase has basically slowed. And the average hours just for PAS hours that includes consumer directed and agency, are basically unchanged from the previous years.
Now we see a different pattern consistent with adilt day where we see downward trends in use of adult day services in southwest from 2016, 2017, to gray bars are 2018. And we see that in the southwest and southeast as well as central part of the state. So this is only picking up from, if you just look at southwest, the difference between orange bar, gray bar, that's the transition to community health choices. So we see a decline in adult day care use.
We also see a decline in the southwest in home meal delivery use. Just in the interest of time, I will pay attention to orange and gray bars on the far left. You can see a decline in home delivered meals. During the time period that community health choices was implemented in the southwest.
However, we were also able to link our participant enrollment data with S.N.A.P. We know that there's been increases in use in S.N.A.P. data. Now this is a little bit confusing but I will just jump to the key finding which is the third group of ours which is people using S.N.A.P. in the southwest. We actually see that more people over all are receiving nutritional assistance and it basically is coming from increases in S.N.A.P. in the southwest.
This is really important trend and we think it is off-setting for the decline of home delivered meals because more people are getting nutritional assistance. All right. I have some data on impact of COVID-19. And let me get through this as quickly as we can. We were conducting two rounds of interviews. So we were interviewing HCBS providers in the early part of 2020. Those interviews were, those were interrupted and then resumed in May. So we have early COVID snapshot of HCBS providers then we started the next round of surveys with HCBS providers in December of 2020 and those surveys are just wrapped up or just wrapping up new but this is preliminary findings. What I want to show is that if we look at, these are --
Okay, here is the provider surveys. On the left that early round, just about 90 providers we were surveyed and you can see that there was a significant impact of COVID on the ability to provide

care.
More thap half reported that workers were denied entry into client homes. 28% reporting no access to PPE. 27% report they had staff refuse to intera client's home. This is the most recent report on the right. And providers are reporting that they are in somewhat better shape in terms of their ability to provide care, although it is still not ubiquitous. 44% report they are able to provide care in-person. 38% report they are able to provide services both either in person or on the telephone.
But about 11%, and that's probably adult day care, are unable to provide services at all. Over the past two weeks, back to December, 42% had a client with COVID-19. 43% were refused entry to a client's home. That is down from May.
But still substantial.
We still see high reports of inadequate PPE and lower but still significant staff refusing to enter homes and also increase much higher rate of staff reporting that they had COVID-19 themselves.
I want to return to participants reporting. We see a decline in participating activityes.
Earlier findings I showed you were very positive.
But just between the 2017 and 2018, 2019 time period, but in 2020 we see a dramatic impact of COVID-19 on the general population. We also see declines in psychological well-being.
But we don't see, fortunately, we don't see increases in depressive symptoms. And then a significant impact on people's behavior, on that chart on the right. I will just wrap up. Enrollment process improved over the three phases. We showed that HCB sfntle utilization in 2018, that the growth was controlled and that there were drops in other service categories but offsets. And particularly with the meals. And participant quality life remains relatively high and either unchanged or slight improvements in 2018, 2018 to 2019 time period and southwest and there is a substantial impact of COVID on participants and providers. And then I just want to give a highlight. We have new data coming out this year. And we are looking forward to sharing those findings with this committee over the next couple of years.
And most importantly, we have a report that summarizes a lot of what is in this presentation today that's on review.
So that's it. Sorry for going over time.
>> Okay, I don't know if any committee members have any questions.
P.
>> I do.
Hopefully there's some reaction on the part of the OLTL staff about finding that skilled nursing facilities have no awareness of behavioral health coordination. This is 4 and 5 years now that this has been presented as an issue and we continue to have it, based on these findings, to have skilled nursing facilities that have no idea that there are consumer groups, that residents for whom they are directed to care have no access to improved behavioral health services versus those in the system.
How can that be?
>> So I will just say briefly we have shared the findings with OLTL. We have shared findings with the MCOs. Shared findings with in a meeting with leadership from the nursing home industry. And we're continuing as independent evaluator, we are continuing to see challenges there.

