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Date: 01/03/2024

Event: Managed Long-Term Services and Supports Meeting

>> MICHAEL GRIER: Hello, everyone. This is Michael Grier. We will get ready to start in just a couple minutes. For folks that are remote, please bear with us. We are kind of of dealing with a skeleton crew today. Please, we appreciate your patience. Thank you.
>> Good morning. This is Jermayn. Attendance starting with Mike Grier.
>> MICHAEL GRIER: Present. Will.
>> Carrie Bach. Anna Warheit. Cindy Celi.
>> Is Cindy.
>> Jay Harner. Juanita Gray. Kyle Glozier.
[Inaudible]
Lloyd Wertz.
Monica Vaccaro.
Patricia Canela-Duckett.
>> Present.
>> Good morning. Sherry Welsh.
And Tanya Teglo is excused.
Are there any subcommittee members who joined that didn't get --
>> Yes, Laura Lyons.
>> Good morning, Laura.
>> Good morning.
>> Anyone else?
>> Carrie Bach is also present.
>> Good morning. I will turn it back over to Mike Grier.
>> MICHAEL GRIER: Thank you.
I will go with some housekeeping points. This meeting is being recorded. For participation in this meeting is your consent to be recorded. Please keep your language professional. This meeting is being conducted in person in the honor suite at 333 market street tower and webinar with remote streaming. The meeting is scheduled until 1 p.m. The logistical agreement, we will end promptly at that time. All webinar participants except for committee members and presenters will be in listen only mode during webinar. While committee members and presenters will be able to speak during the webinar we ask that the attendees, self mute using the mute button or mute feature on your phone, computer or laptop when not speaking. To minimize back ground noise, in the honor suite we ask that committee members presenters and audience members in the room turn off the Mike folks when not speaking.
The commissionist is captioning remotely so it is very important for people to speak directly into the microphone, state their name, speak slowly and clearly.
Please wait for others to finish their comment or question before speaking. This will enable the captionist to capture conversation and identify speakers. Please hold all questions and comments until the end of each presentation. Please keep your questions and comments concise, clear, and to the point. We ask that webinar attendees please submit your questions and comments into the question box located on the go to webinar popup window on the right

side of your computer screen.
Toanter a question or comment, please type into the text box under question including topic to which your question or comment is referencing and press send.
For those attending in person who have a question or comment should wait until the end of the presentation to approach one of the microphones located at the two tables opposite the speaker. And before using a microphone in the room, please press the button on the base to turn it on.
You will see a red lied indicating that the microphone is on and ready to use.
State your name into the microphone for the captionist. Remember to speak slowly and clearly. When you're done speaking, press the button at the base of the microphone to turn it off. The red light will turn on indicating that the microphone is off. It is important to utilize microphone placement around the room to assist the captionist in transcribing the meeting discussing accurately.
There will be time allotted at the end of the meeting for additional public comment. If you have any questions or comments that weren't heard, please send your questions or comments to the resource account identified at the bottom of the meeting agenda. Transcripts and meeting documents are posted on the MLTSS meeting minutes list serve. These documents are normally posted within a few days of the meeting. Ill turn it over to Jermayn for the emergency evacuation.
>> Thanks, Mike. Before I do the emergency evacuation, I want it acknowledge a few other subcommittee members joined us.
[Inaudible]
Jay Harner.
>> Present.
>> Good morning, Jay.
[Inaudible]
>> Present.
>> Anyone else we missed?
>> To evacuation procedure. For the event of evacuation we will proceed to the assembly area to the left of the Zion church on the corner of fourth and market. If you require assistance to evacuate you must go to the safe area located right outside the main doors. OLTL staff will be in the area and stay with you until you are told to go back to the honor suite where you will be evacuated. Everyone must exit the building.
Take belongings with you. Do not operate cell phones. Do not try to use elevator. It'll be locked down. We will use stair 1 and stair 2 in the back of the building. For stair 1 exit the honor suite through the main doors on the left side near the elevators. Turn right and go down the hallway by the water fountain. Stair 1 is on the left. For stair 2, head to the honor suite on the right side of the room, the back doors. For those exiting from the side, turn left and stair 2 is directly in front of you. From those exiting from the back doors, turn left and left again and the stairwell is directly ahead of you. Turn left and walk down the alley to chestnut street. Turn left on the corner of fourth street. Turn left at blackberry street and cross the street to the train station. Mike?
>> MICHAEL GRIER: Thank you. With that, we are going to go ahead and move on to the agenda to our December 6, 2023MLTSS meeting follow-ups. We have a lot of people's voices get heard and I know that there has been individual contact with a number of the folks that were there. So our overall follow-ups are relatively short today.
And Jermayn or Paula, relating to quality management subcommittee member, so public can

review commentes from the quality management plan, Juliet said she would check with OMAP. Related to the 1115 public waiver attendance member Thomas Earl asked if the Keystone for health 1115 public waiver touches on homelessness. Juliet said she would check on that and provide specific detail.
>> >>: This information has been forwarded to Thomas Earl directly. Additional information fact sheet is publicly available on the DHS website. The link will be shared on the MLTSS meeting minutes lit serve shortly after the meeting today.
>> Thank you, Jermayn.
With that said, we will move on to the agenda for OLTL updates. Juliet?
>> JULIET MARSALA: Good morning.
This is Juliet Marsala from Office of Long-Term Living. Before we get started, I wanted to take a moment to recognize the commitment efforts and contributions of MLTSS committee members. Particularly committee members who have had sort of officially the we have invited some of them back today, who officially have terms ending in December.
So I wanted to extend the Office of Long-Term Living and Department of Human Services and that's gratitude to Mike Grier, David Johnson, Neil ild Brady, Gail, Hershey, and Matt for their dedication and support of the MLTSS system, their hard work and effort and representation on the committee. We will see some of these familiar faces likely in February as some of these combine into one MLTSS subcommittee.
Thank you very, very much.
Into the OLTL update today. A few items on the quality strategy. Workforce innovation workforce, memos. Opportunities to learn about PA ABLE saving accounts and updates on the PHE unwinding bulletins coming up. So this is also direct follow-up with Lloyd. So timing is perfect. So managed care quality, MCQS, for Medicaid assistance and -- medical assistance and children's health insurance program. Oh, even better. There is public comment on the PA bulletin on September 23, 2023. The summary has also been posted and is available on-line. Embedded in the PowerPoint.
But if you go to DHS website and type in managed care quality strategy you should also get to that information page. In addition, the final medical assistance and children's medical insurance program and managed care quality was submitted to CMS on December 22, 2023 for review. A copy of that report is also found on the same page for the medical assistance and children's health insurance program managed care quality strategy. If we go to the next slide, PA2024 to 2028 workforce innovation and opportunities act state plan often referred to as WIOA. The state plan draft is now out for public comment. The draft plans, as well as instructions for sub committing comments can be found at the following website, www.dli.pa.gov/businesses/workforce-development/pages WIOA.aspx. On the Department of Labor and Industries website. We have some additional operation memos for folks. One is for the new FED or functional eligibility memo. The CHC2023-10 has been posted with a date of November 20, 2023 that operations memo clarify whens a functional eligibility is required for an HCBS waiver application. If an existing FED is already on file and when an existing FED outcome can be used for the HCBS waiver level of care determination. That operations memo is posted.
In addition, a revised nursing home transition has been revised for the 2019-04 revised edition. This outlines rules and responsibilities and adds clarifications. So that was issued on December 29, 2023. And explains the procedures to follow for qualifying nursing facility residents who are eligible for Medicaid or long-term care. Team this is new o home and community based services. Also revised to include money follows a person or MFP details and how to

communicate that during the NHT process to improve our reporting. We also have a revised PA1768 operationes memo. That operation memo is a revision to 2019-05. And it talks about circumstances when community Health Choices managed caring for Iizations must transmit a community based services eligibility and eligibility for change form referred to as PA1768 to the county assistance office. This was issued on December 29. Again, described with the situation for what communication whereby the CHC-MCO sends the PA1768 to the county assistance office and also includes the money follows the person information and how to communicate that on the PA1768. And how to update the participant's letters.
I also wanted to take a moment to talk about the opportunity and hope that folks who are listening in on the call, all of our managed care organizations, our provider partners and community based organizations and advocacy organizations will help us in spreading the opportunity for individuals, family members and other stakeholders to participate and learn more about PA able. There are three webinars that will occur in January and February. And these webinars have important information about the eligibility requirements for opening of Pennsylvania able many, savings and program designed specifically for individuals with disabilities. The state tax benefits of PA ABLE accounts and how the accounts interact with current individuals and PAABLE accounts are important in helping individuals who wish to seek employment. And are concerned perhaps about income limits. So really important information. Really hope this information is spread widely and people are encouraged to attend these webinars. First webinar is on January 23, 2024 from 6:30 to 7:30 p.m. It is about connecting PA ABLE and work incentives for individuals with disabilities. Experts will explain the savings program and Pennsylvania's work incentive program. The second webinar is titled PA ABLE and Social Security disability program and is about working together for individuals with disabilities within the program and understanding the program. That is held on January 30, 2024 from 4:30 p.m. to 5:30 p.m. And the third webinar, is general information about learning about the PA ABLE savings program held on February 22, 2024 from 12 p.m. to 1 p.m. Additional information can be found on PA.gov website. Just type in PAABLE savings program. If anyone wants specific information, I'm happy to forward it to you. Next is the ex parte bulletin. This includes claims that fall outside the 180-day claim submission timeframe. For Medicaid beneficiaries whose Medicaid coverage for Medicare cost sharing benefits have been reinstated due to changes in the ex parte renewal process. Additionally, the second OMAP bulletin, titled Carr versus Becerra bulletin. That informs medical assist pounce vieders how it submit claims including outside the 180 day claim submission timeframe for those whose coverage has been reinstated because of the decision in the United States district court case Carr versus Bece's under 3:22-cv-09888. Those are the updates for OLTL. I would be remiss if I didn't also say that all of the topics, there are no updates for the CHRFA, for age enswi choice or PA IAB. Our team is in a blackout per period and cannot discuss that. Thank you very much and I will hand this over to Mike for our first public comment period.
>> MICHAEL GRIER: Thank you, Juliet. Any comments, questions, for Juliet? I see none. Moving forward. Jeff.
>> Good morning, this is Jeff Heisman. Question on something that OLTL recently released the bulletin on and that's the EBC compliance for 2024. Wondering if you could make any brief comments to what consumers and providers might need to be doing that's different. Going forward for them.
>> JULIET MARSALA: Absolutely. I don't know if our EBC guru is on the phone.
But I will have Paula check if there is anything I missed. Generally it is about reminding folks about home health care and those requirements. Reminding folks of current requirements for all

