



**Participant Advisory Committee**  
*September 11, 2024*

PA Health & Wellness Northwest Participant Advisory Committee Meeting  
 September 11, 2024  
 Voices for Independence Erie, PA

Internal Attendance Record  
 (X = phone conference, P = in person attendance)

| September | PHW Staff/Observers   | Title  |
|-----------|-----------------------|--|
| P         | Greg Hershberger      | Community Outreach Specialist, Committee Chairperson |
| X         | Kayla Stadelman       | Community Health Services Representative             |
| X         | Dr. Craig Butler      | Medical Director                                     |
| X         | Dr. Davuluri          | Medical Director                                     |
| X         | Susan Foster          | Supervisor, Case Management                          |
| X         | John Savidge          | HEDIS Operations Manager                             |
| X         | Felicia Alexander     | Health Equity Specialist                             |
| X         | Kay Gore              | LTSS and Community Outreach Manager                  |
| P         | Emily Godfrey         | Director of Provider Relations                       |
| X         | Athena Aardweg        | Program Manager II                                   |
| X         | Brendin Tupta         | Project Manager I                                    |
| X         | Jessica Grindle       | Marketing Analyst                                    |
| X         | Tamra Nakamura        | Senior Accreditation Specialist                      |
| X         | Gina Hightman         | Accreditation Specialist II                          |
| X         | Paula Joshua-Williams | Accreditation Specialist II                          |
| X         | Taylor Lovett         | Quality Improvement Coordinator I                    |
| X         | Joanna Lewis          | Manager of Contact Center Operations                 |
| X         | Danielle Bruette      | Senior Manager of Quality Improvement                |
| X         | Crystal Giles         | Manager of Operations                                |



**Participant Advisory Committee**

*September 11, 2024*

|   |               |                                 |
|---|---------------|---------------------------------|
| X | Dreona Bey    | Membership Retention Specialist |
| X | Wanda Proteau | Manager of Operations           |

External Attendance Record

*(X = phone conference, P = in person attendance)*

| September | Name             | Title                     |
|-----------|------------------|---------------------------|
| X         | Yaasmiyn White   | OLTL Representative       |
| X         | Kristen Richard  | OLTL Representative       |
| X         | Matt Couillard   | Staar Alert – PERS Vendor |
| X         | Carrie Bach      | CIL Partner               |
| X         | Aaron Guarino    | Participant               |
| X         | Kyra Dusch       | Caregiver                 |
| P         | Kelly Barrett    | Participant               |
| P         | Melina Jones     | Caregiver                 |
| P         | Amanda Luch      | Participant               |
| P         | Victoria Jackson | Caregiver                 |
| P         | Jenn Ross        | CIL Partner – PAS Manager |
| X         | Ben Kondor       | Bayada Representative     |
| X         | Jennifer Lessa   | OLTL Representative       |
| X         | Shela Bentley    | Bayada Representative     |

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*September 11, 2024*

| Agenda Item  | Discussion  | Decision (Approved or Denied) | Follow-up Action Needed (Date) | Responsible Party |
|--|---|-------------------------------|--------------------------------|-------------------|
| <b>I. Call to Order</b>  | Greg Hershberger called the meeting to order at 1:04 PM   | N/A                           | N/A                            | Greg Hershberger  |
| <b>II. Announcements +</b>                                       | Roll call was conducted.  | N/A                           | N/A                            | Greg Hershberger  |
| <b>III. Review/Approval of the Minutes</b>                       | Greg Hershberger discussed that minutes are posted on our website and reviewed.   | N/A                           | N/A                            | All               |
| <b>IV. New Business +</b><br>A. MD Update<br>B. Health Education | <p>Presented by Dr. Craig Butler.</p> <p>Physical Activity:<br/>Using the term physical activity vs. exercise because you don't have to necessarily exercise to be active. Getting up and simply moving your body is physical activity.</p> <ul style="list-style-type: none"> <li>• Reduce your risk of a heart attack</li> <li>• Manage your weight better</li> <li>• Lower blood cholesterol level</li> <li>• Lower the risk of type 2 diabetes and some cancers</li> <li>• Lower blood pressure</li> <li>• Stronger bones, muscles and joints and lower risk of developing osteoporosis</li> <li>• Positive mood and mental stability</li> </ul> <p>Manage your cholesterol by visiting your PCP annually for bloodwork. Poor diet and being overweight, lack of exercise and genetic all are factors for high cholesterol. Sometimes medication and treatment are needed to lower cholesterol. Living a healthy lifestyle and regular PCP visits are best for prevention strategies.</p> | N/A                           | N/A                            |                   |