But I will leave it to OLTL and DHS to address their activities with that regard.
>> Hi, this is Marie Gonzalez. Thank you for that question. We certainly recognize there are still challenges, I think, overall and I do welcome, and I do invite the MCOs, since they have access, to be able to speak today. We certainly would like it hear from them how their efforts are in reaching out to nursing homes with regards to behavior health. I will tell that you internally we've done a lot of work with not only, as you know the program office within DHS, OLSA is responsible for working with the behavioral of MCOs. We have done a lot of work with reaching out to behavioral health MCO. RCA smnchts COs. And again really making sure that the residents are living in these facilities do have access. We certainly know that one of the issues, we knew that aging population didn't have access to health. That is something that's been on our radar. As Howard mentioned, we at DHS, as well as in other type of forums, we have had a lot of conversations with the various provider associations, they have also expressed the same concern, how do we move the needle? How can we work better? I know that's been enough activities in coordinating and connecting the dots and this is an area we need to continue to focus on and improve. I would like to invite the MCOs to at the very least talk about efforts that they are doing to be able to do that. This is a conversation that we have had with them and it is something that is on their radar as well. And I like it hear from each of them to respond appropriately, to the question because it is important to us. We recognize it and it is part of the design of the CAC program and we like to hear from some of the MCOs. What are they doing to make sure that nursing homes and other accessibility to behavioral services to residents in nursing homes. With that, by like to turn that over.
>> Yeah. And I suggest, because I had actually flagged this for MCO question and answer based on something that got submitted from someone in the audience.
And that would hopefully allow the MCOs, I know they should hopefully be able to get their, if they are not already on their behavioral health coordinator on to talk about educational efforts. That may give us a little more insight. So I could ask I guess, an for PHW, it is that individual is not already on and then Andrea and Mike for UPMC that is probably somewhere around 12:30. Does that work that way? Hopefully a little more robust conversations if they can get their behavioral health coordinators to participate.
>> Yeah. That's fine.
I mean, we have embedded in our quality strategy from the program as well. Very specific quality measures to make sure that MCOs are focused on and that does include the fact that our performance improvement projects from a three-year project, does include strengthening care coordination between the various health care, you know, platforms. Health care settings. That is certainly, and behavioral health is one of those particular areas that we want the MCOs to also make sure they are also focused on.
>> Okay.
Yeah. Thank you.
>> I guess, so Howard, would you be able to participate because I do have a couple of other questions and I also know that we are a little over time and Brian, we have Brian and MCO presentation.
>> Yes, I'm planning to stay through the whole meeting. And we can respond in writing if there is anything we can't get to.

>> Okay.
Great. That would be perfect. Linda, do you want to, unless a committee member has another question then, we can move on to the CAHPS survey?
>> Sure.
>> Hi, good morning, everyone. This is Brian MacDaid. Director of division of quality assurance. From the bauer row of quality assurance and program analytics. Hope everyone is good on this beautiful spring day. I will jump on into this to keep us on track with our agenda. Our first slide here is in regards to just the statewide CAHPS survey overview. This is focused more on the 2020 survey we just did. I want to start things off with as Howard during his presentation did ippedcate that impact that COVID-19 had on all that we do as far as various services that is provided, and I still recall when we were first getting the COVID-19 was coming a year ago, there was a question of whether or not we want to have the CAHPS survey and I'm glad we did it.
One of the things that we learned, and a big take way is even though with challenges of COVID-19, through the CAHPS surveys, we have identified issues as we will see here this morning but over all we continue to stay strong.
Dealing with the challenges of COVID-19.
As in past we continue with the HCBS CAHPS survey. Once again we have the PA specific questions centered around service plan, transportation, housing, dental. And this year for 2020 we had included in the supplemental and nutrition assistance program, S.N.A.P. To be addressed as well.
With that, our response rates between 12 and 20% across the MCOs with the state overall response rate of 15%. And we add target of 700 completed surveys per plan. We came out with 2139 that were completed.
Which of course helped us succeed the 95% competence level with 12% margin of error. Sample size of 383 --
[Inaudible]
Okay, with the next slide, a quick overview and in regards to the state respondent characteristics. As you can see, we were able to close on the fact that we now have 3 years of information collected from the survey and comparing between 2018, 2019 and 2020. For 2018, and on the southwest region of the state. And we just have around 28%. And in response from regards of individuals of African-American. And in 2019 to 49% would be including the southeast region. And then for 2020, across the state, we saw a 33% of response of individuals. Also we did see for nonHispanic that number from southwest from 99% down to 93%.
[Inaudible]
Female once again, primary gender and respondents and once again, as you can see, around 68 to 70% and for education, once again, the top education, top number for education is around high school grad, GED, and some college. Once again that is now 61%. However for 2020 we did see actually 32% indicating as far as -- oh, sorry.
As not being a high school graduate and actually 7% of respondents from college graduates or higher education.
Okay, the next area to address is whether or not someone helped the participant respond and complete a survey.