personal care services and home health. In addition to note that folks read that bulletin. I will take this opportunity for a reminder that within that bulletin it does specify that by January 1, 2015 the goal stated was to move to no more than 15% edit rate.
So if there is a lot of work, a lot of good work, a lot of great progress and a lot of opportunity for improvement. That's what that bulletin is about. Randy, anyone else?
Okay.
>> Just to clarify, did you mean 2015 or 2025?
>> JULIET MARSALA: 2025. Thank you, Jeff.
>> There is additional compliance on that. So we are briefly like a couple things that could happen if agencies or attendance aren't more in line with things when they hatch, with the new year, and in terms of consequences. Is there anything that, if you're not in compliance or doing more than you have been, this is what is going to happen.
>> JULIET MARSALA: So all of that is outlined in the bulletin. So what providers need to be aware of. And is as these expectations move forward, they might experience delays in claims processing if the claims aren't fully claimed and don't follow all of the requirements.
>> Essentially they may not be paid in a timely manner?
>> JULIET MARSALA: I'm glad you brought that up, Jeff. No, they should be paid in a timely manner. Providers have to follow Department of labor wage and labor laws. And so regardless of the status of a claim for reimbursement to an agency, an agency must pay their employees as they are working in federal and state labor laws.
>> Thanks.
>> Any other questions for Juliet on her presentation?
Hearing none, Jermayn, are you going to do the JF2?
>> So we have Sherry working remotely through the chat.
>> Is there anything in the chat?
>> No, we don't have any questions in the chat.
>> Thank you.
>> All right. We adjusted our agenda as you can see. We would like to offer up time for public comment. At this point of our meeting and at 12:15. Because we have a lot of presentations today. So we were -- we would like to take any public comment as of right now. If not, we will just move right into the presentation.
All right. Next up on our agenda is PAS reductions. Last month we heard a lot of people's voices. And we didn't get to the areas we were going to present. So Randy is back from OLTL to talk about PAS reductions. Or turn it over to talk about that. Randy?
>> Hi, this is Randy from long-term living. I would like MCOs to come up to the table to give a presentation. This is a follow-up from last month's meeting in regards to a general overview of PAS reductions and the affects that it has on each of the MCOs will be presenting that and we will take some questions and answers from there. I will turn it over to aher health Caritas and Keystone first. Okay I will turn it over to Ann.
>> Thank you. I will pass the ball to Olivia Martin. She should be on the call. Then I will answer any questions.
>> Olivia, go ahead.
>> Mike, she is on the line and unmuted. So she should be there.
>> Hang on, folks, we are trying to work on this.
While we wait to be able to establish a connection, I also do --
[Inaudible]
We appreciate being a part of chair and co-chair.

But I also wanted to say thank you to the OLTL team.
You guys have been just great to work with and really supportive. So thank you.
Are we close to having it?
>> Good morning. This is Olivia Martin. Can you hear me?
>> We can.
>> Thank you. Technology is always a challenge. Thank you so much for having me this morning and having our teams here to talk about PAS reductions.
Next slide, please.
Okay. So looking into the past few years, I'm going to talk a little bit about personal assistance services or past trends we have seen from MCO lens here. So personal assistance service trends did demonstrate 12.5% decrease in 2021. Less than 1% decrease in 2022. And 7.3% increase in first half of 2023.
Telephonic assessments during public health emergency reduced COVID risk but also resulted in inaccuracies due to not being able to see the participant in their environment face-to-face. So during 2020 and 2021 the decrease in adult base centers and other waiver services did increase the need for additional PAS.
That's due COVID restrictions and there is a lot impacted with the pandemic and closing of other, you know, face-to-face services. There was definitely reduced community participant and integration as well.
So redetermine requirements did create account blt with the requirement and therefore did increase compliance with face-to-face assessments. A little bit about that, we do require all assessments and reassessments so that's initial assessments and also trigger events or annual reassistments to be face-to-face. If they are done telephonically, it is considered an invalid assessment and needs to be performed face-to-face.
Okay so face-to-face assessments allow for a more tour Roy assessment and visualization of the environment. More accurate assessments can have more consistency and allow for other services to be added to the service plan. And visualization of the environment may result in additional services such as pest eradication, home adaptations, skill services, PT, OT, you know, additional, instead of just PAS. So just seeing that environment, home environment and really, you know, build tag face-to-face rapport has been instrumental in increasing the use of all services, not just PAS.
Okay so first, you are most likely familiar with the procedure but just reviewing so that SC does assess the participant using the interRAI, international resident assessment instrument, and they perform a health risk assessment and work with the person centered service plan to come up with the PCSP. There is a request to the plan. And we do have a LTSSUM team that is out long-term services an supports utilization management team and they review past and present assessments, any medical records on file and a a recommendation from a quality review lens. Lastly, a clinical review is recommended.
Okay so possible reasons for PAS reductions. So I suppose an obvious reason would be an improvement condition resulting in improved mobility and functioning. An improvement in the environment such as move to a more accessible location or addition of services or home adaptations. Any other services such as home delivered meals. Personal response systems, medical equipment, skilled care, adult day centers, community integration service plan, change in formal supports.
So service is reasonably expected to reduce the physical, mental or developmental effects of an illness, condition or disability. This is coming directly from 2023CHC agreement section 2. This is the definition of medical. Reasonably expect to prevent the onset of an illness, condition or

disability. Expected to achieve, maintain max numb functional ka pass pipt service expected to improve access to the benefits of community living. So looking at that, step 4 from the slide, the clinical review piece, you know, PHW takes a look from a clinical review lens and medical review aims to evaluate how a host service reduces an illness physical and mental health effort or is expected to revent the onset of illness or worsening of illness. Not attempting to interfere with care given by your primary care doctor. For 2023 as of October 2023, there was approximately 1500 clinical reviews conducted. And our denial rate for home home and community based service says 14% year to date.
Any questions for me?
>> Questions for PHW? Committee members? Audience members?
Anything in the chat?
>> This question comes from Pamela watts. Who conducts clinical very views.
>> The medical director team.
>> Thanks, Olivia. We have no other questions.
>> Thank you. Thanks so much.
>> MICHAEL GRIER: Thanks, Olivia, for the presentation. We will move on to --
>> Sorry, Olivia, we did just get one.
>> Okay.
>> This question comes from Janice. Janice asks the denial to thes rarely mention any other reasons you mention in them. Why is that?
>> The denial notices generally do give a reason as to the reason if there is a reduction taking place.
If you have any specific examples I would definitely be happy to look into that.
But the purpose should be to outline, if there is a reduction, the reasons why that reduction is occurring.
>> Thanks, Olivia. Next question comes from Wanisha Clark. Does the medical team come to the house of the clients?
>> No, the medical team does not come to the house of the clients. The medical team uses the assessments with the person and planning team takes a look at NRI especially to see what those functional abilities are and then also, you know, the recommendation from the SCU point being in-person with that participant. So medical directors are not in person. The SC is.
>> Thank you, Olivia. No other questions in the chat at this moment.
>> Thank you, Olivia. And we will go to next up, is UPMC. David?
>> Good morning. Senior Director of clinical operations.
A couple points just to start off. The move from,.
[Inaudible]
Servicees from telephonic to the in-person assessments, there are certainly benefits to assessment as it allows for a more visual cues to be looked at, particularly in the seen inment and functioning in the participant.
But the telephonic assessment as an option, service providers were trained to ask questions and circle back on things and ensure they were getting as accurate a picture as possible. We didn't see a dramatic swing in the authorization. Of services. And as well as just wanting to note that overall authorizations for services continue it climb up and not just personal services but actually other services within the program as well.
So just to point out, over time we start on the right-hand side of the changes in billed hours, from 2020 to 2023, and these are hours per day. And you can see that in 2020 on average billed for services, slightly decrease in 2021. Allegedly because of some of the COVID and not

being filled, people were not necessarily utilizing services because they wanted to isolate. We did see that as increase again in -- or increase in 202020 as well as so far in 2023. You can see changes that the middle column on the right where again that decrease from 20 to 21 of about 3% but increase of in 22 and 23 respectable. And on the bottom, the picture over all, not just personal system services but total package of services we saw again a similar decrease and again the impact to COVID in 2022 and 2023 and increase as far as overall billed utilization of services. Just looking at average hours of personal assistance and you can see that for 2022 is about 7.16 hours per day for participant. So far in 2023 that is increased to 7.39 and that can increase in hours for participants and that is even accelerated within the most recent one and for purposes of this chart is actually September as far as utilization of 7.67 hours per day per participant. And consistent with the chart on the right where you see overall increase in aughtlyization of the other services. So employment services, adult day services are seeing an increase in addition to the increase in personnel services. So the review of for delivering in person services includes multitude of factors.
That our service providers are working with --
[Inaudible]
And we are looking a at examples, doing screenings. And we also use tools to work with participants. How long it takes for certain activities within a day. How long to clean or do certain activities and bill out that plan for the participant. We also use the NRI is our basis for the tool that Jeff from long-term living, we use that to aassess the individual. And we also look at services for personal assistant --
[Inaudible]
We also look at if there are concerns related to employment or falls or balance. And if there is a need for additional services. And hospital discharges that might have to ensure that we are supporting the individual. So as well as cognition. Again, with additional items we are looking at. What their life planning goals are. If they have Medicare services and also services within the home for the participant. PHQ-9, which helps identify a benefit from Behavioral Health Services. As well as services for an assessment to evaluate if they need housing assistance. And in the community choices health program.
Again, different factors thatter with looking a the to make sure this is the most person-centered process possible.
We have a separate question for employment services. Home modification. Vehicle modification. If they transition out of the nursing facility and how to support them into the community and through that process.
Next slide, please.
And the overall prevalence of past reductions and even on the far left hand slide coming out of COVID where we are catching up on a number of assessments. Frequency of reductions. After we go through the backlog, essentially doing a year's worth of assessments in three or four-month time period. And they have been suspended or in that increase and following that you see a leveling out and then towards the far right of the chart you see a slight uptick of where our number of reductions have moved between the month and that is really following into enrollment into the program. And remaining fairly consistent percentage and it does track into the numbers with the enrollment that we are seeing on the home community baseline. One of the things I wanted to include is also a sample of the language and the letter that is provided to the participants that help explain why a service might be denied. A lot of the language is part after template that the Department of Human Services wants to use. We do conclude some explanations that help inform the participant as to why we are making additional and what we

