WHO WILL CARE FOR MOM & DAD?

Preparing for the Senior Population Explosion:
A special report by Auditor General Eugene DePasquale

Dear fellow Pennsylvanians,

All Pennsylvanians have a right to age with dignity and with the assurance that state government will help to keep them safe and secure.

Nearly 90,000 Pennsylvanians live in more than 700 nursing homes throughout the state,[1] and they represent just a fraction of our aging population. Pennsylvania already has more seniors than all but seven states. Studies show that, by 2040, nearly 25 percent of Pennsylvania's population of about 13 million will be 65 or older, compared with 15 percent in 2010.[2]

Not only is the aging population growing, but it is also increasingly dependent. In 2017, 30.2 percent of Pennsylvanians 65 or over were dependent; data experts project that by 2030, that will grow to 38 percent.[3]

That means Pennsylvania must be prepared to meet the long-term care needs of well over 3 million older adults, many of whom lack the necessary financial resources to pay for such care.

We have to act now to better protect and more thoughtfully care for our loved ones already in need of extra support. We have to plan now to be ready for the significant demographic shifts that lie ahead.

My team and I talked with more than 50 people representing various stakeholder groups for this special report, which describes Pennsylvania's elder care issues and analyzes the current state agency structures and policies dedicated to elder care. We also recommend 30 actions designed to:

- improve quality of care;
- address the healthcare workforce shortage;
- expand access to care;
- prevent abuse, fraud, waste, and erosion of civil rights; and
- begin a public conversation to educate ourselves about aging and implement plans to address the challenges ahead.

I urge state officials, the General Assembly and the people of Pennsylvania to act quickly to bolster our elder care systems and improve access to and quality of care. We are facing an elder care crisis, and we continue to ignore it at our own peril.

Thank you for the opportunity to serve you.

Sincerely,

Eugene A. DePasquale

[1] https://www.snfdata.com/state_statistics.html
[2] https://www.rural.palegislature.us/documents/reports/Population_Projections_Report.pdf
[3] https://pasdc.hbg.psu.edu/Data/Research-Briefs/PA-Population-Estimates

GLOSSARY OF TERMS

Area Agencies on Aging (AAAs): Pennsylvania county government entity coordinating aging programs and services for local residents; serves and protects older adults by acting as a resource for families and investigating reports of abuse.

Centers for Medicare & Medicaid Services (CMS): Federal agency within the U.S. Department of Health and Human Services that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program and health insurance portability standards.

Department of Health (DOH): Pennsylvania state agency providing programs, services and health information to promote healthy lifestyles, prevent injury and disease, and assure the safe delivery of quality healthcare for all commonwealth citizens.

Department of Human Services (DHS): State agency providing care and support for Pennsylvania's most vulnerable individuals and families through seven program offices; works to detect and deter provider and recipient fraud and abuse.

Direct Care: Includes hands-on tasks such as the administration of medication, physical therapy, personal care tasks and patient education.

Guardianship: Binding legal designation by which a person takes legal responsibility for the care of someone unable to manage their own affairs.

Home Care Agency: Private organization that offers in-home services to cover basic needs, physical therapy or skilled nursing services for people who are disabled, recovering from a medical procedure, aging in place or suffering from chronic illness.

Home Health Aide/Personal Care Aide: Provides non-medical tasks such as dressing, bathing and basic hygiene needs for people with disabilities, recovering from a medical procedure, aging in place or suffering from chronic illness.

Long-term Care Ombudsman: Pennsylvania program whose professionals work to resolve complaints and issues on behalf of individuals living in long-term care settings, such as nursing homes, assisted living facilities and personal care homes.

Nurse Aide/Nursing Assistant: Provides nursing-related services to residents in a facility. Is not a licensed health professional, a registered dietitian, a paid feeding assistant or a volunteer.

Nursing Home: Residential facility providing healthcare for people who do not need to be in a hospital, but for whom living at home is no longer a viable option.

Pennsylvania Department of Aging (PDA): State agency responsible for the administration of all aging programs and services for the commonwealth; promotes prevention and protection for older Pennsylvanians.

Registered Nurse (RN): Licensed healthcare professional who graduated from a state-approved school of nursing, passed the RN exam and is licensed by the state board of nursing to perform medical tasks for patients/clients.

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2016 DEPARTMENT OF HEALTH NURSING HOMES OVERSIGHT AUDIT

In 2016, at the request of Department of Health (DOH) then-Secretary Karen Murphy, the Department of the Auditor General conducted a performance audit of DOH's oversight of Pennsylvania nursing homes. Broadly, the audit observed a lack of consistency in surveys and quality standards, undocumented sanction decisions and low direct-care hours. The audit had 13 findings that focused on the following three issue areas:

1. DOH's insufficient review of nurse staffing levels within long-term care facilities may be affecting residents' quality of care and quality of life.
2. Poorly written revisions to DOH's policies and procedures may have compromised DOH's ability to receive, respond, and resolve complaints about care adequately.
3. DOH has considerable discretion in pursuing sanctions against facilities that fail to meet regulatory standards, but rarely imposes penalties under state rules.

The audit, released in July 2016, also had 23 recommendations, including suggestions to:

- Develop written policies and procedures to guide DOH surveyors for the assessment of facility staffing-level reviews.
- Cite facilities that fail to meet the state's 2.7 hours of direct care requirement on a 24-hour basis, and ensure the facility institutes a corrective action plan.
- Work with the General Assembly, the governor and nursing home stakeholders to re-evaluate whether Pennsylvania's 2.7 daily hours of direct care ratio should be increased or otherwise amended in DOH regulations.
- Continue to accept complaints from anonymous sources.
- Document all actions taken to investigate a complaint regardless of whether a deficient practice is found.
- Work with the General Assembly to amend the Health Care Facilities Act of 1979 to provide more stringent civil monetary penalties.
- Document how all sanctions-related decisions are made, including the levels of supervisory and managerial review and approval.

Since the 2016 audit, DOH has made significant changes; however, the extent to which these changes have led to improved quality of care is unclear.

In a February 2019 meeting to discuss this follow-up report, DOH Secretary Dr. Rachel Levine noted that DOH is undertaking an overhaul of its regulations, the first large-scale regulatory rewrite in decades. Officials expect that the regulations will be released for public comment in summer 2019 and will build on new federal policies under the Centers for Medicare & Medicaid Services (CMS), keeping the majority of the CMS policies intact.

Because this report does not provide a preview or review of the regulations overhaul, some of the recommendations offered here could already be addressed in draft regulations.