This number pretty much stayed the same in regards to the following years.
We basically have seen as far as these numbers for -- I do apologize that says 2018 label threw me off a little bit.
But we did have about 21% in regards to the state as far as individuals requiring assistance.
[Inaudible]
>> Brian, it's Pat. We've gotten a couple comments that you're -- and I hear myself, you are fading in and out a little bit. I don't know if you are turning away from your microphone.
>> Okay. Is this better? I do apologize.
>> Yes, much better. Much better.
>> Sorry about that. Don't know why it did that.
>> No problem.
>> Okay.
Thank you.
So once again, we did see as far as assistance as far as someone helping the respondent is very limited to essentially assisting as needed for the participants to fully participate in the completion of the survey. And next slide, please.
In regards to the survey and regards to individual preference for the phone, survey towards 2018 we did not have a question directly designed to capture this information. And in response to 2019 we implemented a question. And also for 2020.
We do want to indicate essentially we did see for 2019 and 2020 that there is a significant increase and as far as individuals preference for phone survey. Of course went from 31% to 60 across the state. I do have a suspicion that the preference for the survey conducted by phone is essentially tied into everything going on with the COVID-19 situation.
As you can see, there was satisfaction of services and across the board is the same over the past 3 years. There is increase between 2018 and 2020 and then between 2018 and 2019, a slight drop but overall individual satisfaction is steady --
[inaudible]
Around 82% and especially with overall impact of COVID-19, there --
[Inaudible]
And the services as far as individual satisfaction with services being provide even with the pandemic going on, individuals are still as satisfied with the services over all.
The MCOs trying to target on the various areas we support and individuals with overall satisfaction and hopefully seeing this increase for about 84% and then of course as years continue we see that continue to flow. And in regards to individual satisfaction within the CHC.
Next slide, please. Okay, one area is supporting across individuals participants and experience is in regards to their ability to choose the services that matter to them. And we did see back in 2018 indicated around 76% and we did see that increase up to 80% from 2019 as well as 2020.
We did indicate the status, however we did see, such as merit health, did have a slight decrease from 2019 to 2020 of 3%.
But over all, still hovering around 80%. Some suggestions that we are trying to encourage with the plans is continuing to work with service coordinators and with regards to improving as far as interviewing technique and as well as their indication --
[Inaudible]

The next is the service plan and that does include everything that is important to the individual. We did see once again, as you can see the past three years on the state level, and around 58% and did inkread to 65%. Some of this is expected to the fact that there has been work on the plans as well as OLTL to continuously try to improve upon the provision of the service plan and make sure that they are working with participants to continuously work toward making sure the plans that are involved do support the individuals, desires and in regards to various services.
On the service plan we continue to still strive pretty well in that area, as far as the state, as of right now with the 2020 around 96% satisfaction in regards to participants feeling that staff were aware as far as various services that are listed on the service plan and in the first service being the line.
Okay, this is also important. Once again we have been seeing that this decline and going down to 89%. And however, we did see that we are still individual participants. And getting changes as needed for the services when they ask for help.
There are areas to continue and the portion of the training of the service coordinators and also not just from service coordinator but also with outreach and participants and with services being provided are being provide per participants request.
>> Also, with the service plan, we indicate as far as individuals ability to fill that are able to plan time and activities.
And we have seen over the past three years, this was around 62% back in 2018. In regards to participant responses. In 2020 we have a suspicion that once again this is with the impact of COVID-19 has had on the community as a whole. For all of us actually.
And not just for participants.
But also, we are on the verge of the plans to continue to work and stride as far as once again with working with participants to make sure service coordinators are working with the individuals to ensure they have a say in regards to current activities or planned out.
And no continue to work in this area. We also saw in regards to this, individuals in --
[Inaudible]
Still at 86% satisfaction rate and in regards to individuals deciding what they would like to do with the time.
Though this is 86% which is positive, we do like to encourage plans to continue to work towards this to improv in this area.
One of the things we saw over the last few years was in the community. We did see that over the course of 2018 through 2020, still hovering around less than 30%. And with a stit, back in 2019, and at 27% and it did decline to 23% and with the response we receive.
We did note all three plans have a downward trend. Once again we are continuing to encourage from plans to continue to work with the participants to improv upon this area. One of the things we did also note as far as individuals ability to as part of this, not just being able to do in advance of the community but being able to do things with friends and family. We did note that this declined as well. And for example, for an ability to get together with nearby family. And so 2018 and 19 around 50%.
But we saw that decline to 47% and once again for individuals to get together with friends.
We saw that decrease to 36% then o 2019, 38%, then decline to 32%. And to keep in mind, that COVID-19 upon the community, however we do want to, we are encourage MCOs to look into it

and see how we continue to go in this area in regards to individual satisfaction.
Next slide, please. All right. And in regards to personal assistance services as well as behavioral health staff, coming into the individuals homes, one good thing is I was quite pleased with this actually and with COVID-19 going on state level over all, and we are about 83% back in 2018. And we did climb up to 86% in 2019 and we stayed that way for 2020.
Despite various challenges that were being impacted on the community as whole as far as participants, individuals did feel their staff was still helpful in providing services in their homes. Once again we were kind of, we did like to see this increase and years and even with the challenges of 2020 and we did see that in the study.
We saw that stay steady as well between 2018 and 2020, naturally it improved.
Next slide, please.
Okay, as far as staff, treating them with courtesy and respect, as we indicated here, we did see the number increase from 2018 and --
[Inaudible]
It is significant as we know the various stress that COVID-19 has had on our community. The providers and individuals that come into their homes to provide services.
We saw improvement of staff listening carefully to the parties papt and regards to during the course of being provided with services and we did see that improve from 79%, climb up to 87% in 2020 across the state. We did see the trend grow up across all of the plans.
Keeping the foot on the gas, per se, as far as working with providers, in the communities to continuously ensure that staff, that it did go to strive to continuously improv in this area and in the work, and with participants that they start.
Another take away, where we saw over 2020, is individuals as far as coming to work on time. And this is actually a positive and I was hesitant. I'll be honest, I was expecting COVID-19 to be potentially a challenge. As you see for 2018, up to 2020, this has increased up to 89%. And we definitely are happy to see that individuals, providing services, are coming to work on time.
Services being provided to help support and stay in the community and involved in the community.
We did see this decline a little bit in regards to individuals made aware and staff providing coming to homes.
We did see for them to address as well. Because of the fact this 2018 is around 81% and that deep decline down and many importantly we want to make sure that participants are given communication, through participants with advance warning, to make sure that they are able to give additional support and to provide services that they need.
As far as transportation, being available for medical appointments, and slightly increasing from 2018 to 2020, 83 to 84% across the state. You see this slightly decrease between 2018 and 2020. And to work with the transportation providers, to continue and one of the challenges we did suspect the survey is for the whole state.
And taking consideration some challenges and some of the communities and the survey at this time. And plans have been continuously working since 2018.
[Inaudible]
The simple fact this is critical to individuals over all health and well-being and making sure that we ensure that transportation, scheduling appointments, arriving in time to ensure that