see through that assessment so this is part of that, as you can see, this is a sample of partial denial of services where this is receiving in 60 hours per week and recommendation is to provide 45 hours. And the rationale concluded, is supporting a participant.
[Inaudible]
And going on to provide information about grievances for individuals. All participants are, in addition to this letter, participants also receive a phone call from the department as well as a phone call from service coordinator to explain the rationale behind a denial of services.
>> Can we go back? Approved as requested or as followed. Do you think the average person on the street --
[Inaudible]
>> Sorry. It helps if I have the mic on.
>> The language in the letters are not necessarily --
>> User friendly?
>> Yes. There is language we have to work within. So it does -- that's partially why we have calls in place. From the U.S. department as well as service coordinator, the rationale within the letter.
>> If a person that just got this letter --
[Inaudible]
>> A is not something we can change. Juliet?
>> I will go back and take a look at this.
[Inaudible]
>> Okay.
>> Yeah, we will take a look at it.
>> Any other questions for UPMC?
Go ahead.
>> Just wondering when you find a score on the general anxiety disorder or PHQ-9, how would that impact personal assistance services?
>> So by itself, an increase in whether the PHQ-9 would direct services, really look at the person at the individual level to identify with the participant and those involved in the planning process. What supports may they also be looking papt this would behavioral health. Also looking at if someone is stable from a behavioral standpoint. They can score really high on the PHQ-9, that can inform our decision as if we want to make a change to that plan because if someone is stable we tend to not want to disrupt that so they can maintain stability within the community.
>> Thank you for the explanation. Would the persons or individuals provided be informed of the individual enrollees, PHQ-9, be added to that area?
>> That is really dependent on the participant's preference on who they want involved in the process. We will not automatically share that information unless the participant can tell us that.
>> Thank you. Any other questions from community members or the audience for UPMC?
>> Hi, Mike. This we have several questions in chat.
This question is from --
>> One here in the room.
>> Okay.
>> This is a question I've been asking, with the medical review team, are they going to get any disability participation on there? I'm asking for all the NCOs. And.
[Inaudible]
>> You can introduce yourself?

>> Pam, --
[Inaudible]
>> Thank you.
>> We talked about this and we have looked into the possibility of having individuals with disabilities participate in the grievance process. For individuals for participation. One of the challenges we have run into in the past is the logistics of that because of the timeframes of the hearing. The availability of individuals as well as ensuring they are truly not affiliated with one of our providers.
Something that we have looked at and continue to look at ways to ensure we are having the most representative review as possible.
>> I know they don't have to have a connection and I know lots of people that don't want to be an advocate.
>> To Jill.
>> First by from Nancy Austin. Please confirm that the clinical review that is performed by medical director is separate are from the OLTL currently conducted in conjunction with the county area on aging offices.
>> So this is Juliet to clarify the reviews that the MCOs are talking about are reviews from person center planning and assessment process. Typically the reviews that we have talked about and presented on from the Office of Long-Term Living in the last several meetings has been directly related to the redetermination process. And is that what you are asking?
Does that help with clarification?
>> I will let you know if there is a follow-up response.
>> Thank you.
>> Next question is from Kate Blakeer. UPMC, you made no mention of service coordinators involvement in Nursing home transitions on the day of moving out. Can you provide some insight on that?
>> Certainly. Our service coordinators are heavily involved in transition process. We have actually multiple service coordinators involved in that process. In the nursing facility, there is a nursing facility dedicated coordinator. There is also a nursing home transition coordinator specifically assisting in spear heading the coordination process. Then a community based service coordinator involved in the assessment and that person-centered planning to set up services to ensure time coming out. So there are three different coordinators that are involved in that process involved in the assistance of moving from the assisted living community.
>> Thank you. Next question comes from Kelly Barrett. As general question across all CHC MCOs. Will decreases in service utilization have a negative impact on recertification, personal assistance hours for participants. Attending care workforce is still in crisis causing many individuals to have troubles getting shifts filled. This is causing problems within service utilization.
[Inaudible]
Service utilization, we do look at nicker tifs and try that for follow up with participant and as well as providers.
But that does not factor into the determination for authorization of hours. So we will look at frequency and reasons from shifts to follow up and talking participant and backup plan and for in the circumstances. And but it will not, if an aid is not available, it does not help with services authorized for a participant.
[Inaudible]
This is Keystone first. Utilization of the hours is not considered during review like David said. So

authorized hours are based on the individual's assessed needs in personalized reflective in their personal-centered service plan. That information does not attach for authorized hours.
>> This is Ann with health and wellness. I agree with David that it would not have any impact on authorized services.
>> Thank you, everyone, for your response.
Our next question comes from Amy longstein.
Regarding the UPMC slide, PAS reductions due to medical review, are the figures of people who received a denial notice or are they the number who actually had their PAS services reduced. In other words do figures include people whether they appealed or not?
>> It is total reviews. Not just those that --
[Inaudible]
>> Thank you. Next question comes from Rico shepherd.
Who is on the service coordinator ancillary team?
>> >>: UPMC has a number of teams that are available to support our service coordinators as well as participants. They could include employment concierges, nursing home transition coordinators, and we also have a home modification team as well as service coordinator associates and coordination teams.
Depending on if there are other examples of change we cannot support the participant and service coordinator.
>> Thank you.
Next question comes from Janice miner. The UPMC stamp of reduction notice does not explain what is different for the people who are approved for 60 hours in prior assessment who is now only approved for 45 hours. This is consistently when notices our clients receive say we really encourage UPMC and all plans to include a comparison reason in the notice.
Has the person's mobility improved? Has their home environment changed to better meet their needs? Has their health conditions improved? Our clients never understand the reasoning or lack thereof of denial notices.
>> Appreciate the feedback. Just that the example here is for a requested number of hours. So not specific for reduction.
But your point about explaining the difference is certainly something that we train our staff on. And identify if you have reduction to services really focusing on what has changed in the circumstances. And does it support that reduction.
>> JULIET MARSALA: This is Juliet. I want to make sure that there is an opportunity, is there a question in the chat for all MCOs, if we can hold that until after the presentation, that would be great.
>> Good morning, everyone. This is aAmeriHealth Caritas. We have questions asked in the presentation and my presentation tailors to the questioned asked. And I would like it preface that. One of the questions asked is how do we come up with the decisions, what is the process for management and has there ever been any changes in that process recently. So for this slide I noted changes for the process in 2023 in comparison. As we mentioned earlier, we do look at each individual and their assessed needs. And in relation to each participant how they are functioning, how they uniquely live in the community. And this information is given to us by the participant and their planning team. So that team consists of whoever the participant would like present for that assessment or for any follow-ups or giving information after the fact. We are using the NRI, which also produces what they have clinical assessment protocol. Which actually helps our service coordinators to identify different goals to benefit the participant and helps to recruit health or help them to prevent the client health based on how they are functioning

clinically. So all of that is taken into consideration. Some things we did change in 2023 is asking participants to walk us through their day. How are we managing? How are you getting your breakfast? What needs do you have? And just really walking us through. And that has helped our service coordinators to better plan to meet those participant needs to identify periods of time where they may have had gaps where they needed that assistance and period of times where they feel they would like to experience independence and not have help and it has helped to really open up the conversation with the participant to fully meet their needs. We also implemented the service coordinator collaboration and input within the decision-making process. And we do require that management and service coordinator within the home conducting assessment agree on any reductions before they are issued. These are some changes we did make for 2023.

If we could go to the next slide, there is some data on here and transparency in the slide because it is repeated on the next slide with additional information. So if we could just go to the next slide, that is the data remains and one of the sections we are asked is if there is impact on the assessment and both UPMC referenced changes that were in place during COVID. We have had increased in our telephonic assessments because of the people wanted to either afraid of getting COVID because of health conditions that they had. With exposure or maybe they themselves had exposure and didn't want others coming into the home. You can see on this chart, the average daily participants a day. You do see increase assess between 2021 and 2022. One thing that David mentioned is that we did do assessments at the end of 2021 in order to catch up for any business that may have occurred. We also started to increase our in-person assessments in early 2022 for them that were comfortable in having a service leader come out to their home. We did see changes in assessments due it service coordinator being out and observing participant in their need and community and we also through assessment, identify people who have other needs such as the need for home --

[Inaudible]

Having the need of talking about the personal responses. As David mentioned, he did see an increase in other services along with PAS services especially with home delivered meals an increase in the request for those. In 2023, at the beginning of the public health emergencies. We are seeing overall increase in service utilization for our CHP, LTSS participants. As Olivia mentioned, the value of the in-person assessment and observational skills and really having service coordinator able to be out there and observe the participant and just to see how they are doing and if they have any unmet needs and how we can add those to the person centered service plan.

Comparing some of the participants who received increase in PAS per year versus those who experience PAS decrease. So we did have participants who both needed increase every year and those who need, that had a decrease in PAS. And again, the decrease could have been due to the introduction of other services that the participant needed. Could have improvement. Could have returned to adult day care. Could have experienced improvement. Or they were established in one of the examples that the participant is reporting that their needs are exceeding the amount of time they are using which per the agreement is not permitted to we have some of those at times as well.