DOH showed tremendous initiative in requesting the 2016 audit, and since that time has made substantial strides in its oversight of nursing homes. DOH Secretary Dr. Levine and her team were cooperative and collegial during this follow-up report process.

II.

2019 FOLLOW-UP REPORT:

OBSERVATIONS AND RECOMMENDATIONS

Observation 1: DOH must better train surveyors to achieve consistency and provide the ability to set expectations, more accurately assess quality and move to corrective action with clear goals.

Each of Pennsylvania's more than 700 nursing homes receives an annual inspection by a DOH surveyor. The process, like that of a Department of Agriculture inspector going into a restaurant, is intended to keep operators honest in their practices and enable current and prospective clients to view survey results to make informed care decisions.

Surveys seem to differ widely across nursing homes, even those owned by the same entity, and can vary across counties and regions. While some variation is natural — certainly every home has different clients with different needs, and the population can change by the day — nursing home operators, advocates, and current and prospective clients and families must be able to rely on DOH surveys and subsequent action plans as one measurement of quality and safety of care.

Elder care advocates and industry experts interviewed for this report expressed a mix of positivity regarding nursing home survey processes enacted since 2016 but noted concern that surveys remain inconsistent, and they emphasized across the board that more training for surveyors is a clear need. One industry expert noted that DOH surveyors are spending more time with patients and more time on-site than in the past, which is a positive development.

A common concern was the predictability of the timing of the inspections — sometimes to the calendar day — which at least removes the element of surprise and, at worst, enables operators trying to cut corners to add staff temporarily to make it appear that the facility is properly staffed. A similar 1998 audit by the Department of the Auditor General called for "focused enforcement, including 'real' surprise inspections." The 2016 audit suggested that "at minimum, three weeks [of staffing levels] are reviewed, and more weeks may be added, if necessary." DOH has made improvements, such as documenting actual hours worked instead of hours scheduled and collecting data over the course of multiple weeks, and should continue to find solutions to the survey timing issue.

The 2016 audit recommended that DOH:

- "develop written policies and procedures to guide surveyors for the assessment of staffing-level reviews";
- "conduct training for all surveyors of the importance of consistently conducting facility-level staffing reviews"; and
- "conduct periodic quality assurance reviews of completed facility staffing reviews to ensure that staffing reviews comply with policy and procedures are consistently applied."

In their response to our request for updates since the 2016 audit, DOH officials noted having "updated policy and procedures" and "educated Quality Assurance staff" to ensure consistent review of staffing levels in nursing homes across the state.

DOH surveyors are dedicated public servants who survey nursing homes on a daily basis, and DOH program directors are responsible for overseeing nursing homes statewide. DOH faces a monumental task in monitoring staffing levels inside nursing homes when its own ranks have been compromised by budget constraints and staff attrition. (For more on staff turnover throughout the elder care sector, see Observation 6.)

Recommendation 1: DOH should closely analyze its surveys and address discrepancies and patterns of inconsistency. DOH should use the result of its overall analyses to improve its written policies and procedures for surveyors and better inform its training content and methods.

Recommendation 2: DOH should explore outsourcing surveyor training to a third party to allow for a fresh look at training content and to take pressure off of participating employees who may not want to share stories or ask questions of internal training staff.

Observation 2: Whether the DOH's new regulations mandate more than 2.7 hours of direct care per resident day is a decision for policymakers. All direct care must be quality care: Raising the minimum requirement of 2.7 hours per day will not improve patient outcomes if DOH does not adequately address the quality of care in homes with histories of violations.

Current state regulations require at least two nursing service personnel on duty and set a minimum direct care staffing requirement at 2.7 hours per resident per day.[4] (Direct care includes hands-on activities such as administering medication.) CMS cites studies that suggest 4.1 hours of direct care per resident day should be a minimum requirement for quality care.

The 2016 audit found that while "current regulations allow DOH to require nursing homes to increase staffing beyond 2.7 hours of direct care, [DOH] has not used this authority." Auditors recommended that DOH begin to exercise its authority to mandate additional direct care staffing when a facility fails to implement a corrective action plan related to staffing concerns, or if a facility continues to have deficiencies related to quality of care. DOH did not address this issue in its communications with us for this follow-up report.

Regardless of the exact number of hours set as the minimum requirement, DOH should prioritize establishing clear guidelines focused on consequences for corrective action plan failures and quality deficiencies.

The 2016 audit also recommended that DOH "work with the General Assembly, governor, and nursing home stakeholders to reevaluate whether PA's 2.7 daily hours of direct care ratio should be increased or otherwise amended in DOH regulations." DOH is currently reviewing nursing hours per patient day and will update the policy in the new regulations.

The issue of direct care staffing levels is complicated and controversial. Some experts argue that mandated direct care hours improve quality and health outcomes, while others say that the regulation is burdensome and that the number of hours is not the best key metric on which to focus.

Officials with LeadingAge PA, an advocacy organization for nonprofit nursing homes, said that staffing thresholds are too simple and that "the federal approach of no set ratio is superior." Pennsylvania Health Care Association (PHCA) officials, who represent for-profit and nonprofit nursing homes across the state, want flexibility for home administrators to make staffing decisions. Labor representatives such as the Service Employees International Union (SEIU), however, would like to see direct care hours mandated at the CMS-recommended level of 4.1 hours.

Recommendation 3: In addition to evaluating direct care hours and establishing minimum time requirements that will lead to better care, DOH should have set policies for acting on its authority to require additional nursing home staff when DOH surveyors perceive it to be necessary, and should use that authority as a tool to get resources to nursing home clients who are lacking direct care.

Recommendation 4: DOH should prioritize establishing actionable, unambiguous guidelines addressing consequences for corrective action plan failures and quality deficiencies.

[4] 28 Pa. Code § 211.12(h)(i).

Observation 3: DOH must follow the letter and the spirit of the Centers for Medicare & Medicaid Services' guidance for complaint handling if it employs it.

The 2016 audit tested 90 complaints in order to analyze the sufficiency of investigations and the quality of communication with complainants." Since that audit, DOH worked quickly to improve the complaint handling process, most notably by adopting the federal CMS priority assignment system, documenting all actions taken to investigate a complaint (even when no deficiency is found). DOH set a policy of accepting anonymous complaints in 2015.

Despite these improvements, complaint handling was on the priority list during interviews with nursing home sector stakeholders. Advocates describe a power dynamic where complainants are marginalized while the focus centers on the administrator, in contrast with CMS' resident-centered guidance. Some advocates characterized relationships between DOH surveyors and facility administrators as sometimes "too familiar," leading to perceived insufficient complaint investigations or mild consequences for violations.