individuals do arrive to their various local appointments to maintain their health and well-being. So once again, we did tai from 2018 to 2020 and satisfaction of 73% satisfaction, and so, honestly, the plans have been make something headway in this area and working with their transportation providers. However we do like to see this --
[Inaudible]
And there is improvement in regards of steady growth as far as availability of transportation to be on time.
Not just for medical but also we want to address as far as transportation of the individuals to get to nonmedical appointments.
We did see this did improv.
And from 2018 to 2020 and 82% across the state to 86%.
We do see this as improving and growing over the next several years.
Once again, with individuals, not an issue to help still improving and socially active and also able to still be independent and other appointments, and never go --
[Inaudible]
>> I think we are losing your audio again.
>> Oh, seriously?
>> Yeah.
>> Can you hear me now?
>> Yes.
>> I apologize, sorry. Got it love technology.
We just want to stress that we did see improvement in regards to nonmedical appointments in which individuals are able to get transportation to various appointments and remain independent in their community. We did see this increase once again as recap from 82% back in 2018 up to 86% in 2020.
Next slide, please. Next slide going to dental services.
As far as individuals indicate that they received in the form of dental care within the dental office or clinic in the past six months. From 2020 we did see this decline basically from 2018 and around 35% and then around 2020, well 2019 first we did see improvement in this area. We decline from 22 to 26%. And so once again, with COVID-19, and I'm sure the audience is aware, the impact of COVID-19 had on various providers, especially providing communities, especially with dental and in which a lot of the providers were not able to per se provide services during earlier months of COVID-19. So we suspect some of that did play a part in this number. However we do continue to encourage them to continue to work with their dental community and encourage individuals to receive these services and importance of these services especially as far as the individual's overall health and well-being.
And you know, really starts with a lot of the factors that play in with not having dental or oral hygiene.
And continuing to work to improv in this area.
So next slide, please.
This is the department as a whole because of impact of COVID-19. And definitely this year, probably more than any other years of the past, this is a very important area for us to make sure that participants areware of how they can report and do find themselves in a situation of

exploitation. We did see this decline in 2018 and 2020 from around 96% response as for as individuals indicating that this are aware as far as the report and that did decline to 87% come 2020.
The department as whole with the fact that COVID-19, that way limits as far as individuals interaction with not just from the afters of learning but all populations that are served pretty much by DHS as far as making sure that individuals are aware that they do find themselves in a bad situation and ask for help.
Even though it is 87% and based on satisfaction and we definitely want it see them continue to improv this because this is one of the areas where we definitely want it make sure we see a response as far as individuals aware of how they can report abuse and neglect and exploitation. Next slide, please.
>> And tying into that as I indicated earlier COVID-19, and one of the biggest challenges for all of us in our communities as whole is the fact this we don't have day-to-day interactions that we normally would without COVID-19 especially in the course of 2020.
This is early posting as far as whether or not the participant felt they had someone they could talk to, if someone did something to them that they did not like. We did see the decline from 2018 down to 2020 for 92% for 2018 and then forcing decline to about 86% in 2020. Once again, this is an important area even though it is 86% and encouraging the plans to focus on this and make sure that individuals areware as far as how they can report any type of abuse or neglect and they feel that they have someone or availability of someone that can actually assist from what they do need to talk with someone about during a situation where they are potentially facing being abused. So we definitely want it make sure plans continue to work with this. Service coordinators as well as providers that come into the home.
In individualwareness as far as housing rights and knowing how to get information. We did see 2018 this is around 78% and we do see decline to about 74% p one of the factors to keep in mind is that the implementation of the survey through the whole state, so we have found traditionally some individuals and some in rural communities are less likely per se to be aware of some of these areas of availability, housing rights and however we do continue to have plans to work with individuals and especially service coordinators and make sure individuals are in a quorum and --
[Inaudible]
And in services such as housing rights and make sure that they are aware of the seriousness that are available to them. And as far as housing. And next slide, please.
And of course as time has a little bit with the assistance and that you need and with housing issues and we still see this kind of hover around 20% area and 2018 and around 23% and stated earlier and you see this decline for 2020 down to 20% and maybe for the individuals responding that the actual need of assistance is to help them with housing conditions.
Okay, this is actually statewide in regards to the appointment and experience and this is essentially driven information and this data comes from the employment questions which are asked. And out of those, the responses that we have for 2020 in regards to the employment questions and we have about 203 respond.
P we had 51 individuals report they wanted to work. However for 2020, it did increase up to 270. We had for example for 2020, we had 13 individuals indicated that they --