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| B. Covid-19/Fluvention | <p>Men’s Health:<br/>           Regular screenings like colorectal and prostate exams. Eating healthy and exercise, keeping weight in check. Getting rest and preventative care are all essential for men’s health.</p> <p>Women’s Screenings:<br/>           Pap/cervical exams and mammograms. Physical exams and STD testing, if necessary. Preventative care is key.</p> <p>Q: Is very low cholesterol just as dangerous as high cholesterol?<br/>           A: Unsure how you could treat it other than diet. Sounds like it may be rare. Make it a priority to speak about this at your next PCP appointment.</p> <p>Presented by Susan Foster.<br/>           Recommends everyone over the age of 6 months should receive both the Flu and Covid-19 vaccines.<br/>           Covid-19 cases are surging across the U.S. and in PA.<br/>           Starting end of September 2024, you can go to CovidTests.gov and request 4 free Covid-19 tests.</p> <p>Anyone who had a COVID-19 infection can experience Long COVID, including children. Covid-19 vaccine is the best way to prevent Long Covid. Symptoms can include: fatigue, brain fog, and post-exertional malaise (PEM) are commonly reported symptoms, but more than 200 Long COVID symptoms have been identified.<br/>           Other symptoms include fatigue, difficulty breathing, chest pain,</p> | N/A                           | N/A                            |                   |

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| C. HEDIS Operations | <p>dizziness, difficulty sleeping, change in smell and or taste, depression, and many more.</p> <p>RSV vaccine is also recommended for at-risk population. You can take all 3 vaccinations at the same time but take with your PCP to make sure what is right for you.</p> <p>Q: If you have, or recently have had Covid-19 do you still need to be vaccinated?<br/> A: Check with your PCP but usually they will recommend still being vaccinated.</p> <p>Fluvention is a campaign that will run October 2024-May 2025. Programs goals are:</p> <ul style="list-style-type: none"> <li>✓ Decrease flu among high-risk Participants</li> <li>✓ Increase overall flu vaccination rates from the previous year</li> <li>✓ Reduce flu-related utilization (ER visits, hospitalizations)</li> </ul> <p>This program focuses on specific high-risk groups, including Participants who are 65+ years, those with chronic health conditions or pregnant.</p> <p>Presented by John Savidge.</p> <p>Osteoporosis Management</p> |                                     |                                   |                      |

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| D. Marketing Materials | <p>Osteoporosis is a disease that causes bones to become thin and weak – that means a higher risk for bone fractures. 10 million Americans have Osteoporosis, 44 million Americans have low bone density. Age, gender, race amongst other factors can put you at higher risk. Symptoms can include: back pain, loss of height over time, stooped posture, and easily broken bones. Bone Mineral Density Test is how it is diagnosed. Medications and modifying risk factors are the treatment.</p>   | N/A                           | N/A                            |                   |
|                        | <p>Presented by Jessica Grindle on Managing Cholesterol.</p> <p>Heart disease is the leading cause of death in the country. Having a high total cholesterol can raise your risks for heart disease as you age. Although medications are helpful, small changes to your daily life have the greatest impact. Here are a few things to try to lower your risk: 30 min. of high intensity exercise 2x/week, snacking on fruits and nuts instead of high fat and sugary items, fill up half your plate with vegetables at meals, eat more lean meats like chicken and fish. Save money by buying the fruits and vegetables that are in-season.</p> <p>September is Healthy Aging Month: skincare is healthcare so wear sunscreen when exposed to sunlight, don't skip brushing your teeth, protect your eyesight by wearing sunglasses outside, keep your heart healthy.</p> <p>Health Education Advisory Committee Concluded at 1:56 PM</p> | N/A                           | N/A                            |                   |

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| Agenda Item   | Discussion  | Decision<br>(Approved<br>or Denied) | Follow-up Action Needed<br>(Date) | Responsible<br>Party |
|---|---|-------------------------------------|-----------------------------------|----------------------|
| <p>A. Complaints and Grievances Q3 2023</p> <p>B. Customer Service</p> <p>C. PHW Services – Participant Directed Option</p> | <p>Participant Advisory Committee Started at 2:10 PM</p> <p>Presented by Cystal Giles.</p> <p>Q2 information for 2024. Medical/PCP has the highest complaints in Q2. Attitude and Service is highest complaint in Q1. Home health has the highest grievances for Q2.</p> <p>Presented by Joanna Lewis.</p> <p>Participant and Provider incoming calls - PHW met the metrics for Q2 2024: 12 seconds average speed to answer PTPs, 11 seconds average speed to answer providers. Abandoned rate for calls Q2 2024 was 1.01% for participants and 0.71% for providers. All goals met.</p> <p>Presented by Jenn Ross from VFI.</p> <p>Service #11 Participant-Directed Community Supports - This service is for participants who want to direct their own services, hire, and train their direct care worker, direct their Direct Care Worker (DCW) schedule, and when necessary, terminate the employment of their DCW.</p> | <p>N/A</p> <p>N/A</p> <p>N/A</p>    | <p>N/A</p> <p>N/A</p> <p>N/A</p>  |                      |