DOH and the Department of Aging (PDA) should continue to advance interagency collaboration to make sure all investigative work, whether performed by DOH or Area Agencies on Aging (AAAs), is considered when assessing complaints and nursing home facility compliance.

Recommendation 5: DOH should continue to improve its training around all oversight processes, keep pace with its improved documenting procedures, continue to work on complainant communication and foster collaborative interagency work streams.

Observation 4: DOH has shown progress by increasing use of civil monetary penalties for care deficiencies, and it should expand on those improvements by tracking the effectiveness of fines to show that the oversight tool is leading to improved outcomes.

DOH Fines Levied, 2014-2018			
Year	**Total Fines**	**Number of Fines**	**Provisional Licenses**
2018	$2,300,000	165	3
2017	$1,100,000	100	33
2016	$412,200	57	38
2015	$170,050	31	19
2014	$62,000	11	9

Civil Monetary Penalties

The 2016 audit found that while "DOH has considerable discretion in pursuing sanctions against facilities that fail to meet regulatory standards," it "rarely imposes penalties under state rules."

Since 2016, DOH has significantly increased its use of monetary penalties as an oversight tool: in 2018, DOH levied fines totaling $2.3 million for 165 infractions (for an average fine of approximately $14,000). The 2018 figure is more than double the $1.1 million assessed for over 100 infractions in 2017, and more than fivefold what was levied in 2016.

DOH Secretary Levine, who was appointed in 2018, has emphasized that "we want our civil penalties to be meaningful but not punitive" and "the priority is not the fine; the priority is to make sure the problem is corrected."[5] DOH's response for this follow-up report noted that "the department regularly reviews all sanctions and as a team establishes progressive discipline sanctions, as needed, if the facilities fail to make improvements to the quality of care and life for residents."

The end goal must of course be quality of care, not the fines themselves, and DOH's more aggressive use of civil monetary penalties is appropriate. However, there could be more clarity around the fine assessment formulas, processes and timelines. DOH needs to be more deliberate in tailoring its penalties to particular violations and choose enforcement actions that will drive change in facilities.

Dr. Levine has noted that appeals processes can delay disclosure of fines, which can make strict timelines for public notification difficult to meet.

This rapid uptick in penalties illustrates that DOH continues to work to improve its system to nudge nursing home administrations to do better.

Recommendation 6: For the benefit of administrators, advocates, policymakers, clients and families, and the public, DOH should track and share data in an "administrative penalty tracking report" to be posted on its website on a quarterly basis that show the impact of civil monetary penalties on quality of care.

[5] https://www.rural.palegislature.us/documents/reports/Population_Projections_Report.pdf

Provisional Licenses

Provisional facilities licenses are given to facilities that need closer monitoring; the license to operate is for just six months, compared with the standard annual license. A provisional license is a serious, red flag to members of the public and others that the facility has problems it must fix in short order.

DOH has made progress utilizing civil monetary penalties as a tool. However, it is very concerning that in 2018, it drastically reduced its use of provisional licenses as penalties for facility and care deficiencies. In 2017, the ratio of fines to provisional licenses was 3:1; in 2018, that ratio was 55:1.

Any punitive tool must align with business realities in order to be effective. Many stakeholders contend that fines do not work, as they rarely impact a facility's ability to operate and, often, the amount of the fines pale in comparison with other, normal expenditures. If operators view fines as simply the cost of doing business, the tool is unlikely to change behavior.

Provisional licenses, on the other hand, are a licensing downgrade and can motivate a nursing home administration to make the changes necessary to earn the right to operate on a standard license. While it is rare for a facility to lose its license altogether, a downgrade to provisional sends a clear message and is an important oversight tool.

Asked why provisional licenses were employed so much less in 2018 compared with 2016 and 2017, DOH officials explained that "it is important to not compare one year to another when looking at the sanctions, whether fines or provisional licenses … we compare nursing homes to themselves, in looking at the deficiencies that occurred, the severity of the deficiencies, frequency of deficiencies, etc." While there should be no threshold for how many provisional licenses DOH should issue in a year, the 90 percent decline in one year brings up questions of whether DOH is swinging the pendulum too far to the side of civil monetary penalties.

Effective oversight procedures will have an array of tools, varying in severity, with clear assessment methodology and a well-known, persistent threat of taking the drastic but sometimes necessary step of closing facilities that do not comply and do not improve.

At the federal level, CMS designates a small number of homes as "chronically under-performing" under its Special Focus Facility (SFF) Initiative.[6] The SFF designation can carry significant weight for the operator, as SFFs that do not improve stand to be terminated from Medicare and Medicaid.

SFF "participants" are publicly-designated facilities subject to more frequent surveying and increased enforcement actions; "candidate" facilities are on the cusp of designation, but their names are not disclosed to the public.[7] The SFF program has a serious flaw in that it designates a static number of facilities at one time – in Pennsylvania, 4 participants and 20 candidates – despite the fact that more than a set number of homes could be severely deficient at any one time.

DOH Provisional Licenses, 2014-2018

Year	Total Fines	Number of Fines	Provisional Licenses
2018	$2,300,000	165	3
2017	$1,100,000	100	33
2016	$412,200	57	38
2015	$170,050	31	19
2014	$62,000	11	9

Recommendation 7: DOH must be cautious to avoid defaulting to civil monetary penalties. DOH should assess its use of oversight tools and their effectiveness, and respond to violations with appropriate severity and with the goal of driving change; provisional licenses are an important tool and DOH should utilize them.

[6] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/sfflist.pdf
[7] https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/2016-2017-Nursing-Home-Action-Plan.pdf

Observation 5: DOH must adopt more stringent, thorough, clearly outlined policies for vetting nursing home facilities license applicants.

Licensing and Vetting

Elder care advocates warn that DOH has a "siloed" approach to licensing and must look beyond basic criteria when evaluating applications. The vetting process should be comprehensive, taking into account the operating entity's financial stability and track record — not just for quality of care, but also for financial responsibility and accountability toward clients and state governments.

In October 2018, Harrisburg-based media outlet PennLive released a follow-up report to its 2016 investigative story on Pennsylvania nursing homes. PennLive detailed the story of the New Jersey-based company Skyline, which financially failed in April 2018, thereby abandoning approximately 100 nursing homes across the country, including nine in Pennsylvania. The cost for Pennsylvania to take temporary control of these homes was $408,000.