[Inaudible]
And out of the overall we saw that 4 individuals reporting receiving the help they needed. The one take-away concern and still addressing with the plan is individuals did not know they could get help with getting a job and still around 123 participants that responded to the supplemental questions indicated that they did not know that they could get help in getting the job and --
[Inaudible]
So that were the plans to continue to work in this area.
And once again, service coordinators to make sure that individuals are taking full advantage of the various employment assistant programs that are available.
Next slide, please.
>> Brian, real quick time check.
>> Yes.
>> Make sure, do you think you will be able to wrap these last couple of slides up fairly quickly so we can move on to service coordination.
>> Will do, Pat. Will do.
>> Okay. Thank you.
>> Okay.
And real quick, in regards to S.N.A.P., we asked this question for 2020. This came through conversations that came up with some of the meetings and others in which we got a lot to start seeing as far as CAC participants use as well as knowledge of the availability of the S.N.A.P. program. The supplemental nutrition assistance program. With some assistance with our friends at OIM, we developed these two questions. First one indicating in three months. And we have about overall 70% in the state indicating they do use the S.N.A.P. program. And p not receiving S.N.A.P. in the last three months, those individuals indicating that they were aware that 52% of those individuals indicated that they were aware that they may potentially be eligible for S.N.A.P.
--
[Inaudible]
And for transportation for nonmedical appointments area improved as well. Other areas for improvement we did see some of the continuing issues that we saw for 2018 and then continuing with 2020 and we did see the new one in which we did see as far as participants and planning activity answers we did see decline in 2019 and 2020.
>> We are looking at the MLTSS sub MAAC --
[Inaudible]
And we have progress and ideas and they identified areas of concern and plans to put in place for last year for 2019 and as well as for 2020.
And so we know we are excited about the upcoming 2021 survey. Where we will look into the survey once again from earlier, from August 1 to October 31. Once again, still targeting about 700 for each and then we are looking to pull together results getting us to by November 15 and right after that, probably 2022 and we will be getting started with our presentations in this group as well as others.
And our last slide please, everyone's favorite, questions. So with time, and I'm not sure if we have any questions or not, Pat?
>> We do but probably we will need to do those off line.

To try to transition on to the MCO portion.
>> Fair enough.
Once again, thank you for your time. Relay the questions. Have a great day.
>> Thanks, Brian.
Now, we have AmeriHealth.
Okay, Jen.
>> Can you hear me? Oh, good, there I am. Thank you so much.
>> Yes.
>> All right.
>> Good afternoon, everybody. My name is Jen rogers. I'm director of LTSS program management and quality. Here to present today information we want to share about contacting your health planning and your specifically your service coordinator.
So if you're a participant with us, how do you know who your service coordinator is and how to get into contact with them? Each service coordinator assignment to the person who is responsible for coordinating your CHC service plan is documented in our LTSS plas form. You have a couple options to reach your service coordinator by phone. Can you dial your coordinator directly as each coordinator has a company cell phone. Can you all our participant services line. That line is open 24/7. The numbers are listed on the screen for reference.
Health plan access to all contact information. So when a participant or anyone calls in to our participant services line, at their fingertips, contact service representatives are able to see the assigned coordinator, their phone number and e-mail. Service coordinators are trained to set --
[Inaudible]
As we reenter, this is something that is for our participants.
So when we think about when is it appropriate to contact service provider coordinator and when to contact the services line, a service coordinator --
[Inaudible]
Also our personal --
>> Jen, Jen.
Jen.
Service coordinators are -- --
>> Jen.
>> Jen, we are -- Jen, we are having a hard time hearing you.
>> The design of our team, and --
>> Our personal care training life service coordinator so they are able to -- Pat, were you having a hard time hearing me?
>> Yes. I was. And I don't think you could hear me. We were having a -- you were really very distant and breaking up.
>> Okay. I'm so sorry.
I apologize.
>> Okay, so this is an example everybody of the lead behind the magnetic information card. As your service coordinator changees this is where we want service coordinator to update their information and make a recommendation to participants post on their filing cabinet or where it is easily accessible to be referenced in the event you need to contact your service coordinator

