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EXECUTIVE SUMMARY

As the State Unit on Aging, the Pennsylvania Department of Aging (PDA) is responsible for providing the leadership necessary to develop, implement, and administer a State Plan on Aging in accordance with all Federal statutory and regulatory requirements. PDA is required to submit its State Plan on Aging to the United States Department of Health and Human Services’ Administration for Community Living (ACL). The state plan carries out the complementary objectives of the Older Americans Act (as amended and reauthorized in 2016), ACL, the department, and the commonwealth. PDA submits this plan every four years in order to provide a vision and direction for Pennsylvania’s network of aging services. This plan will be effective from October 1, 2016 through September 30, 2020.

As the State Unit on Aging, PDA is responsible to serve as an effective and visible advocate for older Pennsylvanians and to coordinate all state activities related to the purposes of the Older Americans Act. In order to uphold these responsibilities, PDA laid out core principles that will guide the operation of the organization over the course of the next four years. Mission, Foundation, Values, and Goals – these principles, first and foremost, are crucial to understanding the vision that PDA has for aging services in the Commonwealth of Pennsylvania. The plan embraces two key initiatives: Aging in Place and Elder Justice.

In designing the State Plan on Aging, the department sought to create a document and an approach that are responsive and responsible, considered the needs of the people we serve, and continued to incorporate their feedback. PDA created and carried out a process which solicited input from the entire spectrum of stakeholders – department staff, consumers of services, caregivers, professionals, and anyone who had an interest in the future of aging services. The department convened internal workgroups and a series of facilitated conversations, held seven community listening forums throughout the commonwealth to hear about how aging services are or are not fulfilling the needs of older Pennsylvanians, released a draft state plan, and received testimony on that plan at three public hearings. Additionally, Pennsylvania residents were able to submit feedback through an online survey, via email, regular mail, or even call in by phone.

All of this feedback made it possible to craft a plan that was truly considerate of the needs of Pennsylvania’s older adults and those who serve them. The core vision for the plan resonated with those who provided feedback. PDA heard repeated calls for innovation and collaboration, as well as recognition of the
importance of Aging in Place and Elder Justice. PDA received valuable input on what needed to improve, all of which has been incorporated into the plan.

Pennsylvania has a diverse population of older adults with different needs, and the aging services network must be prepared to effectively serve those needs. The commonwealth is home to more than 12.8 million residents. Of these, approximately 2.9 million are adults age 60 and older, and more than 300,000 are aged 85 and older. By 2020, the population of older Pennsylvanians is projected to increase by 25%, and the population of Pennsylvanians aged 80 and over is projected to increase by 20,000 individuals.

The Department of Aging was created by Pennsylvania’s Act 70 of 1978, which established “a cabinet-level State agency whose jurisdiction, powers, and duties specifically concern and are directed to advancing the well-being of Pennsylvania’s older citizens.” It further established that PDA would “serve as an advocate for the aging at all levels of government.”

In conjunction with administering the Older Americans Act and the Administration for Community Living Discretionary Grants, PDA coordinates a comprehensive array of services that benefit older Pennsylvanians, their families, their caregivers, and the aging network. These services are made available primarily through a network of 52 local Area Agencies on Aging (AAAs), which are responsible for planning, developing, and implementing a system of services for persons age 60 and over in their respective planning and service areas.

The aging network is also composed of senior community centers, adult daily living centers, and Aging and Disability Resource Centers (ADRCs). These linkages are crucial to the delivery of services and the well-being of older Pennsylvanians. Senior community centers promote socialization, engagement, and a positive quality of life. Adult daily living centers provide social, recreational, therapeutic, and nutritional support. ADRCs improve access to long-term care supports, expanding the use of community-based solutions, promoting consumer-directed decision making through person-centered counseling, and improving the quality of services regardless of an individual's age, physical or developmental disability, or ability to pay.

PDA also benefits from several advisory councils, such as the Pennsylvania Council on Aging and the Cultural Diversity Advisory Council, which provide recommendations on aging services, diversity, inclusion, and other long-term care issues. Additionally, beginning in the fall of 2016 the Pennsylvania Long-Term Care Council will be initiated in order to advise the Secretary of Aging on topics ranging from facility-based care to home and community-based service systems.