So the next two slides are reduction notice examples. They are examples, they are not actual, from actual cases. They are based on --

[Inaudible]

And as David mentioned, there is template language that we cannot use. We copied a portion of the denial. The denial letters are much longer. They have appeal rights. How to request

additional languages. Which is not copied and pasted on to our slide here but are included in the notices. This first notice is a reduction based upon the assessment and their assessed needs during their last assessment. That is based on the participant report on what they need and also service coordinators observation on the needs of that participant to function as independently as possible in their homes and in the community.
And they are included in the handout in the webinar. And on the next slide, an example of parties path reported they are using majority of their activity daily living and a reduction with the contractual requirements for PAS and having any activity within daily living that support that are in support of the PAS and they cannot compromise the majority of those services.
And I will take any questions that you may have.
>> Thank you.
>> Hi.
>> Hi. My name is Diana Mitchell. My question to you is, the assessment, the personal care assessment that you do, that assessment is done and the person that gets to decide what needs to be cut, I don't understand how they get to decide that when you have three doctors saying that she needs these hours.
But someone that has never met her, doesn't know her situation, can say, that the hours need to be cut.
>> Good morning.
>> Good morning.
>> Thank you for your question. I would be happy to answer any individual case questions off line so we are protecting any health information. As I mentioned in the presentation, we are including the decisions from our service coordinator who is in the home doing the assessment who knows the family, participant and so the decisions are not made on documentation that is just read by someone who never met the participant.
But your question sound very individualized and I would like to handle that one off line.
>> You can turn your mic on, please?
>> I have another question. The coordinator is in your house for 15 minutes, or less, so they don't know the situation.
They know what they see at that time but they don't know the full situation.
>> Thank you for your concern.
Service coordinators do come out to do checks and they Don take as long but a full assessment lasts much longer than 15 minutes. So I would like to discuss that with you as well.
>> Okay.
[Inaudible]
[Inaudible]
>> Good morning. Center for independent living of Pennsylvania. I'm coming back after being a home health care provider. I think the disconnect is we know there is a turn over with care workers. A lot of consumers fall through the cracks when there is no bridge of communication. When there is a scramble to find a coordinator no cover someone else's caseload, that when the revalidation get messed up. That's when the decrease of hours can happen. I'm curious to know what is plan looks like to avoid that in the future. Thank you.
>> Thank you for your question.
To answer your question, we do have service coordinators working in teams. We have a team that is assigned to a supervisor. A coordinator is up-to-date on the caseload of the other service coordinator. They are not going to know, to your point, as well as the assigned service coordinator. There is cross knowledge to try to avoid what you mentioned. There are certain

things with participants, like access into their home. If you need to have a code or if you need o call ahead of time for someone to be at the door, or come in through a side door and not the front door, we need to make sure that knowledge is available to others.
[Inaudible]
>> With providors, I know it is about --
[Inaudible]
But we are the person. They call us. That's why it is integral for us to be a part of constant conversation because we know participants better than a service coordinator.
>> This is not always the case but we have more hand-offs when transferring from one coordinator to another to make sure they can provide.
[Inaudible]
Make sure there is no disruptions. All of our information is contained in the electronic system, case management system, which includes as missy references, as pertinent preference, access to the house, pet information. A service coordinator picking up on that.
>> This may be to Olivia since she is closer to that.
>> All right. She lost audio. I will read it out. We had a supervisor and individuals who back them up. And so we hope that there is not any kind of loss. Always potential for gap which is where we rely on our documentation. We have a system where documentation is across the board where service coordinators assignment participant to see what is going on and they keep a log of contacts with pretty detailed documentation.
>> I know the question was directed to MCO, and I think it is important point to hone in on. And you know, it is a participant-driven process and a service planning team. And that service planning team should be numbers that the participant likes to identify and what we have included is representation from providers that know them best. Community members. Clergy. What have you.
I just want folks to really reinforce that with participants that they do have that right and it is encouraged. Because none of us really --
[Inaudible]
I wanted to hone in on that as well. Thank you.
>> Thank you.
>> Hello, my name is --
[Inaudible]
NCIU. Home health care worker. This question is for UPMC. Can you clarify for me how often a reassessment is done per participant?
>> Reassessments are completed at least annually.
But can also be interim. If there is a change in living condition or change in support force or gap in services, there is an additional assessment over the course of the year.
>> Thank you.
Hearing it said that there is a buddy team when it comes to the service coordinators and if they are shifting positions, that they speak with the person, and the person coming in after them, sharing information and saying that is standard for UPMC.
>> When possible. So the person is leaving the company may not always be possible.
But the standard is that there is a warm hand-off to ensure that we have, as seamless of a process as possible.
>> I can say that from my experience, that has not been the case. And we can say from the UPMC side, on the participant side, any participant -- my participant has not known the last two service coordinators. They were told they were leaving, so there is suddenly someone new on

her case. And trying to get in contact and we cannot. Is there any way to -- I'm letting you know that is not the reality of what participants are thinking but is there any way you are trying to figure this out on a broad --
[Inaudible]
>> Certainly.
[Inaudible]
We can address that. It is something we do, we look at similar to what was said. Within the system we can see who is involved in the case and if there is someone speeding up the process and following up and active in management of the plan and working together. And members of the team. So we definitely monitor it and want to follow up on circumstances for the process and make sure it is as possible if there is likely disruption and it n changing different coordinator and difference on to work with and make it as smooth as possible.
[Inaudible]
>> I appreciate that. And want to clarify there is no -- there may be a hand off between -- and with the participants of some heard of -- sorry, does not know who it is and when the time comes for reassessment, it is like the tools and has been on the job for less than a few weeks or a month and so is there a participant and that is clear that model right now.
>> Thank you.
I will let you guys go ahead and after when we are done. Jeff. You're up next.
>> Okay. This is Jeff from Pennsylvania. I have two-part question on employment. First part I heard mentioned, seeing more request for employment reports. I was wondering if the other two could comment or are seeing if it is increase, decrease or still the same regarding employment supports and services.
>> Good morning, Jeff, thanks for your question. Those employed and those requesting some type of service, we are seeing increase across the board. I don't have the numbers handy but we do have the numbers.
[Inaudible]
Agreeing with what we are seeing similar information but really we have a pivot in the last year, year and a half, to hone in on individuals wanting to get employed. Because they are not always great about self disclosing that they are employed. And I think there is still that fear. That fear out thereabout if I say I'm employed I lose services or my services are reduced or my Medicaid is impacted. We have to dig deep and say this does not change your services. And why do you want to know. Any support to participants out there, this is just a positive feedback item we are looking for is helpful.
>> The second part of my question touches on what Juliet mentioned about your support team. A counselor or maybe somebody else that is subcontracted or whatever from employment supports, are they allowed to be part of the participants -- at all?
>> Anybody as part of their person-centered planning team is welcome to be there and we will also outreach and coordinate and schedule on behalf of the participant.
>> I see nods from all of the MCOs.
I want to go to the chat real quick. For about 8 minutes. Because we will stay on schedule. I did such a terrible job last month of staying on schedule.
And I know we have questions in the chat.
So let's go ahead and answer them for the next 8 minutes or so.
>> Thanks, Mike. This question is from Pamela watts for missy. Please explain how the input works. If the SC disagrees with reduction, will that mean the reduction occurs?
>> Is missy. There is a meeting and most often held telephonically. The supervisor of the

utilization management and/or supervisor of coordination is on the call. If there is no collaboration of, then we have a medical director get involved.
But if the service coordinator disagrees with the reduction, it is likely the reduction will not occur.
>> Thank you, missy. Next question comes from Amy lowenstein. AmeriHealth Caritas increases versus decreases 2022/23. Does the percent total participant who PAS increase include people who are new to HCVS? In other words does it include people who have not received any PAS because they were not enrolled in the CHC waiver?
Ie, someone who moves from the nursing home to waiver or someone who is newly approved for waiver, is the percent total participation whose past hours decreased the total whose PAS was actually decreased. If so, what percent of the total HCVS population were sent a notice proposing reduction in each year?
>> Hi, so increases do not include those new to the program and those who receive an increase in their PAS over an established baseline, and the participant to PAS decrease are those who actually experience a decrease in their care.
>> Thank you, missy.
>> I think there were additional data questions that we wouldn't expect her to know off the top of her head, Amy.
But perhaps she can follow up with you afterwards.
>> Next question comes from Janice minard. AK example discussion states that you self reported the time needed for each task, clients report to us they are never asked by their service coordinators for specific times for tasks making the notice very confusing. This is problematic.
>> Is missy. Thank you for the feedback, Janice. I look forward to you reaching out to me so we can discuss these examples.
>> There are more questions in the chat but not specifically for missy. So we can ask them during public comment period.
>> Great. Lloyd?
>> Hi, Lloyd here. The potential of a service reduction recommendation coming from someone other than the service coordinator. I got the impression that UM can recommend something and service coordinator can agree or disagree and then based on that decision. How does that happen?
>> The documentation regarding participant's request. We may have a participant ask but that's an extreme example. Asking for 24-hour care but not have any supervision needs for 24-hour care. Coordinators establish with the client that it is not aligned with the request of 24-hour care. And they may still insist that request goes through. Based on the documentation that is provided for review, the decision would be made to not grant the 24-hour care because it is not supported by the assessment.
>> That is reasonable. However, is it possible -- I'm just trying to figure out how a UM group could make a determination about service reduction in less than obvious case than the one you just presented. That doesn't include someone from that UMP having been in the environment where the consumer lives.
>> Great point, Lloyd. Sorry for missing.
We did implement that feedback loop frommer is advise coordinator for that very reason. Th service coordinator in the home, the assessment of the environment, so there is not a decision made unless there is a current UPMC.
>> Thank you.
>> Sure.