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| D. PHW Services – Personal Assistance Services | <p>Presented by Jenn Ross from VFI.</p> <p>Service #12 Participant-Directed Goods and Services - Participant-Directed Goods and Services are services, equipment or supplies not otherwise provided through the waiver only available through Service My Way. The participant is given a budget for services, and allowed to save funds to purchase items that address an identified need in the participant’s service plan. Example of service: Participant identifies a need for a microwave to increase independence in meal preparation and purchases it through funds saved in budget.</p> <p>Presented by Jenn Ross from VFI.</p> <p>Service #10 Personal Assistance Services (PAS) - This service offers hands-on help for activities of daily living such as eating, bathing, dressing, and toileting. PAS options can include both PDO and/or Agency Model. PAS services should be utilized in conjunction with informal supports and community resources. Example of service: A participant has a Personal Attendant in their home 20 hours/week to assist with bathing, transferring, preparing meals etc.</p> | <p>N/A</p> <p>N/A</p>         | <p>N/A</p> <p>N/A</p>          |                   |



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| E. PHW Services – Personal Emergency Response System (PERS) | <p>Presented by Matt Couillard from Staar Alert.</p> <p>Service #14 Personal Emergency Response System (PERS) - This service provides an electronic device which is connected to a participant’s phone and programmed to signal a response center with trained staff when the participant presses a portable “help” button to get help in an emergency. Example of service: Participant wears pendant around their neck with a button that can be pushed to alert medical assistance in the case of a fall and participant is alone.</p> <p>In-home PERS device is for use only at home. Does not require a cell phone or Wi-Fi – connects directly to a landline or cellular network. Waterproof buttons automatic fall detection available. Available in a necklace or watchband.</p> <p>Mobile GPS device is perfect for active users. 4G LTE Cellular Technology for quicker response, provides GPS Location, places a 2-way voice call to monitoring center, Automatic Fall Detection Available.</p> | <p>N/A</p>                    | <p>N/A</p>                     |                   |
| F. PHW Services – Nursing/Home Health Aide                  | <p>Presented by Ben Kondor from Bayada.</p> <p>Service #16 Nursing - Nursing services of are ordered by a doctor and performed by a registered nurse or licensed practical nurse.</p>   |                               |                                |                   |

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| <p>G. PHW Services – Community Services</p> | <p>Services include diagnosing and treating health problems through health teaching, health counseling, and skilled care prescribed by the doctor or a dentist. Example of service: This helps participants who require skilled care for their medical needs.</p> <p>Service #25 Home Health Aide - Home Health Aide services are necessary to enable the participant to integrate more fully into the community. Services are prescribed by a physician, a nurse practitioner or physician assistant and are in addition to any services furnished under the State Plan. Example of service: A participant needs to have their medication administered.</p> <p>Presented by Greg Hershberger</p> <p>Service #13 Respite - Respite is a short-term service to support a participant when the unpaid caregiver is away or needs relief (can be provided in the home or a NF). Example of service: Home Option: Joe’s mother takes care of him informally on the weekends, but Joe’s mother is going to be on vacation for two weeks. Respite services can be requested to be provided by a PAS agency to cover the weekend time that Joe’s mother would usually assist but can’t because she is away.</p> <p>NF Option: Joe’s mother takes care of him informally on the weekends, but Joe’s mother is going to be on vacation for two weeks. Joe would stay in a NF who would provide services during</p> | <p>N/A</p>                    | <p>N/A</p>                     |                   |

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|             | <p>the time that she is away.</p> <p>Service #22 Structured Day Habilitation - Structured Day Habilitation services are directed to preparing a participant to live in the community, which include supervision, training, and support in social skills training. Example of service: A participant meets in a group setting with a program leader to assist with learning problem solving skills and/or task completion.</p> <p>Service #22 Residential Habilitation - Residential Habilitation are services that are delivered in a provider-owned or operated setting where the participant lives, which include community integration, nighttime assistance, personal assistance services to help with activities of daily living such as bathing, dressing, eating, mobility, and toileting, and instrumental activities of daily living such as cooking, housework, and shopping, so the that participant get the skills needed to be as independent as possible and fully participant in community life. Example of service: A participant needs some assistance with eating and food preparation or household chores (e.g., bed-making, washing dishes, laundry).</p> <p>Service #8 Adult Daily Living Services (ADC) - Adult Daily Living services assist participants in meeting, personal care, social, recreational, mental, cognitive, nutritional, dietary, and therapeutic needs (PT/OT/Water therapy). They are furnished on a regular scheduled basis in a non-institutional, community-based center that provides both health and social services. Example of service: Four hours/day, a participant goes to an Adult Day Center</p> | N/A                           | N/A                            |                   |