quickly and you don't have that person's name or number programmed into your phone.
The role and responsibility is for the benefits and services and also on the team and closely aligned with service coordinators are personal care connectors and trained on the benefits and services. The service coordinator is processed and they have read-only access to ELCS system.
Questions handled by service coordinator and include anything and everything related to LTSS benefits and services and what is authorized on a person's service plan. And help with scheduling and answering questions related transportation.
And connecting to community resources. With the participant resource role are trained in managing participant inquiries about their physical health benefits. Updating primary care physician. Requesting that replacement ID cards.
So our participant service associates also have that read-only access that I have spoken to previously to access ELTSS and other systems that will enable them to answer benefits specific information or benefit question and give participants information we are looking for. If they aren't able to reach their service coordinator because of service coordinator is traveling or in a participant facing visit.
So again, questions that can be easily answered and managed by participants are the replacing ID cards, explanation of benefit information, primary care provider changes. Appeal information.
And importantly, adult protective services and older adult service inquiries are routed to participant service line as it is in 24/7.
How did your past agency or past service provider know who the coordinator is? Always responsible for coordinating with the participants chosen in path agency. Trained to coordinate and collaborate with the pass agency staff and service coordinator are responsible for making any changes, update extensions of service authorizations which require communication with the PAS agencies on behalf of the participant. Coordination is available in HHA exchange or Navi net.
SC contact information is accessible in LTSS which can be preferenced by our provider network management and provider services associates.
You can call in our provider network management team or provider services associates, all have that information at their fingertips.
So how is a change participant and supervisors trained to outreach participants to confirm that the service coordinator changes align with what the participant is requesting.
When an in-service coordinator is chosen by participants and it is updated in our system, a let are introducing the new SD mailed to the participant. This letter contains the coordinator's contact information so their e-mail and mobile phone number. And also the changes are documented in our ELTSS as progress notes and of course capture change history so at any point in time a caller or anyone making the inquiry can know who the service coordinator is.
That's all I have. I apologize my audio was bad.
If you want me to take questions now or hold until later, I'm available.
>> Thanks, Jen. We may, depending on time, do them later.
So thank you very much. And then I guess we will go to PHW next. And I believe, is that going to be Norris?
>> Hi, it will be myself and Marcus hicks.
>> Okay.

>> Thank you.
So thank you, again, my name is Joe Elliott. I'm with PA health and wellness. Thank you for allowing us to talk to you today regarding how participants access service coordinators. I will talk a little bit about what participants can expect when they speak with our customer service representatives and Mark jus going to speak to the interactions to the participants and service coordinators.
An initial outreach is made by service coordinator it welcome them and provide them a choice for selection of an available service coordinator employed by that service coordination community partner.
During welcome call, the initial assessment is also scheduled but additionally the service coordinator name and contact information is included in a follow-up welcome letter once the final participant service coordinator selection is made. And in the event that a participant needs to speak with their service coordinator, PA health and wellness has one statewide Toll-free number for participants for all purposes. In this manner, participants that need to speak with tir service coordinator can call that number, and the call sent are representative will transfer them to their specific service coordinator. If the service coordinator is unavailable, say out of office for with another participant that time, the customer service representative will ascertain a level of urgency and either connect the participant to the soup riser on call or arrange for a call back within a timeframe acceptable to that participant. Additionally a participant with call that same number in the event they would like to request the change to their current service coordinator which would follow the process to facilitate that. If a participant service coordinator suddenly resigns or transfers or changes for sh reason the participant is contacted bay new service coordinator immediately and given the opportunity tore choice per hour standard process. Service coordinators have regular contact and where they are not contacted by phone the plan sends a letter to service coordinator and to the participant and service coordinator does a well-being check. So what I will do now is I would like to give Marcus an opportunity to talk a little bit about items that the SC would help accomplish.
>> Thanks, Joe, can everybody hear me?
>> Yes, we can. Thank you.
>> All right. Awesome. Thanks, Joe, again, for transitioning this over to me. My name is Marcus hicks. I will talk a little bit about questions that a participant should or could ask their service coordinator in relation it calling into participant services and being connected to coordinators. As Joe stated, participants can utilize our member services number.
If it is more of a one-shop stop approach for participant needs. This assures that any questions coming through are effectively triaged and ensured they are handled by appropriate parties. So you will see the list of bullet points and you will talk through some of these. In terms of reporting a change of condition or need whenever a trigger event happens, you can utilize the mental services number to help you reach your SC. If you are not outreaching them directly. And at times a trigger event and request for different services for services will go hand in hand and so, as stated above calling in allows appropriate triaging of those issues.
And we can always help you contact your SC through a warm transfer or make the outreach to your SC to make them know you have some sort of unneed met to address. It is always the service coordinator's responsibility to follow up and make sure that unmet needs are addressed.