>> Any other questions from the audience for committee members? Thank you, all. That being said we will move on to diversity, equity and inclusion, Jill, are you there?
>> Good morning, everyone.
Yes, I'm here.
>> Great.
>> Good morning, everyone. This is Jill Vovakes. I'm director for quality assurance and program analytics at Office of Long-Term Living. And it is my pleasure to kick off the community Health Choices presentations on diversity, equity and inclues.
Today's presentations will provide some background on expectations that the department has for our MCOs with regard to health equity accreditation and staff in each of our take to ensure equity for participants. So I believe we will hear in order of UPMC, PHW and AmeriHealth Caritas. Not sure if I'm handing it off to Mike. I didn't see Mike on the line. I don't know if he is in the room or someone else will be presenting from UPMC.
>> Hi, Jill. This is Mike Smith. I'm in the room today.
>> Awesome. Thank you.
>> Happy to join the call.
Next slide.
So happy to have this conversation, OLTL, I want to thank OLTL and the committee for having this discussion. I know we tried to have it on the agenda a couple of times. And I'm looking forward to talking about what we are doing in some space. UPMC has earned accreditation and health equity and health equity plus from UPMC. And there is information on the slide that it really is about us embracing the diversity of our staff and the people that we serve really to help just attain the highest levels of help possible. And we really focus on our internal culture as part of this accreditation process.
If provides a framework for health equity that means we have to understand the population we are serving and that graphic from those populations offer language services and have providers in the network with the diversity of the people we are serving. This includes staff and in these meetings but our staff reflect the community and so you know, populations and go versus somewhere in Clarion county will be served by participant and staff that reflected the diversity in these community and often times speak the language that they speak. So we have Russian speaking service coordinators, Spanish-speaking service coordinators and so on. So we have the ability to communicate whenever possible. And it is not every single case.
But it is our goal to create a health plan that we address as diversity of those reserve. We have a council and they regularly meet with staff and with the staff on that council to basically to address diversity and inclusion, health equity, and part of the plan with this status as accredited agency. And to accreditation and health equity and, next slide, please. So obviously, UPMC staff training plays a major role. We have a lot of information on this slide and I will just highlight a few. We have additional help cultural competency requirements but we also have done culturally informed approach to MLTSS and to really dive into refugee and other populations in the state of Pennsylvania that have specific cultural diverse approaches to care in their community so we can train our staff specifically on that population. We have gender affirming trainings part of our efforts as well.
So we have employee, an employee resource group that helps our staff address projects around health equity. And diversity inclusion in the workplace.
We have a mentoring program. And that I participated in and mentor mentee type of training and working with staff.
Beyond the plan, you know, itself, we have staff, contracted providers who play an important

role in our delivery system and I want to mention this is not just like broad base of providers and that we provide training and for these providers to address cultural competency.
Some of that is increased awareness of cultural diversity.
We make sure that they have language services available. Help with racial and cultural differences. For the people that we serve, sometimes health care providers, we do some specific training with them. Around the populations that we serve. And so that we are making sure that they understand diversity and cultural needs of the people that are in the program.
Federal regulations require language service available. So anybody on the call today needs to know that if you are not getting translation services, whether AFL, sign language, American Sign Language, ASL, or other materials in your preferred language, you can certainly request those as needed. They can also translate written materials as well, including discharge notes, education and things of that nature.
We have providers who are in find my care directly that are identified as LGBTQ IA + affirming providers designation and other designation regarding language and things of that nature are available for providers.
So in terms of eliminating efficiency, there is a topic to make sure we are covering here. It is not just training for service coordinators. This goes to teams that they mention as well. Right? So home 3-D based, home modification teams, people doing housing outreach and employment concierge, all of those folks are aware of the limiting language efficiency requirements and must be taking advantage of those things. This includes folks on telephone lines and do utilization, pharmacy, anything engaging with us, should be actively pursuing or using those services.
In addition, service coordination, you know, has the ability to have conversations over the phone with folks in the language that is appropriate to them. If they don't already speak the language. They also can schedule ASL, American Sign Language, folks to be participating with them in the community if needed.
And looking for providers who --
[Inaudible]
Because of other individuals they are serving when possible.
Participants. We have folks engaged in the community engagement program, and we, recently, last fall, had a Spanish-speaking event, all in Spanish. And we will plan for more of those types of events.
Next slide, please.
And I think I skipped ahead some of that information that we just talked about.
Here in terms of the special event we are doing. I will mention, it is not just about events and staff and this type of thing. It is also Handbooks. And benefit guides. And things of that nature.
If you have something you need, we have we can request the translation of anything.
Sometimes it takes longer.
But we have about 7 or 8 translated languages for almost every document. And then you go out and get translation on additional documents.
Next slide, please.
So really wanted to talk a little bit about, in this slide, what I have already mentioned here, is that reflecting culture and language and background of those in the area we serve. We are very proud of that. I know we talked earlier today and I'm anxious to get together with David and speak with the staff person who mentioned the turn over in staff because we have a pretty good retention of our staff.
We are growing fast.
As we grow, we bring along the act that reflect the cultures and those that we are serving and

sometimes that growth also leads to, you know, disconnect service coordination as well. So people that are leaving but also the number of people we are serving is growing.
Last thing to talk about is applying for the NHT program. We have a story of how we work with an NHT participant who is Muslim and they are meeting with a provider and learning about the customs and nursing home transition coordinator and staff were learning about their customs. Thing like knocking on the door before coming in, giving her time to put on her hijab before being in the presence of a male. So we can take questions. I will be around to take questions.
>> Go ahead.
>> Considering that 15 or so percent of our population is black and about 3 or 4% of our population of community psychiatrists are black, how do you deal with a person who requested services with a person who looks like them? For your clients?
As you know, that is a difficult question to ask, in that a lot of services provided are under Medicare as well as behavior health MCOs. We try to make sure the provider network is up-to-date and has information necessary for folks to have folks that look like them, have a background were their back ground as well.
It is a bit of challenge. We're not always the primary care of services. We have MCOs connect with them.
>> So what do you do to try and increase that availability in the areas you have the services.
>> I would have to get back to you on that, Lloyd. Thanks for the question.
>> Any other questions from community members?
Audience?
UPMC?
>> Hi, this is Barbara Robinson. The meetings that I go to, I really do like the collaborative effort within the community. So I appreciate the PAC meetings.
>> Thank you.
>> Anything in the chat for UPMC?
>> Hi, Mike. Yes, we do. This comment comes from Kate Blakeer.
UPMC you stated that service coordinators know the participants. I've had at least three service coordinators in the past year and my recent one I've had since September and I've yet to meet them.
I'm sorry. When I asked for a supervisor I was told I couldn't speak with a supervisors.
>> Kate, that sounds like a very specific issue and concern you are raising here. That would not be the normal process for participants in the community.
To not have at least received the opportunity to meet with their service coordinators and you should have received notice by mail as well as a call to you to introduce themselves. Then ultimately, they do have a requirement to come see you in the community if that's what you would like. Prior to your next assessment.
That would be more of a warm welcome. Then requesting to speak with their supervisor should be something available to you. I will have to get more information from you specifically to your circumstance.
>> Thank you. There are no other questions in the chat specifically for UPMC.
>> Thank you. Is Olivia doing this one?
>> She is. She should be right there. Olivia can be can you hear us?
>> Olivia, are you with us?
>> She can't get off of mute.
>> The back up plan was for her to call in.
But I can start

>> Sorry, can you hear me?
>> There she is.
>> Oh, my goodness. I apologize. And I just want to apologize to the entire group. I did intend to be in person today. Family emergency is keeping me close to Pittsburgh at the moment. So please, I do apologize.
Okay.
If you can still hear me, I will kick this off and talk a little bit about DEI or diversity, equity and inclusion training that we do require of our PH study staff and service coordination teams. Okay. So this first inclusive and responsible works place enables employees to identified the workplace culture and implement the core values in their everyday work, and interactions by number one understanding personal responsibility for maintaining diversity, equity and inclusion in the workplace culture. Preventing interactions that could put them or organization at risk including harassment or discrimination and resolving situations and providing solution based items. Second traching doo DEI and authentic allyship to action focuses own defining allyship and understanding what it means and the role and purpose of allyship and tools and resources to identify allyship skills. And i want to state for the six trainings listed here, these are required upon hire and upon annually. Excuse me. The third training culture of humility and health equity, allows us to empower our staff to serve each other and our participants. Unconscious bias. I guess we are all a little bit unconscious bias. Such as race, ethnicity, gender, height, sexual orientation, place of birth and a multitude of other factors of the lens in which we view the world. We are trained to recognize, acknowledge and recognize our own bias when engaging with participant and working effectively within the community and our teams.
Culture awareness and sensitivity. It does focus on cultural consciousness across areas including race, ethnicity, language, sexual orientation, age, class, education, gender, religion and how that impacts health care.
And lastly, cultural humility, building on the foundation of competency. Basically how it relates to cultural competence as a foundation. So considerations relating to the role biases, having decision making is a really big focus of this training.
Okay so PHP has what we call EIG, or employee inclusion groups. We have multiple employee inclusion groups local and then we also have it at the corporate level. We encourage our PHW employees, staff, all of our staff service coordinators to be a part of these EIGs we call them. And right now I'm just didding to highlight five different of the EIG groups we have. First one is addition so the mission of people with disabilities and caregivers, employee inclusion group is to support and enable employees to use their full potential in the workplace. There are still mas associated with people and disabilities and caregivers and to expand on the knowledge base of cultural competency throughout the company and enterprise. Our next EIG is base CENVET. It extend to our workforce. Vet advance and military families include group, CENVET is for employees who served in the armed forces.
This touches upon conversations that may be helpful and beneficial and different approaches when speaking with some participants who have a military background as well.
CPRIDE, supports and inclusive work environment for lesbian, gay, bisexual and transgender to bring their full selfs to work. And also it results in enhanced interaction is that we have within the community and raises awareness of some of the considerations that we need to be aware of for our LGBTQ IA plus communities.
Inspire. PHW's women inclues group inspire aims to help professional and personal goals at all careers and life stages. This targets tagger el development sessions and mentoring as leaders and help them take on all levels of leadership in a company. And lastly, mosaic. Through