PennLive's analysis of seven of Skyline's licensing documents for facilities in Pennsylvania "found no evidence the [DOH] assessed the financial health of the company."[8]

While relatively uncommon, if a company like Skyline financially fails, it falls on commonwealth employees at DOH to install temporary management and ensure that residents continue to receive safe and quality care. The process takes valuable time from DOH employees, but is also disruptive and potentially traumatic for frail clients who must acclimate to a changing environment. In cases where DOH must provide temporary management, costs are covered by the Civil Money Penalty (CMP) Fund; while these are not direct taxpayer funds, taxpayers should benefit from penalty funds going to much better use than covering for a private company's poor financial management. Through DOH's licensing process, the commonwealth should have the authority to demand collateral or a form of insurance from operators that would cover the costs of installing temporary management should that become necessary.

In addition to financial stability concerns and calls for greater transparency into financial projections, policymakers, advocates and journalists also express concern over some for-profit nursing home companies' opaque contracts with lessors and subsidiary companies.

PennLive's reporting described how, in the wake of the opening of a Pennsylvania Attorney General investigation into its practices, national nursing home operator Golden Living transferred its three dozen Pennsylvania licenses to other chains, including Skyline.[9] PennLive discovered that Golden Living continued to own all of the real estate associated with the 36 homes, so it serves as a landlord for the new operators. Adding to the continued ties, "Golden Living required Skyline to buy certain amounts of goods and services from its subsidiaries."[10]

DOH's vetting process should require applicants to provide lease agreements, contracts with subsidiaries and ownership information for these subsidiaries. The investment trend of private equity firms buying up nursing home chains is a salient example of why state governments need ownership information in order to make license decisions: Private equity investors are career investors, not elder care specialists. The burden of proving they have competent management and genuine interest in the health and safety of clients should rest on these firms.

Private companies will push back that they do not have to reveal this information or the identity of entity owners; however, it is taxpayer money that pays the majority of the client bills, and these entities should not be allowed to operate in the shadows.

Cases like Skyline and Golden Living are the extreme; across the board, stakeholders acknowledge that the majority of operators are doing business in good faith. In any industry, however, there will always be bad actors, and regulators must have the tools they need to deny licenses if necessary, and to protect clients and taxpayers from getting stuck with the costs of cleaning up after companies that abandon their responsibilities.

Recommendation 8: DOH should work with its General Counsel to review how other states review new applicants, and set policy to mandate detailed, thorough vetting, including past and current litigation, vendor relationships, real estate relationships, ownership interest in other healthcare providers, and staff and client complaints.

[8] http://stillfailingthefrail.pennlive.com/solutions/
[9] http://stillfailingthefrail.pennlive.com/
[10] http://stillfailingthefrail.pennlive.com/lingering/

Five-Star Quality Rating System

The Five-Star Quality Rating System is the rating system most members of the general public see when they research nursing homes. The system is administered by CMS, not individual states, but weaknesses in the CMS system demand that DOH have appropriate oversight in place to be able to confirm or question the ratings.

The CMS system does not rely on in-person assessments. Until April 2018, nursing home operators self-reported staffing levels in these surveys, leaving the CMS system especially vulnerable. CMS now collects payroll data, but the system still has significant room for improvement, which means that DOH's approach and data are even more critical.

DOH recognizes the potential inaccuracies in the CMS system, and provides the public with important information in order for consumers to make care decisions. DOH releases inspection reports online on a monthly basis so that potential clients and families can access the most up-to-date facility assessments.

Recommendation 9: DOH should continue to provide transparent information to the public; given the challenges with CMS' Five-Star System, DOH should work toward creating an independent rating system that captures information from DOH, DHS and PDA to maximize the accuracy of information about nursing home facilities available to potential clients and families.

Building Trust

Sector stakeholders identified more frequent communication between DOH and administrators as a potential solution to some of the oversight issues on both sides. Given the seriousness of the charge on the shoulders of all professionals involved in elder care, it seems appropriate to encourage more communication rather than less.

In doing so, DOH should keep in mind the examples of "familiar" relationships between regulators and administrators. It should ensure that increased communication does not lead to an easing of standards, predictability of inspection timing or inadequate complaint handling.

More robust use of oversight tools such as provisional licenses, paired with clearly communicated criteria for improvement, could open up communication channels, build trust between regulators and operators, and lead to better quality and safety of care.

III.

BEYOND THE DEPARTMENT OF HEALTH: OBSERVATIONS & RECOMMENDATIONS

Observation 6: Pennsylvania's looming healthcare workforce crisis must be addressed or it will leave older adults without critical care, harm family members and household finances at every income level, and threaten the commonwealth's long-term economic viability.

Every conversation during the preparation of this report included discussion of the serious workforce issues in elder care. Nearly 90,000 Pennsylvanians, many of them age 85 and older,[11] live in more than 700 nursing homes throughout the commonwealth,[12] and they represent just a fraction of our aging population.

Studies show that by 2040, nearly one-quarter of Pennsylvania's population of about 13 million will be 65 or older — that is compared with 15 percent in 2010.[13] That means well over 3 million residents will need to be on their way to having a solid long-term financial plan, will have an immediate need for care or will already be receiving care.

Pennsylvania already has the 8th-highest median age in the U.S. The state's dependency ratio — meaning the number of children and older adults compared with working-age adults — is expected to increase by 26 percent by 2040.[14]

The U.S. Department of Labor projects that by 2022 — in just three years — the nation will need 1.1 million new registered nurses (RNs) to replace retiring RNs and avoid a nursing shortage. Pennsylvania could be short over 4,000 RNs by 2030.[15]

Elder care advocates consistently emphasize the hardships direct care staff — those who are nursing assistants or other non-RNs — face. Wages are low relative to the physical and emotional demands of providing direct care: Pennsylvania Department of Labor and Industry (L&I) data show that healthcare support careers offer an entry wage of $23,020, an average wage of $31,380 and an experienced wage of $35,550.[16] Employers may offer health insurance, but it is uncommon to find long-term benefits that provide financial stability such as 401(k) plans.

As is the case in any workplace, employees need to feel that their opinion is heard and that it matters. "It is radical for administrators to sit down with their workforce," said Matt Yarnell, president of SEIU Healthcare PA. Direct care staff are often left out of meetings with families of nursing home clients or management meetings regarding care plans, having a potentially negative impact on the client's wellbeing and making the staff member feel undervalued. Examples like these, where communication is lacking and management decisions are misaligned with employee needs, may be influencing the high turnover rates in direct care.