PDA facilitates the provision of important aging services, including caregiver support, employment, health and wellness, help at home, housing, insurance, legal assistance, meals, ombudsman, prescriptions, protective services, and transportation. The 2016-2020 State Plan on Aging recognizes the role of each of these services and lays out an approach to improving their provision in the goals, objectives, strategies, and performance measures.

The state plan also accounts for several ongoing initiatives that touch aging services in Pennsylvania, including Community HealthChoices (a managed care long-term services and supports program), the State Plan for Alzheimer’s Disease and Related Disorders, the Governor’s Office of Transformation, Innovation, Management and Efficiency (GO-TIME), the Governor’s Food Security Partnership, the Reauthorization of the Older Americans Act, and the Affordable Care Act.

There are four state plan goals – promote existing services, improve access to services, enhance quality of services, and empower the workforce. These are designed to encompass all initiatives that the department will undertake to improve aging services in Pennsylvania. As conditions change, the department may find it necessary to retool its approach to certain services. An objective may need to be reshaped, or some strategies may not work and will need to be replaced by new ones, but the goals are comprehensive and will provide a lasting way of thinking about the department’s initiatives.
The Pennsylvania Department of Aging has laid out core principles that will guide the operation of the organization over the course of the next four years – mission, foundation, values, and goals. These principles are crucial to understanding the vision that PDA has for aging services in the Commonwealth of Pennsylvania.

**MISSION**

*Enhance the quality of life of older Pennsylvanians by empowering diverse communities, the family, and the individual*

The Department of Aging is required by ACL to draft and submit a state plan, and from a legal standpoint, that is why we created this plan. More importantly though, this plan outlines how PDA intends to follow through on its duty to serve and protect older Pennsylvanians. Even in the absence of federal requirements, PDA would still create a strategic plan, and our values would not waiver. Older adults deserve to live well and free from all types of abuse, and we strive to ensure they are able to do that because it is our mission. In this 2016-2020 State Plan on Aging, the Department of Aging attempts to refine our vision for the services we provide and the actions we take that enhance the quality of life of older Pennsylvanians.

**FOUNDATION**

*Prevent instability of health and wellness by enabling citizens to age in place with dignity | Protect the most vulnerable from abuse, neglect, abandonment, and exploitation*

Older Pennsylvanians face many obstacles to remaining healthy in the environment of their choice – nutrition, transportation, the cost and availability of health care and prescriptions. They are also more likely to become victims due to their vulnerability, and too often they are abused, neglected, abandoned, and exploited.

For these reasons, the foundation of the Department of Aging is twofold: *to prevent and protect.*
VALUES

Innovation and collaboration, focusing on stakeholder engagement, to further improve the provision of person-centered services

Our values statement clarifies how the department aims to carry out the actions which will enhance the quality of life of older Pennsylvanians. We are dedicated to innovation because the way aging services have been provided in the past will not be sufficient to face the challenges of the future. Collaboration – working together and establishing partnerships – will allow us to accomplish much more than we would alone.

Our efforts to innovate and collaborate will be informed by consistently seeking stakeholder engagement. We will listen to older Pennsylvanians, their families, and those who serve them in order to better understand the needs that we seek to address. Ultimately, this will allow us to better provide services that are person-centered and built around the needs and understanding of the consumer.

GOALS

Promote existing services  |  Improve access to services  |  Enhance quality of services  |  Empower the workforce

The plan contains four goals, each of which was specifically designed to capture the initiatives that PDA uses to improve aging services. Every action the department takes to carry out its mission falls into one of these categories.

The department promotes services to connect people with the resources they need. We improve access to services so that consumers do not come up against barriers. We enhance the quality of services in order to better provide for the needs of consumers. We empower the workforce – meaning all those who serve older Pennsylvanians, paid or unpaid – to ensure that they are supported and well-equipped.