networking, mentoring and coaching and has awareness and supports employee engagement and retention.
This is where I'm just going to spotlight a few of the provider trainings and some of them I did review in the previous slides.
The first unconscious bias, addressing our own biases when making decisions working within the community and also engaging with participants and the cultural awareness and sensitivity training and focuses on cultural consciousness. Across multiple areas. Such as race, sexual, race, gender, education and how it affects experience of health care. Lastly, cultural humility. This is building on the foundation of competency. It designs to create practical concepts of cultural humility and cultural competence and the role of the biases that I spoke about before having participant interaction. These trainings are also done for onboarding. And also, annually these are required from our providers.
Okay, looking at PHW language services we work with a few different providers that serve us for language services. Biggest provider would be offering interpretation, video interpretation, phone interpretation in over 200 languages and also American Sign Language as well.
Okay. Health equity lens. What does this really mean? You know, basically, it is an understanding and awareness that long standing system has population groups at risk of getting sick, poor overall health and worse outcomes when they do get sick. It is a look at potential positive impacts with messages made and how that impacts our participant experiences. And stakeholders such as community partners, participants, providers and our staff.
Helps us realize this health equity is not a program. It helps people receive the opportunity for their full health potential.
I know Mike Smith from UPMC touched on this in the previous presentation.
But achieving health equity accreditation. This focuses on the foundation of health equity work. Building internal culture and collecting data and helping the organization create and offer language services and mindful of this linguistic needs and identifies opportunities to reduce health inegg wets and i improved.
PHI, the name has been changed and some specific cultural experiencees have been changed here.
But it does reflect a real journey here.
So this is Raisa. She is an older adult. Ukrainian American participant who recently moved to the southeast area of Pennsylvania. She does have a history of below amputation of her leg due to a trauma. She has rheumatoid arthritis and depression. She does not have local family, or any ow srt she wishes to be part of the center planning team. She does request a Russian speaking service provider.
Over the course of her time with Raisa she sat with her and learned about her past, her goals for the future. And also, she discovered that Raisa only left home on public transit for trips to the doctor or local grocery store. She had limited interaction. She also has no support or family nearby. Delivering meals to enable her to call for help if needed. She discovered she could benefit from support due her decreased mobility from the amputation and rheumatoid arthritis. She was just fit for a new prosthetic for her left leg. She needed personal assistance to help with that adjustment as well. She initially refused assistance help due to being new in the community and fearful of new people and she might be misunderstood. She was able to hit Raisa's agreement to assistance. And specifically speaking Ukrainian.
Then a service coordinator connected her with a local cultural center that offered things for seniors. She is involved with other activities for her connections at center. Also noticing that Raisa can benefit from a home modification 37 the bathroom was tight and the placement of the

sink does not make room for a shower chair. SC arranged for home assessment from the therapy vendor using video translation services and also made herself available during visit as well. Raca is undergoing a bathroom adaptation for use of a shower area.
Next slide. I this I that may be it. Yes.
Any questions ?
>> Thank you, Olivia. Any questions for Olivia from PHW? From committee members, audience. Anything in the chat?
>> Yes. This question is from Kathy.
>> Is anti-ageism a part of your curriculum. If not, how is trained upon staff?
>> I can get to you on trainings we have regarding angism and Anna Keith may be able to expand on this a little bit.
But on one of my slides I did speak about kind of in-depth about our employee engagement groups. Our EIGs. Employee inclusion groups. We have a new one that just rolled out this past summer and it does focus on multigenerational topics. So not just ageism but also just different generational differences and how that looks within the workplace and for our participants.
>> I can jump on that one. I can talk about DEI most of the afternoon. I get excited about it. I have been President of the PHW the last three years. We hold out stages, intergenerational employee inclues group. It helps those of us that are both getting closer to 60 or understanding young irgroups as well. Millennials, Genxers. Genzers. You see through a different lens and this is impactful. So in doing a lot since activity and understanding for different generations that we interact with daily.
And how to be more sensitive and accepting of differents in those groups.
>> Thank you, Ann. Anything else in the chat?
>> This is a question for all MCOs. With equity and inclusion, are there service coordinators with disabilities that work with the consumers with disabilities? I cover that a lot that they understand or if they feel intimidated when they ask for something.
I don't think I have ever seen that. I know there are different cultures but also disability of culture.
So just asking a question.
>> Let me grab that one first.
>> We would welcome individuals that have disabilities that would be either individuals of lived experience or service coordinators where often seeking individuals with different background to be employed in those roles.
But always welcome ideas for and we work closely with our selves so we can reach out at any time.
But we really encourage folks of different backgrounds and ability levels to apply for those issues that we open. Very valuable.
>> Is Mike Smith from UPMC. Yes, we do have individuals on our staff and we actively recruit people with disabilities through the disability employment program that we run at UPMC. We are actually looking for folks that have lived experience to be part of the team and we have a number of folks with devices and to navigate the community as well as service coordinators with differing cognitive and other issues that would typically without training and support make that a more difficult transition.
But we do do a lot with that as part of our efforts. We we are excited. I agree with Anna, we are always open for opportunities if you come across somebody. That's one of the things when we are asking about employment opportunities, with participants and learning about what they want to do and what they don't want to do is, thinking about the opportunity. There is a lot on-line

now. That you can do virtually.
So there is numerous opportunities.
>> Thanks for your question. We have a variety of service coordinators in place. I don't have the number offhand. There are some service coordinators that are on disability but like Anna said we do encourage people of all backgrounds to apply. So you know, if you are here and you are interested in that position, by all means, we strongly encourage them to apply.
>> I would just add, and not even just service coordinators, we have folks in department across the organization, interest are opportunities.
And we have a director if training for all of our staff.
>> We are in the field and we don't understand and you hear those things. So you know when you try to bring 10 people together with the same background and have the understanding, that's why I ask the question.
Thank you, everybody.
>> Thank you.
>> Thank you guys for responding.
And we will turn it over to AmeriHealth for the last presentation.
In the diversity equity and inclusion.
Just so you guys know. You will have about 15 minutes. P we are trying to get through, we are trying to get everything. And if we have additional questions we will do it at during public comment.
I will turn it over to AmeriHealth.
>> Thank you, Mike. Thanks for the reminder on the time limit. We have a team on-line that are in today. We have on the -- she is not here today. Julie Ann will take over for her. We turn it over to Julie Ann and Rachel.
>> Hi, this is Julie Ann. Are you all able to hear me?
>> We can hear you fine. Thank you.
>> Thank you.
If you could go to the next slide, please.
So to review for AmeriHealth Caritas, our staff training overview as an organization we do use a learning management system that allows us to assign, register, monitor, track and report training outcomes.
The diversity equity and inclusion training topics are assigned to all new associates upon hire. Additionally specific annual training topics are assigned to new and existing associates.
As an organization in the health plan we have a vast amount of training on topics of diversity, inclusion, equity, belonging and other topics such as disconsider imnation, sexual harassment and hostile work environments. This is for associates and leaders. You will see as we go on that some coursers are very specifically for leaders other are for all associates.
What I talk about in the first bullet point that we can register, monitor, track and report, literally our learning management system does allow us to do that. Supervisors, managers, directors, can run reports from the system to determine that all of their direct reports have completed annual or required trainings.
And we can report out on the two different areas of the company or out to the state if required.
Next slide, please.
>> Okay.
So diversity, inclusion and belonging, this is an on-line course. It is assigned at hire and it is for all of our people leaders. And the training explores the approach to help leaders discover how to activate within their teams and why it is important to our business.

Other required courses, we do have a culture and linguistic service. Training class. This is an on-line delivery method. It is required of all of our associates and it is required at the time of hire.
So this training very specifically is going to overview cultural competencies, language barriers. Language barriers and health. Health literacy and class standards.
Next one that all associates are required to do at hire is health equity training. This training makes you aware of health equity, along with health disparities.
Next slide, please.
Two more of our required courses. Both of these are required at hire and then annually.
They are both on-line courses and they are required of all associates. First one is health equity and cultural responsiveness. This is a training class that continues our bath towards health equity and is a continuation of the health equity and class and cultural health work screenings. It provides you with an overview of health disparities and how AmeriHealth is addressing the issue. We also have a roycing and reducing bias. Again, on-line course all associates at hire and annually. And it does provide an overview on bias, ways to reduce its impact and how it impacts health outcomes and equity.
The associate guide book is very important to associates. It is at-hire and also annually. This is also on-line. Training provides access to all of the AmeriHealth policies and procedures and along with requiring the employee to read the whole associate handbook they do have to attest that they have read and will follow the rules of expected behaviors outlined in our so Isate handbook.
We also have civil treatment workplace for employees. This is on-line and also in-person upon request.
The training is designed to provide employees with an understanding of why creating a civil workplace is necessary during the training associates will discover what it means to have a workplace that guards against discrimination and harassment and how to create an environment where everyone can feel safe and received. They will learn how to speak up to address concerns. Before they become an issue.
Very important. Next. Now this is for all of our people leaders. And this is required at-hire. Civil treatment workplace for leaders. Again, this is one of those classes that is on-line but upon request it can be provided in person.
So it is designed to provide leaders with an understanding of thement responsibility in creating a civil workplace.
During this training leaders will discover why they are responsible for creating and upholding a workplace that guards against discrimination and harassment. They learn when, where and how to address issues upon they they become workplace violations. Additionally, leaders will practice how to create an environment where everyone can feel safe and importantly, accepted.
We also have sexual orientation on gender identity class. This is an in-person class. It is led by certified facilitators. And it is recommended -- not recommend ped tp is is required at-hire for all members and providers associates.
For people leaders, we have an inclues of leadership training p tp is on-line. It is available 24/7. And it is a recommended training for our new people leaders.
Another for all of our associates is on-line. So available at any time. Skills for inclusive conversation. Communicating about culturally sensitive issues. This is for all associates. And because it an on-line class is it is important to associates any time day or night.
Now I will pass it off to Rachel D.
>> You can hear me okay?