So in order to did that, the service coordinator has to end up completing reassessment that reassessment is connected to updating your service plans. If there are indeed any gaps to identify. In addition to those things, can you also utilize your service coordinator to help report critical incidents or service disruptions and in addition making sure you're safe, you can, the service coordinator would reassess for gaps and be working with participants on alternative services and of course working with participants on creating a viable emergency backup plan to pro vie a lapse in service.
So your service coordinator as you are meeting with them for your schedule context and visits, and participants of course have the opportunity to obtain information about various services to support you in the community. And perhaps assistance is needed understanding the assortment of services offered via CHC.
And with contact and procurement manager and wanting information pertaining to resources or other community resources.
Regardless of those needs, the service coordinator is a resource to utilize and they can help you locate and access those supports.
In addition, to those LTSS services, the service coordinator can help you access expanded benefits for PHW that will include anything from nursing home to help with education yl materials and support. And of course lastly, mentioned on here but not least, service coordinator can also be support when there is a need or desire to follow a grievance. They can directly assist the participant in calling in with services showing the need and you can reach someone on our complaints and grievances team to get the information to where this t needs to go to schedule a grievance hearing or fair medication hearing. According to what the issue is.
So those are just some of the items that service coordinator handles in conjunction with the call center. I'll go ahead and turn it back over to Joe to talk about some of the specifics about the participant services line.
>> When a participant calls into that number, the customer service representative would be able to assist with some of these other requests. So for example, if the participant needs to update their contact information or request a new card those are items that customer service representative could easily facilitate and take care of over the phone.
They could additionally assist with updating participants PCP or helping them find one. They would be able to answer any questions about Al gentleman built benefits or services and provide any information regarding community resources, or help them change a provider or arrange for transportation. The customer service representative could help in filing a grievance or appeal. And additionally help the participant understand and navigate our website or establish a participant portal account. Or if they just have, if the participant just has a request for information or any additional assistance our customer service representatives and participant services line would be able to assist with that.
>> Marcus?
>> Yeah.
>> Thanks, ultimately the point we want to get across is that participants services and service coordinators work in conjunction to help provide support to participants. We want to make sure we are here as resource to ensure that all needs are met. We work as a unit. We want to be viewed in one for all approach.

So participants and providers, make sure you utilize them as such and we want to make sure we are working towards continuing to provide care and support needed whether participant provider or otherwise.
That is all for us.
>> Thank you.
>> And then we will transition over to UPMC.
>> Can you hear me now?
>> Yes, I can. Thank you.
>> Oh great. This is what happens when you mute yourself twice.
Hi, everybody.
The other plans are covered already, and maybe this is a different fashion.
So I just wanted to say, you know, in advance of getting into coordination realm here, that we have a broad network of supports that are associated with service coordination. So just provided you this sort of organizational chart to share you all of the different entities and activities that are associated with service coordination. And they are supporting us wean have medical management staff supporting us, telephonic service coordination associates, member services, and a broad range of behavior health coordinators and things of that nature that are behind the scenes at UPMC that are supporting not only the participants but the service coordinators and coordination associates that you know, are there on the front lines talking to participants on a regular basis.
So, you know, similar to the other plans we have several different ways to sort of support participants who are coming into the and we have service coordinators assigned to you that are there to support participants and then we have service coordination and associates and member services lines that are really there to help provide some ancillary support and again, as both of the other plans explain, these call centers and supports are really there to help out when service coordinators in the field and give someone a warm hand-off to service coordinators when there is something that they can't work on or through our electronic health system to make referrals over to them and make sure that information that a participant wants it rely is getting to service coordinator when they are not available.
You see here on the screens, our numbers are on the far right-hand side and we put our names of our service coordinators at the bottom of that magnet so that people know how, you know, who their service coordinator is. And we hand out business cards. And we go through how to identify or how to contact your service coordinator in participant hand book and telephone numbers as well. And who is where we get into you know making sure that we point the participants and say, you know, when we are working with them and we provide them with our cards and we provide them with our contact e-mail as well as on the magnet itself.
But then in the plan, you know, every single plan, that is sort of the most important place people can go to look for the information on their service coordinator and make sure that, you know, can you find that person and you have the information. We encourage the magnets we provide are placed some place in prominent display and we update those if there is a change in service coordinator to update those easily through we just basically put either provide a new one or put a name place over the top of the other name.
So we leave behind service coordination business cards and service plan and on the magnet and

an addition to the service coordinator talking a little bit about the FDA a, service coordinator associates, what they can do and they have available to somebody to talk to when your service coordinator is not immediately available for a warm hand-off. They can help out with resolving a number of issues, scheduling transportation, relaying messages to your service coordinator, scheduling, looking at issues around authorization of services. And looking at complex matters that can be handed over if your service coordinator is not available to the supervisor. Routine matters, they try and handle as many as possible on the calls and not have participating having any call back in.