Other factors contributing to high turnover are physical challenges and injuries, burnout and narrow options for promotion. There are few obvious paths out of direct care and into management roles; increasingly, nursing home administrators have business backgrounds, not healthcare backgrounds. Additionally, as the "aging in place" movement gains momentum, competition for nursing homes to retain staff is intensifying, as home care agencies offer more flexible schedules, which are especially appealing to younger workers.

Barriers to attracting individuals to healthcare also include inconsistent and confusing licensing and credentialing standards, especially across state lines. For example, Pennsylvania does not have a designation for a certified nursing assistant (CNA), despite job postings for CNA positions across the state.

Clarifying and consolidating job titles, descriptions, qualifications, credentials and licenses would ease the burden on hiring managers, give clients and families peace of mind, and serve as a boost of confidence for professionals looking to make a career in elder care.

Given the dire need to recruit and retain staff to provide direct care, Pennsylvania must work quickly to create and implement a comprehensive healthcare workforce plan. The Pennsylvania Workforce Development Board's Healthcare Workforce Ad Hoc Committee is developing a "crisis statement outlining the importance of addressing the current issues related to the direct care workforce"[17]; this statement appears to have been stalled since at least September 2018.[18]

[11] https://www.phca.org/news/press-releases/prioritizing-care-pennsylvanias-frail-elderly-population-includes-adequate-funding-lawsuit-abuse-reform
[12] https://www.snfdata.com/state_statistics.html
[13] https://www.rural.palegislature.us/documents/reports/Population_Projections_Report.pdf
[14] *Ibid.* The dependency ratio is expected to rise from 68:100 in 2010 to 86:100 by 2040.
[15] Juraschek, Stephen P., Zhang, Xiaoming, Ranganatham, Vinoth, Lin, Vernon. "United States Registered Nurse Workforce Report Card and Shortage Forecast." University of Nebraska – Lincoln, 2012.
[16] https://www.dli.pa.gov/Businesses/Workforce-Development/wdb/Documents/2-12-19-briefing-book.pdf
[17] Quarterly Meeting Briefing Book, May 1, 2019, p. 86.
[18] Quarterly Meeting Briefing Book, February 12, 2019, p. 5.

The plan must cut across sectors, from state and local agencies, to institutions of higher education, to nonprofit and for-profit corporations. Aging is a nonpartisan issue: Members of the General Assembly, federal legislators representing Pennsylvania, and state and federal officials must do everything within their scope of authority to work across the aisle to provide the critical funding and programming necessary to properly address this crisis.

Recommendations 10-17: To mitigate this crisis and achieve necessary, lasting improvement in the healthcare workforce environment, policymakers and industry leaders should consider the following recommendations:

10: Healthcare employers should raise wages to family-sustaining levels and increase non-salary benefits such as certification reimbursement, tuition reimbursement, student loan assistance, paid family leave, childcare assistance, gas cards and transportation assistance;

11: Healthcare employers should form partnerships with labor associations to amplify the voices of direct care workers and facilitate management-workforce collaboration and communication;

12: Nurses and aides are providing direct care and their opinions need to be sought out and valued. Healthcare employers should include direct care staff in organizational, safety and care decisions; they should put mentorships in place and encourage career advancement;

13: Healthcare employers should explore innovative employment programs, like shared employment agreements between different companies or public agencies in order to give employees variety, the opportunity to cross-train, and to rotate physically and emotionally demanding direct care roles;

14: The departments of State and Health should work together to clarify and consolidate titles, certifications and licenses for nursing and healthcare professionals, including adding CNAs; they should also ease licensing restrictions for medical professionals, e.g., psychiatric mental health nurses should be able to prescribe medication (21 states have this in place);

15: The Department of Education should work with educators and industry leaders to promote medical fields as attainable, desirable careers in K-12 schools, focusing on specific career paths beginning at the junior high level; they should promote behavioral health, trauma care and social work fields in the same manner;

16: U.S. nursing schools turned away 56,000 qualified applicants for undergraduate programs in 2017 because of a teacher shortage that exists in part because practicing nurses make more money.[19] Therefore, the commonwealth and healthcare employers should work with Pennsylvania's State System of Higher Education (PASSHE) and other education institutions to prioritize nursing program expansion and offer more seats to aspiring nurses in Pennsylvania; and

17: The General Assembly should increase Medicaid funding, but with new funds specifically allocated to direct care and wages. Healthcare employers have a responsibility to pay their employees a living wage; short-term cost savings on labor may boost quarterly net income, but the risk of failing to provide quality care and losing nursing staff should outweigh increased profits.

[19] https://www.aacnnursing.org/Portals/42/News/Surveys-Data/Vacancy18.pdf

Observation 7: Quality healthcare for older adults is expensive and difficult to find – or not readily accessible – in many areas of Pennsylvania.

Improving Access to Care

Human beings are not numbers; they cannot be represented by the cost of their daily care, and should not be discharged from nursing homes because someone in line behind them can pay more. Reports from some elder care advocates paint a dark picture of this reality in some facilities.

The case for increasing Medicaid funding is clear. Studies show links between Medicaid funding levels and increased quality of care: "Low Medicaid reimbursement rates are an important contributor to shortfalls in the quality of care … if reimbursement rates are very low, as is commonly claimed for Medicaid, nursing homes have little incentive to compete for Medicaid beneficiaries through better quality of care."[20]

Legislators at state and federal levels have an obligation to adequately fund Medicaid and supplement access to nursing homes, in-home care, emergency medicine, preventative care clinics and rural hospitals.

With increased funding comes increased responsibility, however: Nursing home operators have a responsibility to respect that the nature of their business is caring for human beings who cannot fully care for themselves. Increased government funding must go to caring for people, not to padding the bottom line. Corporations making decisions based on profit margins should understand that this management style will not be tolerated by state agencies; state agencies must enforce the regulations and utilize the tools it has to prevent profiteering off older adults.[21]

Recommendations 18-22: The following recommendations could increase access to care and save taxpayer money through increased efficiencies in the elder care system:

18: The Department of Health should apply to CMS to shorten the wait time for Medicaid approval for in-home care, which would expedite access to care;

19: The departments of Health, Human Services and Aging, as well as healthcare providers and insurers should seek to educate older adults and families about long-term care insurance;

20: Nursing home operators should work with the departments of Health, Human Services and Aging to expand mental health and dementia care programs at nursing homes;

21: The departments of Health, Human Services and Aging should work with the Department of Corrections and re-entry experts to address the rising population of formerly incarcerated older adults; and

22: The Department of Health and the Department of Military and Veterans Affairs (DMVA) should address wait lists at DMVA homes.