>> Yeah, we can hear you fine.
>> Hi, my name is Rachel D. These next two slides are for cultural competency requirements for providers.
Providers need to understand there are many things that can impact access to services.
If a participant is inned into the of translation services, the providers does have a responsibility to make arrangements. In addition, to ensure there is no gap related to this, a plan utilizes language servicees soates of language service chess network providers can the opportunity to utilize as well.
We also look to contract with providers of many different background if a pr tais Pate is not interested and they can have the service coordinator know so those providers can be shared with participants.
Participants can be contacted to utilize help and translation services or in living interpretation is available upon no cost. It is requirement that network providers offer interpretation services and is prohibited that the family memberring the interpreter in lieu of interpreting services.
Interpretation services must include all services. As mentioned previously, we do contract with providers on many different backgrounds. Those who wish to po choose providers and particular background or language can reach out to specific services or coordinator for assistance.
The health plan also provides opportunities for providers to receive free continuing education credits and on-line sources.
Training specific to those needs of those on the LGBTQ AI + community available on owb website as well.
Management educates on items. Written and oral language assistance is available at no cost to participants. Participants are notified in their language format about assistance services.
Providers have post and offer asy to read signage in the common culture of groups in the providers service area. All documents must be available in requested language or for hot.
This includes tookments such as patient information forms and consent forms.
Providers are discourages from using family as oral translators.
This helps ensure that all information is conveyed impartially. And finally translation service says available through the health plan if needed.
And I will pass this on.
>> Hello, you can hear me?
>> Yes we can hear you fine.
>> Hi, so my name is Laurie, I'm one of the managers of service coordination for AmeriHealth. I know we are running out of time. I will be brief and share one example here. I would just like I say we have a very -- regarding staff and coordinators are positioned well to assist participants with wants, desires. You know, for culturally competent care that meets their needs. So just to give the first example on this slide that is up here, this was a participant that was receiving an initial assessment. So following that initial assessment we had 73 participant who expressed preferences for service delivery and was ultimately assigned rush grab speaking service coordinator, attending a Russian based adult day sent earn received Russian meals as part of their approved home delivery meals. Sorry for running out of time here, but for you all it see what we do work with our participants to identify what their wants and desires are and try to meet the needs through service provision. That's it. If anyone has questions for our team we will be happy to respond.
>> Thank you.
We will probably pick up questions during public comment section of our meeting.

But I thank you guys for being sensitive to our time since we have so much to cover today. Next up on the agenda is women's health initiative. Dr. Appel.
>> Hi, good afternoon, everyone. Almost afternoon. Any my name is Larry Appel. I'm medical director for Office of Long-Term Living. I'm joined today by my colleagues medical directors from each of the Health Choices plans.
And we are going to present to you an overview of our health initiative work which began last year. And you know the focus on women health initiative began as we were able to finally in 2023 turn some of our attention away from COVID-19. And really focus on some of the other really pressing stuff that were both national and common wealth and CHC program. And so really devise a new approach to some issues related to women's health. We saw there was a huge need for that. Certainly nationally.
Certainly nationally, of the 48 million seniors in America in 2016, about 5% were women. Women have a higher life expectancy than men by about five years. And in the CHC program 59.6% of participants, and so as in our population, we notice that women have the propensity to develop needs related to chronic health problems in their later years.
So what we did which is unique is we started with a different approach to data and our goal is really to define populations that were at high risk for disease processes. And that we could do something about.
And manage. And prevent quelling from p.m. so we use the assessment tool quite extensively. In 2023 we began this and now this journey towards excellence in these areas is continuing. We focused on three key areas affecting women. Cardiovascular disease. Osteoporosis. Specifically fall and fracture prevention. And screening and biopsy for breast cancer.
When we talk about cardiovascular in women and why? It kills more women than all forms of cancer combined. Only 44% of women recognize that cardiovascular is their greatest health. Hypertension, high blood pressure, is very, very common. 51.9% of high blood pressure related deaths are on women. Out of all women, 5.6% of black females have hypertension. That's more than any other race or ethnicity. If people just don't know that they've got it and if they do know they have it, it is just a number. It doesn't mean anything.
They can function, move about, function this their daily lives. Not real eyes how much this blood pressure is contributing for kidney, heart, lung problems and strokes. And huge strokes and not so huge strokes. This is why we started focusing on this. And to identify populations and our health plan are doing a lot of work in making sure that appropriate referrals are done and appropriate materials and education are available and blood pressure ares are coming down.
The second area we focused on is osteoporosis. Focusing again on falls and fractures and why? It is common in wrist and spines and estrogen as we know in women helps make and rebuild bone and estrogen levels drop after menopause. So I know osteoporosis is most common in older women. Over the age of 50 most people have osteoporosis and have fractures 5 to 10 years Earl year than men. 27.9%, 615,000 older adults fell and went to emergency rooms. Very common problem. With falls and fractures and osteoporosis and great work has been done so far and with more to come on identifying those at highest risk for bones and fractures. And preventing that. The next area is breast cancer. It is very common as we can see. The rate per hundred thousand women in Pennsylvania is 12 9.7. Nationally, that's little bit below the national average. Nationally 129 and we are at 121.
Go two slides.
As you can see on the map, he are blue and we have a lot of breast cancer.
There is a lot of work it do to make sure that those who need screening get it. And those who get the screening, get a biopsy. A lot of great things can happen in those biopsies are done

timely and a lot of knew therapy in terms of chemotherapy. Minimally invasive surgery et cetera. Developing with biopsy. With that in mind.
Next slide.
Again, just the rate. And one to two. Turn this over. We can take questions at the end. I will turn this over to Dr. Erica David-park who I believe is on the line. She can present a little bit about AmeriHealth. Dr. David-park.
>> Thank you, Dr. Paul. Can everyone hear me?
>> Yes.
>> Per. Thank you, Dr. Appel. This focus is a really important one. I'm thankful for what we and our health are doing for this initiative. Today we have decided on three a topic areas to focus on cardiovascular disease. So just to give bullets on the overall cardiovascular approach. First off we will start with the assessment on the clinical assessment pro calls known as the cast. I will talk more about that later in the presentation.
We approach service coordinator education. That's a key component there. We use data analytics to pull everything together. To tell you about the CAPS are a clinical assessment protocols. The way it works is that the clinical assessment protocol are triggered using specific assessments itself. I will show an example in a moment. When we are looking cardiovascular disease there are responses to particular questions that are pulled into the service plan. During time plan process and based on answers and responses to questions, those are a potential if are a goal. So at that point if we get that information, service this enwhat as discover and can talk about the response of creating a goal. Consider y that would be Ben personal to them. Why that is something to think about and work on.
If a participant agrees on creating a goal, whether something vfing blood pressure or stroke prevention, but what is agreed on the goal, the goal is created and of course incorporation, work with a primary care practitioners and improve cardiovascular help overall. This is an example of why some of the questions that can result in a trigger. If someone has had their blood pressure measured offer the last year and if someone says no and they have not had it measured that's problematic.
Then you start putting together goals. Same thing for stroke. Someone with prior history of stroke, then we can also get this CAPs triggers and get discussion and on the educational documents surrounding stroke prevention.
To tell you p our handouts, we use the responses. And based on the response, if there is something that is a potential area of concern, the service coordinator can then provide cardiovascular health handouts directly to that pr tais pant. So the handouts contain very specific information but the main points of them are so promote health literacy. I think knowledge is power and making sure participants understand conditions and if they have cardiovascular disease and understand riskes a enthings they can do to help themselves. That's a key component.
A key important component is always following up with their p physician. In addition to providing handouts, it is important to hair the handouts with healing care workers. It is an important part of it. Wasn't to make sure it is not just the parties Pam. It is a team approach. Making sure the pair it is pant is sharing with direct care workers and with full support and make sure that everyone is part of the team and that they are getting the right education. And understanding to try to tackle that condition.
So some work we are doing as whole, I think at AmeriHealth, home ec wit is part and parcel of what we are doing.
Now just for understanding, there are clinical studies that have racial and ethnic disparities.

So because of that information and that we have the disparities that control is not as good, and in these two particular groups we have done a few things. One of this ch is using text campaigns targeting African American black and there Tino participants. So having specific notice we noted there are these inequities. We are in community events with strong afterly can American and Latino press pens many we work on education and awareness. Instead of a general approach we make sure it is very specific per culture.
We have emphasis.
>> Just a second.
>> She needs to slow down.
>> Okay.
>> Could you slow down just a little.
>> Oh, absolutely.
>> Absolutely.
>> Thanks.
>> Very welcome. Thank you.
>> So next I want to tell but a pilot initiative that we are working on that also is surrounding controlling high blood pressure. This is controlling high blood pressure initiative. And standing for health care effectiveness data and information set and it is away of improving quality overall. This particular initiative is a pilot program that is 77 of our participants in southeast and that fit into the following criteria. These are individuals who are afterly can American females found to not be client in the heated measure for the past 2 or more years. It is essentially to keep blood pressure underrates of 140 over 98. To control their blood pressure. And they have not had control. We also look at documentation with health literacy and those not compliant with medication. So in this initiatives what we are doing a targeted education to both participants and what this does is includes blood pressure monitoring for self checks. We encourage individuals to check their own blood pressure and share this information with their primary care physician. In addition we encourage if someone does not have a blood pressure monitor available he have the ability at the pharmacy benefit so they can check their blood pressure at home. In terms of adhering to medication, there are box to use to keep track of medication and make sure they are taking their blood pressure medicine appropriately. We also created a provider toolkit along with health equity team that is really educational for their primary care physicians and so this information gets to them and gives them culturally specific education to help use to help. We hav educational documents that are specific to this population. Next slide, please.
At that point I think we are leaving things for questions at the end. So if anyone has any quick questions, feel free. Thank you again for your time.
>> ThThank you.
>> We don't see any so we will go right on to UPMC.
>> Good after continue, everyone. This is Dr. Clark. Are you able to hear me?
>> We can, thank you.
>> Wonderful.
>> Thank you for having us here and thank you. I'm Dr. Clark. Thank you, Dr. Appel. If we can go to the next slide.
We were very excited to help about the priorities identified by OLTL in 2023. And on this slide, there is a pie calculator that basically shows many of the areas UPMC is focused on in women's health, breast cancer, cardiovascular, bone disease, falls, follow-up, maternity mortality, incontinence, urinary tract infections and dementia and memory loss. This dove tails nicely with the priority areas that OLTL is focused on, breast canser, heart disease and osteoporosis and