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| <p>H. Community Relations and Outreach</p> | <p>and socializes with other people, does crafts, plays game, etc. while providing a safe, interactive, and supervised environment.</p> <p>You can locate PHW’s 32 services on our website at: <a href="http://pahealthwellness.com/members/ltss.html">pahealthwellness.com/members/ltss.html</a></p> <p>Presented by Kay Gore.</p> <p>Community Connect is available on PHW’s website, is a free website to find resources in your area by searching your zip code. National Senior Center Month: No charge to attend the center and activities funded through the Area on Aging, contributions may be requested for some activities, come whenever you want, no minimum attendance required. <a href="http://www.aging.pa.gov">www.aging.pa.gov</a></p> <p>Upcoming events in NW PA:<br/>           Party for the Paws: A Fall Festival and Walk, Sunday Farmer’s Market (June-Sept), Erie Downtown Fall Fest (October)</p> <p>For information on Community Events please e-mail <a href="mailto:PHWCommunityOutreach@PAHealthWellness.com">PHWCommunityOutreach@PAHealthWellness.com</a>. You can also follow PA Health and Wellness on Facebook.</p> <p>Felicia Alexander: Make sure to get out and vote and know in-advance where your polling place is.</p> | <p>N/A</p>                    | <p>N/A</p>                     |                   |

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| <p>A. Performance Improvement Project (PIP) – non-clinical</p> | <p>This concluded the Participant Advisory Committee Meeting at 2:51 PM.</p> <p>The Board Advisory Committee meeting started at 2:51 PM.</p> <p>Presented by Brendin Tupta.</p> <p>Transitioning Participants from the Nursing Facility to the Community Non-Clinical PIP presented by Brendin Tupta. The new non-clinical PIP has been finalized and PHW will complete its proposal submission on August 27<sup>th</sup>. 2 performance indicators from the previous non-clinical PIP are remaining for the new project: Medication Reconciliation and Remain in Community.</p> <p>There are 3 new performance indicators that round out the project:</p> <p>LTSS Reassessment/Care Plan update after NF discharge</p> <p>PI 1 – Percent of NF discharges resulting in LTSS re-assessment within 30 days of discharge.</p> <p>PI 2 – Percent of NF discharges resulting in an LTSS re-assessment and care plan update within 30 days of discharge.</p> <p>LTSS shared care plan with Primary Care Practitioner (SCP)</p> <p>PI 3 – Percentage of LTSS members with a care plan that was transmitted to their PCP or their documented medical care practitioner within 30 days of development.</p> | <p>N/A</p>                    | <p>N/A</p>                     |                   |

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| B. Performance Improvement Project (PIP) – clinical | <p>Presented by Paula Joshua-Williams.</p> <p>The New Clinical PIP – Strengthening Care Coordination has been finalized and PHW will complete its proposal submission on August 27, 2024.</p> <p>The objective is to implement an LTSS Service Coordination program to improve the transition of care process and outcomes for our participants.</p> <p>Strengthening Coordination PIP will focus on the following performance indicators: Reassessment update after inpatient discharge, care plan update after inpatient discharge, shared care plan with PCP, medication reconciliation post-discharge, plan all-cause readmission.</p> <p>The new clinical and non-clinical report will be broken down into three different sub-populations:</p> <p>Subpopulation 1: Medicaid-only members with CHC benefits<br/>           Subpopulation 2: Members with CHC benefits with the same MCO<br/>           Subpopulation 3: Members who have CHC benefits and Medicare benefits with different MCOs.</p> <p>This concluded the Board Committee meeting at 3:02 PM with a reminder that the next meeting will be December 3, 2024.</p> | N/A                           | N/A                            |                   |



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*September 11, 2024*

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| <b>VII. Next Meeting Date +</b> | December 3, 2024                               | N/A                           | N/A                            | N/A               |
| <b>VIII. Adjournment *</b>      | Greg asked for a motion to adjourn at 3:03 PM. | Adjourned                     | N/A                            | N/A               |

Respectively submitted,

|  |                   |                           |
|--|-------------------|---------------------------|
| <b>Minutes prepared by (name &amp; title):</b><br>Kayla Stadelman, Community Relations Coordinator III | <b>Signature:</b> | <b>Date:</b><br>9/11/2024 |
|--|-------------------|---------------------------|

+Informational or Old Business

\*Action Required