[20] Hackmann, Martin B. "Incentivizing Better Quality of Care: The Role of Medicaid and Competition in the Nursing Home Industry." National Bureau of Economic Research, December 2017.
[21] The Department of the Auditor General will release a follow-up to its 2016 DMVA audit in 2020.

Observation 8: Public and private systems for preventing elder abuse are unprepared for the volume and diversity of challenges facing older adults in Pennsylvania.

Elder Abuse Literacy

Elder abuse is a broad term that can mean physical, mental or sexual abuse, as well as neglect or financial exploitation. Unfortunately, elder abuse occurs everywhere. Pennsylvania has an obligation to identify gaps in our elder care systems that enable abuse to proliferate.

While legally complicated, state agencies must explore strengthening the background checks system for employment in and around elder care facilities.

Lifetime employment bans for offenses under the Older Protective Services Act were ruled unconstitutional in 2015 in *Peake v. Commonwealth*,[22] leading to an important caveat: criminal history should not necessarily bar someone from employment in elder care. For example, a past narcotics offense may not have any bearing on whether someone would take proper care of aging nursing home clients. Often elder abusers have no criminal record, and are able to jump from facility to facility without a record of convictions trailing them.

Recommendation 23: State agencies including the departments of Health, Labor & Industry, Human Services and Aging, as well as the Office of the Attorney General, should work together to implement a tracking system for professionals, including administrators, to prevent poor or neglectful employees and managers from moving on to new facilities. The General Assembly should add a provision to the Older Adults Protective Services Act[23] that will help stop abusers from moving from facility to facility, similar to the "pass the trash" provision of the Public School Code.[24]

Complaint Confusion

There are currently three numbers to call to report abuse and complaints, which can lead to confusion for nursing home clients and families. Quality and facility complaints go to one DOH number, other complaints go to a second DOH number and the long-term care ombudsman is a third option. Information boards in the lobbies of nursing homes may have posters advertising all three numbers – or they may be missing one or more at any given time.

Streamlining the system into one hotline could ease this confusion, help oversight authorities to better track patterns of complaints and create financial efficiencies for the state. For example, employing and training operators to field phone calls could fall under one administrative body instead of crossing through DOH, DHS and PDA.

Recommendation 24: The departments of Health, Human Services and Aging should streamline elder abuse and complaint reporting hotlines into one system, in a manner similar to Pennsylvania's ChildLine system for child abuse and neglect complaints.

[22] *Peake et al. v. Commonwealth of Pennsylvania et al.*, 132 A.3d 506 (Pa. Cmwlth., Dec. 30, 2015).
[23] 35 P.S. § 10225.101 *et seq.*
[24] 24 P.S. § 1-111.1.

Law Enforcement Involvement

Financial exploitation and fraud is a serious but under-reported issue in elder care. The Office of the Attorney General has consumer financial protection resources which can help, but it is county district attorneys and law enforcement who are on the front line. Area Agencies on Aging (AAAs) are experiencing an investigative workforce shortage, often burdening investigators with double the number of cases they are meant to have.

Recommendation 25: Local law enforcement must recognize the prevalence and severity of financial exploitation against older adults, participate in Elder Justice Task Force meetings and engage with Area Agency on Aging peers to investigate exploitation cases and prosecute when possible.

Recommendation 26: State and local officials should seek a regional solution to elder abuse and exploitation, perhaps following the Child Advocacy Center model. District attorneys will be critical to this effort by illustrating consequences, deterring criminal activity and even by simply focusing on older adults as an at-risk population.

Guardian Education

Guardianship – taking legal responsibility for the care of someone unable to manage their own affairs – is an additional issue that stakeholders across the spectrum raised in conversations for this report. An estimated 1.5 million American adults have a guardian; these guardians control billions of dollars in assets. Guardians do not have to be family members, and in some cases a court appoints a guardian, sometimes without immediate family members being notified.

Stories of court-appointed guardians taking advantage of older adults and transferring their wealth to themselves by selling their assets and charging exorbitant "fees" are sadly common. These scammers drain the finances not just of the older adult and their family, but also of taxpayers because Medicaid will have to cover the cost of the older adult's care that much sooner.

Many states are far ahead of Pennsylvania in combatting guardianship abuse. Pennsylvania is leading the way in one important aspect, which is its new Guardianship Tracking System (GTS) that tracks guardians and requires criminal background checks.[25] The Pennsylvania Supreme Court has established a robust Elder Law Task Force and Advisory Council on Elder Justice to propose changes to the General Assembly and state government.[26]

Recommendations 27-29: Additional steps Pennsylvania should take to prevent guardian abuse include:

27: The General Assembly should pass a law instituting the right to counsel for people under guardianship, facing guardianship or experiencing elder abuse and exploitation;

28: The General Assembly should establish a protected person's bill of rights, as Nevada did in the wake of severe, successfully prosecuted cases of guardian abuse; and

29: The governor and the General Assembly should work together to create an Office of the Public Guardian, similar to Delaware's, to provide vetted, accountable guardianship services to Pennsylvanians who are unable to manage their personal and financial affairs.

[25] https://ujsportal.pacourts.us/Guardianship.aspx
[26] http://www.pacourts.us/courts/supreme-court/committees/supreme-court-boards/elder-law-task-force

Observation 9: We are not paying enough attention to the needs of older adults in Pennsylvania.

We all have a responsibility to take care of our health and plan for our financial futures. No matter how careful we are or how much we plan, we will age, and we will need care. Elder care literacy is vitally important in the same way as financial literacy. We all need the information, regardless of our income or professional background or family medical history.

As a commonwealth, we have an obligation to put the infrastructure in place to facilitate quality care for all Pennsylvanians. We owe it to ourselves and our loved ones to break down the stigma around nursing homes and nurture the idea that nursing homes are safe places. We need to encourage peers and young people to go into the healthcare workforce, and more appropriately value the work and commitment of professionals in that workforce.

Recommendation 30: State officials within the departments of Health, Human Services and Aging should study successful public education campaigns around aging and formulate a plan to increase public awareness of aging issues, including in K-12 schools; to destigmatize nursing homes; and to promote long-term physical and financial health planning. The General Assembly should provide funding for this effort.

IV.

APPENDICES

Commonwealth of Pennsylvania
Department of the Auditor General
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EUGENE A. DePASQUALE
AUDITOR GENERAL

December 20, 2018

Secretary Rachel Levine, M.D.
Department of Health
8th Floor West
Health and Welfare Building
Harrisburg, PA 17120

Dear Secretary Levine:

As I stated at the start of my second term, in addition to maintaining an aggressive schedule of new audits my team will be revisiting several major performance audits to determine the extent to which the recommendations were followed.