falls. As my previous presenter said, health equity has to be at the center of this. We do know that women experience even with heart disease which is a primary killer in men and women, women experience heart disease differently than men. As Dr. Appel said, later in life but also after a severe heart attack for example women are more likely to die or survive the heart attack but develop a heart fail tour after a severe heart attack.
So you deal with the same disease, based on gender, age and race and ethnicity. If we look at breast cancer and UPMC population, we did see a lower screening rate in our nursing facilities, compared to those of us participants in the community.
That is not surprising. As women get older and it a certain age, mammograms are not recommended by a certain age group by. With still see an opportunity to close that gap in the nursing homes and improve our rates in our community baits participants. We also note there was a gap that enlarged during COVID when many elective procedures like mammograms had to be postponed.
But we are making up grounds in those delays that occurred from COVID. That was a national pattern. That wasn't just due to UPMC.
Some of the things we are doing to close and improve breast cancer screening gaps we have a gap and care tool that our member services team so our call banks, when any time of our members call in, they're screened and we look at a screen to see if there are any health screening services that they are overdue for and we can talk to them about scheduling those or just reminding them that they are due or it is coming up or they are overdue and how to get the screenings scheduled. We send out blaster calls for breast cancer screening. To remind members and they can press a number from that automated message and be connected to someone that can help them schedule.
We also have regional programs that were developed. One in Pittsburgh area and Medicare faith and wellness program. And this was something that we piloted and really took off with the church base community called ma'am and blam we we talked about breast cancer screening and included it in a porpoise experience. You know, make up and fashion and that type of thing. It became part after real positive experience and we've had great success with that looking to see how we can you know extrapolate or remove that successful approach into other areas of the state. We also remind our special needs because they are Medicare product pe have access to incentives for getting basic trainings so we have that as well.
For cardiovascular again, I won't repeat statistics but controlling blood pressure is one of the most important thing to do for cardiovascular health you can do. The first thing and most important thing. And it does fall along racial and ethnic lines as far as the need for better control. So we have done a number of things trying to help providers, remind providers with hearing to standard of care around cholesterol lowering drugs, stattens.
When we see there are differents in performance I wassed on national standards. We are also looking through our health record to look upon blood pressure readings that are out of the range and look at conditions we can manage even we have also done pharmacy initiatives to look at our participants that are on a number of medications. Usually more than 10 to see how we can line up and ensure that they understand which medications they should be on. How to prioritize the dosing. How to get rid of medications they may be taking inadvertently that they shouldn't because they had them at the house and didn't realize they should no longer not taking the medications.
In our bone health and fall prevention, we do have more women in this program, women fall more primarily because they are with us longer, they age longer. We launched a falls initiative about two years ago because we had great information about falls. The great information is one

fall is a predictor of another fall. We use information to send letter toes participants helping them understand that they are at risk for another fall. And what things that they can do on their Joan to decrease their fall risk but also things that we think would help for them to do with their primary care provider and with us for example, talking with your primary care providers about medication make sure that med considerations that doses timing are not causing or increasing your risk are imbalancing falls. Also because we have great benefits like home modifications, to take with the PCP, primary care physician, whether whether you need therapy, occupational therapy evaluation, maybe you would benefit from a home modification, grab bars with be if your balance started to decline because of your age.
>> Pardon me for interrupting. p but we have another group presenting after you. I was wondering if it would be possible for you to move to your priorities for 2024.
>> Absolutely.
This program is very successful. We plan to give this to folks who have not fallen yet. We collaborate across the entire health plan. We learn a lot from members. So we want to see where their opportunity are expertise that we have may have gained in other parts of the state. Medicare, Medicaid. And also we want to many research best practices and innovation and develop a more after continuous improvement model.
When we start a project with falls, what works well, how do we improve and how do we share what we learned across the state? We also want to find a way to improve all of this communication to key stakeholders, including participants.
And our participant forums.
But we like to find a by to do more. I will end there. Thank you.
>> Thank you for your flexibility. I will turn it over to PHW.
>> Karen -- can you group hear me?
>> We can.
>> Thank you.
Appreciate everyone allowing us to speak on this important topic of women's health.
As as mentioned in the DEI and colleagues noted, focusing on assessing and monitoring participants through health equity lens. We have an awareness that there are says stillic social and health inequity have put some population groups at increased risk. We know there are key disease affecting females which account for about 60% of our membership. This includes, breast cancer with be hypertension, stroke, and osteoporosis among edges o. We also look at contributing factors to over all health. These can be living arrangements, fall, and dementia.
We partnered with HHAX leveraging direct care workers in assisting clinical risk for women eal health concerns. This helps with breast cancer screening within the past two years. Any increased history of falls. Any issues with keadcation and assessing living environment opinion and ka data capture process, they address these for far tis pant coverage. This is risk and including overall health outcomes.
And one of, now he, an example of one of the different outreaches we have done here, gathering data participants in different high risk categories. One area we decided to focus on is breast cancer awareness and prevention. According to the centers for disease control prevention, breast cancer is the second most common in the U.S. We did a multiprong approach for outcomes in this area. These include a targeted referral program where the care management team provides outreach educating participants on the importance of b of breast cancer screening.
I know we are almost out of time. I tried go pretty quick. If there are any questions from the group I can help answer.

>> Thank you for being so cognizant of our time.
Very much appreciated.
I think have heard this -- thank you for this comprehensive presentation. Any questions?
[Inaudible]
How is the approach for the organization and when the members enroll are also enrolled in Medicare and also another plan for Medicare. And is there an underlined Medicare plan, how do they coordinate to avoid duplication of care management efforts?
>> Dr. Park, I can answer that. Yeah, that is definitely a challenge. Asker somewhere along the lines of the program but we do try our best and we have our staff actually makes as many as possible to try and coordinate and have open lines of communication with the other plans. When some things aligned, we have very direct communication and try to ascertain if there are any other clinical programs and so there is not duplication.
But I think the key things with it is open lines of communications as much.
>> Possible to we are not overwhencating and unihope that was an answer to your question.
>> Thanks you so much.
>> Thank you. Dr. Park, we do have care management that does work with our participants and can reach out to our members on the line to see if there is any additional supports they need it access the benefits and services.
>> >>: Thank you. Any other questions ?
Go ahead, Lloyd.
>> Is there any mental health component in the women's health initiative? Or not?
>> Mental health is sort after more ongoing concern and we did want to focus on the three diseases. At this point we are still focused on measures, having discussions at our our --
[Inaudible]
We focus on this and about care coordination related to this and identifying those that have depression. Within the major depression disorder. Or minor and how those folks are screened. On you know, the tools, et cetera. And I'm identified and making sure behavior health and curbing. These are ongoing issues, they do affect older women. One component in particular related to breast cancer and chemotherapy. And those folks often do have depressive episodes and that is of particular bone.
That is an going even on for a very large population.
>> Go ahead, Pam.
>> Pam hour. Just wondering if -- I didn't hear much discussion about the lack of access to equipment, medical equipment.
And access when i go to get a test for the first thing I ask is, can you stand? And I usually have my daughter with me. I don't bring somebody with me. I'm able to do it. Not everybody can. Is there a program to monitor the doctor's offices that you guys contract with. So that women have access to the true modern equipment.
>> So you know, each MCO does this differently. I will say that as part of this initiative, when it comes to the overall osteoporosis management and falls and fractures, I think one of the MTS there, with occupational therapy and it is very good and pa what you are talking about and are those occupational means being met? Are people in -- do they have the physical skills as well. That carries over to the physicianes a office as well.
>> So the answers, each of the MCOs and their providers network are required to have directer access to care. And in excessible medical equipment. My recommendation would be to encourage participants to call the help line, other MCOs, to get that assistance and make that report that there is inaccessible wilt.

Thank you.
>> You guys have a great program. Love it.
And working with different groups to monitor it would be great if that had been taken care of. If you guys gave them money to be successful. No matter how many times I talk to doctor's offices, they look at me like I'm crazy. If there is something the MCO can do in advance and make sure -- and one more thing. And for anyone testing about this, with your DEI, maybe change your DEI or looking at it in terms of DEIA. Without access, people with disabilities do not have -- and actually have a program access. Often times when you look at the program like that, one of the first things you think of is access. And including access.
So equipment, mammogram machines and all this needs to be accessible for everyone.
Sp.
>> Jeff.
>> And maybe, if you were to follow up with what Pam was saying, and you will be taking comment owns 504 compliant. So that is something else I need to fix in here today.
I and just to mention that the first part of depression with be to a fit in, one of the things that is determining,.
>> You can add additional follow-up maybe on my times, I worked for an tardy care and home visitations. Thank you.
>> Thank you.
>> I would like it hop in, Jeff, to see that maternity care is a huge priority for services as whole. So I'm sure talking more about that throughout 2024. And what a difference that makes.
>> And if it fits into this particular space.
>> Go ahead.
>> And I just wanted to respond to a --
[Inaudible]
I would like to add this if I was more proactive than that. And I know ahead of time that I have qualified to pay and why do we get on the table? Do I have to do this or do that?
I assume that you can be a lotof people in the pro gals many that don't know that.
And then wasting a ro prop.
>> Thank you, man.
We are out --
>> One last thing here. This is Randy from OLTL. We add transportation meeting early December. I told you. It will be February 7 from 1 to 3. More information coming out. Hopefully this week. With the invite. It'll be an open meeting.
So for people with stories, issues with concerns, transportation. No presentations but the same group of people at it. So February 7.
>> Thank you, Randy.
And for our stuff we have in the chat maybe we can do that as a follow-up. Our next meeting is February 1. Our first meeting, that's what it says at the bottom of the sheet.
So thank you all for your participation today.
I very much appreciate it. Everybody showing up and everyone on-line, too. Thank you, guys.