Really, whatter with doing, what is service coordination doing? We are reaching out to participants, making the initial contact in a very short period of time after eligibility has been determined. We want to get that assessment done in the first five days. And we serve on the left-hand side, you have our assessment and care planning process. That we go through. And part of the introductory call and talking about choice of service coordinator, and we have service coordinator for that initial assessment to get out and see them and participant would like to have somebody different at any point, they can request that and call in on member services line at one of the hubs and get someone to talk to about transitioning to a new service coordinator within the UPMC family. And right now, you know, there is some major, you know, activity that on the right-hand side that we want to see service coordinators, you know, working with participants on certainly issues of questions around their PCSP, and wh what services there are on there and if something needs to be changed or if they have a concern about, issues regarding services themselves and they can be reach out to their service coordinator to work through those issues and in terms of member services and you know, very typical things like requesting new ID cards and Handbooks and talking over benefit coverages. And when I talk about that, and I'm talking about their, you know, anything to do with their dental benefits and things we have been talking about that were working to i improve as well as medical benefits and that nature. All of that can be done by a service coordinator but also opportunity for participants to talk to somebody about these without having to wait for a service coordinator. These are the major aspects of the service coordination process. We have warm transfers and so anyone who is picking up the call and working with a participant whether coordinator or not, they are going to have the ability to know what next steps might need to happen based on the information in the system. So with that, I turn it back over to Pat and I'm sure that folks will have questions out there.

>> Yes. We do have questions, Mike. And I guess I will ask, do you want it take questions now. We have about 10 minutes left. Or do you want to handle those off line? Go back and cover some of the behavioral health questions. How would you like to proceed?

>> I would like to hear if there are any questions about the behavioral health.

>> Okay, we will transfer to that. We have behavioral health coordination, so I think that the main question that we got initially was that from the survey responses and focus groups that there were issues with skilled nursing facilities weren't aware of what behavioral health services were available and to start, and I guess we will start with AmeriHealth then and what efforts are you making to educate nursing facilities about, what services are available and help to increase the access.

>> Sure. Can you hear me?

>> Yes.
>> So I wanted to talk a little bit about the quarterly meeting that has been held and the attendees incluesing nursing facility and providers and the association of providers. And the county and age administrators and the three CHCMCOs. That is what we have comprised of as partners meeting and this is the platform where these exact information will be occurring. While we have been challenged with attendance from providers and so in 2021 and sending out invitations to the nursing providers encouraging their attendance. The MCOs and CHCMCOs have information on how to access coordination assessments. This includes the information for all of the MCOs and step by step process for accessing coordination.
So prior to closing, I can see our plan specifically we met face-to-face with nursing facilities to provide education and answer their questions and provide direct context with our plan for coordination.
We also since COVID we attempted telephonic outreach, however these are not successful and I can only assume you did the fact that the nursing facility has been focusing on COVID which I know their top priority. And I do want to say and share with this group that the next partners meeting scheduled for March 24 from 10:00 to 12:00. Thank you, Pat.
>> Thanks, Jen. I guess I know that if you share that information again and Gail can help distribute that for you.
>> Heather Clark is on from PHW.
>> Hi, there. Just to echo similar efforts that AmeriHealth explained, I was going to say that partnership meeting, which is a great avenue for us to share information regarding behavioral health referral coordination so really going over that because of the great job of the partnership meeting. Can I tell that you we have been collaborating with the PHMCOs to outreach to all of the nursing facilities that we are contracted with to provide them with an overview of what behavioral health services are available. How to refer to behavioral health services. And most of the outreach efforts have been unsuccessful. Only a few of the nursing facilities did engage with us in partnership to receive that training.
I don't have the numbers offhand but I could gather them.
I know that a few nursing facilities and in the Philadelphia area were open to receiving mental health first aid training but the bulk of the facilities did not respond to outreach efforts.
>> And Pat, this Norris, we have met regularly with all of the nursing facilities associations and going back and we met once a week and then once a month and we still do. So we talk about issues that are important with what is going on, what is significant. So we will bring this up at our next meeting with the nurse facility associations and just restart bringing this issue back up to reemphasize what we discussed. And we met with them last week and our next meeting will be in three weeks.
>> Okay.
>> Can you hear me?
>> Yes.
>> I would echo a lot of what Jen and Heather indicated about the partnerships. Those are great opportunities and avenues for all of the behavioral MCOs. The CHCMCOs as well as counties and other individuals involved in the oversight of behavioral services to communicate. We often highlight service types that are available. Again as referenced what is coming up this

month, we have made the effort to expand the number of providers involved. We are working with our network teams to send those direction communications out to those partnering with the trade associations to ensure we have represent ifs from the various organizations at those meetings.
In addition to the partnership meetings, some other things that we have done in conjunction with the MCOs, through various data sharing, as well as ongoing meetings, discussions about different pilot options of services have been implemented at various places across the common wealth and a lot of it is overscene by county oversights but there have been case management services as well as expansion of peer and telehealth services in nursing facilities. I will also point out, we were seeing incremental in facilities in CHCMCOs prior to the pandemic.
But a lot of energy was target on direct care. So that did derail some of those increases but it was incrementally increasing in that communication prior to COVID beginning last year.
>> So a follow-up question real quick, since we are almost at 1:00, David, the service planning process, --

Chat

Writer: Hello, this is your captioner, Michelle
Guest: Sound is significantly muffled
Writer: Yes, I can't understand what she is saying.
Writer: I have to leave for me next meeting. I will be disconnecting now.