The Department of Health's oversight of nursing homes will be included in the series of special reports from my office following up on previous major performance audits.

I have taken notice to changes that you have instituted at DOH since my July 2016 audit such as increasing the sanctions against poor-performing homes. This follow-up report provides an excellent opportunity to highlight the work you have been doing in your agency regarding oversight of nursing homes.

My team will contact you in the next few weeks to schedule time to discuss changes that have been implemented based on recommendations in my 2016 audit report, which is available online at: www.PaAuditor.gov/Performance Audit PA Department of Health Nursing Homes.pdf.

Thank you for your time and I look forward to hearing about the progress DOH has made in ensuring the continued safety of older adults and people with disabilities living in nursing homes.

Sincerely,

Eugene A. DePasquale
Auditor General

cc: Michael Brunelle
Elena Cross

General DePasquale

Auditor General Eugene DePasquale
Office of the Auditor General
613 North Street
Harrisburg, Pennsylvania 17120-0018

Dear General DePasquale:

The Department of Health (DOH) and the Division of Nursing Care Facilities (DNCF) thank the Department of the Auditor General for their work regarding the performance audit of the Nursing Homes Oversight and for providing recommendations on how to improve oversight and bolster our elder care systems and improve access to and quality of care.

Overall Response to Findings

As a result of the audit and recommendations made during the 2016 audit, the DOH has made significant progress in implementing changes, many of which were implemented during the audit. DOH, as well as DNCF, are fully committed to addressing the issues identified in this follow up report. As referenced in your report, DOH has committed to reviewing and revising the current nursing home licensure regulations, which have not been updated since 1999. The Centers for Medicare and Medicaid Services (CMS) have recently updated the federal regulations and are entering the final phase of their three phase roll out of the changes.

Specific Responses to the Special Report

Observation 1: DOH must better train surveyors to achieve consistency and provide the ability to set expectations, more accurately assess quality and move to corrective action with clear goals.

Recommendation 1:

DOH should closely analyze its surveys and address discrepancies and patterns of inconsistency. DOH should use the result of its overall analyses to improve its written policies and procedures for surveyors and better inform its training content and methods.

DOH Response:

DOH is working to more closely analyze the survey results and address patterns and inconsistencies within the survey field offices. We are using this data to make improvements. We receive Survey Outcome and Activity Reports from CMS to compare data from our previous quarters, previous year and to other states.

Recommendation 2:
DOH should explore outsourcing surveyor training to a third party to allow for a fresh look at training content and to take pressure off of participating employees who may not want to share stories or ask questions of internal training staff.

DOH Response:
In 2017, the Long Term Care Survey process was changed. With this change CMS improved the training experience for survey staff. DOH is contracted by CMS to perform survey duties related to Medicare and Medicaid Services. CMS provides mandatory training, which all our survey staff complete as required. Most of the training is web based, this would include initial training and annual training. Since November 2017, CMS has implemented new training protocols. These protocols have been established and adopted by DNCF to be used for training. Examples of the courses are: Foundational Investigative Skills, Basic Writing Skills for Survey Staff, Universal Infection Prevention and Control and New Long Term Care Survey Process. There are approximately 23 courses that all survey staff must complete.

Observation 2: Whether the DOH's new regulations mandate more than 2.7 hours of direct care per resident day is a decision for policy makers. Regardless of the amount of time mandated, all direct care must be quality care: Raising the minimum requirement of 2.7 hours per day will not improve patient outcomes if DOH does not adequately address the quality of care in homes with histories of violations.

Recommendation 3:

DOH should have set policies for acting on its authority to require additional nursing home staff when DOH surveyors perceive it to be necessary and should use that authority as a tool to get resources to nursing home clients who are lacking direct care.

DOH Response:
DOH is currently reviewing and revising the Long-Term Care Licensure regulations. CMS implemented regulations in November 2017 that requires facilities to perform a Facility Assessment to include resident needs and staffing with competencies necessary to provide the level and types of care needed for the resident population.

Recommendation 4:
DOH should prioritize establishing actionable; unambiguous guidelines addressing consequences for corrective action plan failures and quality deficiencies.

DOH Response:
The State Operations Manual from CMS requires us to follow a process for surveying. The survey process involves identifying deficient practice, facility implementation of a plan of correction and DOH follow up to ensure the plan of correction has been implemented. If the facility does not implement the plan of correction and the deficient practice is not corrected, the action against the facility is progressive. Steps taken can include increasing fines and the progression to higher levels of provisional licenses. The department also can place a temporary manager, and if the facility continues to be deficient, closure is an option.

Observation 3: DOH must follow the letter and the spirit of the Centers for Medicare & Medicaid Services' guidance for complaint handling if it employs it.

Recommendation 5:
DOH should continue to improve its training around all oversight processes, keep pace with its improved documenting procedures, continue to work on complainant communication and foster collaborative interagency work streams.

DOH Response: DOH continues to follow CMS guidance for complaint handling and utilizes opportunities to improve through online and in-person trainings for our staff related to this guidance. DOH continues to foster relationships with other agencies, collaborating and easily sharing information between agencies to ensure residents are provided with quality care.

Observation 4: DOH has shown progress by increasing use of civil monetary penalties for care deficiencies, and it should expand on those improvements by tracking the effective ness of fines to show that the oversight tool is leading to improved outcomes.

Recommendation 6:
For the benefit of administrators, advocates, policymakers, clients and families, and the public, DOH should track and share data in an "administrative penalty tracking report" to be posted on its website on a quarterly basis that show the impact of civil monetary penalties on quality of care.

DOH Response: DOH currently posts sanctions against nursing homes on the website monthly. The facility name and the specific sanction is posted for public viewing.

Recommendation 7: DOH must be cautious to avoid defaulting to civil monetary penalties. DOH should assess its use of oversight tools and their effectiveness and respond to violations with appropriate severity and with the goal of driving change; provisional licenses are an important tool and DOH should utilize them.

DOH Response: DOH currently utilizes provisional licenses along with civil monetary penalties, having issued approximately 24 provisional licenses in 2019 so far.

Observation 5: DOH must adopt more stringent, thorough, clearly outlined policies for vetting nursing home facilities license applicants.

Recommendation 8: DOH should work with its General Counsel to review how other states review new applicants, and set policy to mandate detailed, thorough vetting, including past and current litigation, vendor relationships, real estate relationships, ownership interest in other healthcare providers, and staff and client complaints.

DOH Response: DOH has reviewed how other states review new applicants. We are presently exploring opportunities for the improvement of this process related to vetting new owners. With the current review and revisions of the Long-Term Care Licensure regulations, this process is a focus area. Additionally, DOH has been involved in the Intergovernmental Long Term Care Task Force which is examining this and many other issues.

Observation 6: Pennsylvania's looming healthcare workforce crisis must be addressed or it will leave older adults without critical care, harm family members and household finances at every income level, and threaten the commonwealth's long-term economic viability.

Recommendations 10-17: To mitigate this crisis and achieve necessary, lasting improvement in the healthcare workforce environment, policymakers and industry leaders should consider the following recommendations:

10. Healthcare employers should raise wages to family-sustaining levels and increase non-salary benefits such as certification reimbursement, tuition reimbursement, student loan assistance, paid family leave, childcare assistance, gas cards and transportation assistance;

11. Healthcare employers should form partnerships with labor associations to amplify the voices of direct care workers and facilitate management-workforce collaboration and communication;

12. Nurses and aides are providing direct care and their opinions need to be sought out and valued. Healthcare employers should include direct care staff in organizational, safety and care decisions; they should put mentorships in place and encourage career advancement;

13. Healthcare employers should explore innovative employment programs, like shared employment agreements between different companies or public agencies in order to give employees variety, the opportunity to cross-train, and to rotate physically and emotionally demanding direct care roles;

14. The departments of State and Health should work together to ease licensing restrictions for medical professionals, e.g., psychiatric mental health nurses should be able to prescribe medication (21 states have this in place);

15. The Department of Education should work with educators and industry leaders to promote medical fields as attainable, desirable careers in K-12 schools, focusing on specific career paths beginning at the junior high level; they should promote behavioral health, trauma care and social work fields in the same manner;

16. U.S. nursing schools turned away 56,000 qualified applicants for undergraduate programs in 2017 because of a teacher shortage that exists in part because practicing nurses make more money.20 Therefore, the commonwealth and healthcare employers should work with higher education institutions to fund nursing program expansion and offer more seats to aspiring nurses in Pennsylvania; and

17. The General Assembly should increase Medicaid funding, but with new funds specifically allocated to direct care and wages. Healthcare employers have a responsibility to pay their employees a living wage; short-term cost savings on labor may boost quarterly net income, but the risk of failing to provide quality care and losing nursing staff should outweigh increased profits.

DOH Response: DOH supports efforts across stakeholder groups to help mitigate the crisis and achieve lasting improvement. Stakeholder groups and interagency personnel are involved in the review and revisions of the Long-Term Care regulations. DOH is an active member of the LTC Council that meets to address specific issues in LTC, some of which have been mentioned in this report.

Observation 7: Quality healthcare for older adults is expensive and difficult to find – or not readily accessible – in many areas of Pennsylvania.

Recommendations 18-22: The following recommendations could increase access to care and save taxpayer money through increased efficiencies in the elder care system:
18. The Department of Health should apply to CMS to shorten the wait time for Medicaid approval for in-home care, which would expedite access to care;
19. The departments of Health, Human Services and Aging, as well as healthcare providers and insurers should seek to educate older adults and families about long-term care insurance;
20. Nursing home operators should work with the departments of Health, Human Services and Aging to expand mental health and dementia care programs at nursing homes;
21. The departments of Health, Human Services and Aging should work with the Department of Corrections and re-entry experts to address the rising population of formerly incarcerated older adults; and
22. The Department of Health and the Department of Military and Veterans Affairs (DMVA) should address wait lists at DMVA homes.

DOH Response: DOH has a collaborative relationship with the Departments of Human Services, Aging, DMVA and Corrections and works with all of the agencies to work toward addressing the issues.

Observation 8: Public and private systems for preventing elder abuse are unprepared for the volume and diversity of challenges facing older adults in Pennsylvania.

Recommendation 23: State agencies including the departments of Health, Labor & Industry, Human Services and Aging, as well as the Office of the Attorney General, should work together to implement a tracking system for professionals, including administrators, to prevent poor or neglectful employees and managers from moving on to new facilities. The General Assembly should add a provision to the Older Adults Protective Services Act 24 that will help stop abusers from moving from facility to facility, similar to the "pass the trash" provision of the Public School Code.25

DOH Response: DOH fully supports the fight against elder abuse and is interested in engaging in a collaborative effort to add provisions to the Older Adults Protective Services Act to stop abusers from moving from facility to facility.

Recommendation 24: The departments of Health, Human Services and Aging should streamline elder abuse and complaint reporting hotlines into one system, in a manner similar to Pennsylvania's ChildLine system for child abuse and neglect complaints.

DOH Response: DOH will consider options surrounding streamlining the abuse and complaint reporting hotlines.

Recommendation 25: Local law enforcement must recognize the prevalence and severity of financial exploitation against older adults, participate in Elder Justice Task Force meetings and engage with Area Agency on Aging peers to investigate exploitation cases and prosecute when possible.

DOH Response: DOH is a participant in the Elder Justice Task Force meetings and will encourage local law enforcement participation.

Recommendation 26: State and local officials should seek a regional solution to elder abuse and exploitation, perhaps following the Child Advocacy Center model. District attorneys will be critical to this effort by illustrating consequences, deterring criminal activity and even by simply focusing on older adults as an at-risk population.

DOH Response: DOH supports this endeavor and would be happy to provide input from a regulatory perspective.

Recommendations 27-29: Additional steps Pennsylvania should take to prevent guardian abuse include:

27. The General Assembly should pass a law instituting the right to counsel for people under guardianship, facing guardianship or experiencing elder abuse and exploitation;

28. The General Assembly should establish a protected person's bill of rights, as Nevada did in the wake of severe, successfully prosecuted cases of guardian abuse; and

29. The governor and the General Assembly should work together to create an Office of the Public Guardian, similar to Delaware's, to provide vetted, accountable guardianship services to Pennsylvanians who are unable to manage their personal and financial affairs.

DOH Response: DOH supports this endeavor and would be happy to provide input from a regulatory perspective.

General DePasquale

Observation 9: We are not paying enough attention to the needs of older adults in Pennsylvania.

Recommendation 30: State officials within the departments of Health, Human Services and Aging should study successful public education campaigns around aging and formulate a plan to increase public awareness of aging issues, including in K-12 schools; to destigmatize nursing homes; and to promote long-term physical and financial health planning. The General Assembly should provide funding for this effort.

DOH Response: DOH supports this endeavor and would be happy to provide input from a regulatory perspective.

Thank you for the opportunity to respond to this report. If you have any questions, please contact

Sincerely,

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