OBJECTIVES, STRATEGIES & PERFORMANCE MEASURES

Finally, the objectives and strategies are the initiatives that PDA will undertake to achieve the goals. For example, an objective under the first goal – promote existing services – describes what services will be promoted and in what way. The strategies under that objective describe concrete actions that will be taken to accomplish it. Performance measures will allow the department to evaluate the progress of these efforts and recalibrate as the landscape of aging services of Pennsylvania evolves. Each of these components is designed to be flexible and responsive to changing needs.

DESIGNING THE PLAN

In designing the State Plan on Aging, the department sought to create a document and an approach that is responsive and responsible, which considered the needs of the people we serve and continued to incorporate all feedback received. This approach allowed us to account for the valuable input of the public and the aging services workforce as well as our organizational capacity and legal limits. The plan would have to be flexible to best deal with the challenges that lay ahead, and it would have to be coherent so that everyone could understand what it intended to accomplish, and how it would be done. It needed to be a
The process began by reviewing the 2012-2016 State Plan on Aging and identifying what we could do better. In the fall of 2015, the secretary convened the State Plan Steering Committee, composed of the department’s executive staff, bureau directors, program leads, and other subject matter experts. Together, they assembled a vision for the department: our mission, foundation, values, and goals. Then PDA began to solicit input to make the 2016-2020 State Plan on Aging a reality.

We began by listening to our own staff. We coordinated workgroups and held meetings internally where we discussed what each program area was working on and what needed to be accomplished in the next four years. These discussions helped form preliminary objectives and strategies, which were reviewed by the department’s entire workforce at a February 2016 all-staff meeting. Staff shared their observations and suggestions via a facilitated discussion.

In March 2016, PDA, the Pennsylvania Association of Area Agencies on Aging, and Pennsylvania Council on Aging held their annual convention. A full session was devoted to a facilitated discussion to encourage dialogue while soliciting feedback from these vital aging services network partners.

Next, to ensure that we understood the needs of our consumers and the workforce, we held seven community listening forums throughout the state. The public also submitted input through a survey on our website. This was done to solicit their input on programs and priorities, and to measure their awareness of services and supports. 230 individuals participated in the sessions and 400 individuals responded to surveys. The results represent a broad cross-section of consumers, aging network partners, advocates for older adults, caregivers, and government representatives.

Like PDA, the Area Agencies on Aging develop plans in order to fulfill the requirements of the Older Americans Act. PDA issued an Aging Program Directive in March 2016 which outlined the department’s philosophy for the new state plan and how the department and the AAAs could be mutually responsible for aligning their efforts in the future. The AAAs later submitted area plans to PDA to identify critical issues and trends as well as common barriers and needs that served as the basis for developing goals and objectives common to both the state plan and local area plans.

Finally, a draft version of the plan was presented on the department’s website and opened for comment at three public hearings in May 2016. This testimony, along with the concerns and suggestions that Pennsylvanians shared via the department’s website and email, were used to revise the 2016-2020 State Plan on Aging.

CONCLUSIONS & ADJUSTMENTS

The community listening forums and public hearings affirmed much of what we had laid out in our vision for the plan. We heard time and again about the importance of services and supports that allow older Pennsylvanians to age in place and secure justice in instances of elder abuse. We were told that the solutions of the past would not solve the problems of the future; we would have to innovate. We were told that so much more could be accomplished through effective partnerships and alignment; we would have to collaborate.

There was also much that we hadn’t fully accounted for. We heard calls for increased cultural competency and the need to focus on serving diverse and hard-to-reach populations. In particular, we heard about the changing needs of LGBT seniors and those living with HIV/AIDS (the majority of people living with HIV/AIDS in the U.S. are now over the age of 50), as well as the needs of older adults with limited English proficiency. We revised the plan to renew our commitment to engaging with trusted community organizations, providing language-appropriate resources, and conducting cultural competency training.

Many people felt it was important that we recognize the changing nature of being an older adult. People are living longer and healthier lives than ever before, and a new generation with different values and lifestyles is entering retirement. This calls for new ways of thinking about aging services to include flexibility,
adaptability, and continuous quality improvement.

PDA further recognizes the importance of effective communication to ensure that efforts throughout the commonwealth are aligned to enhance the quality of life for older Pennsylvanians. For that reason, PDA has built in strategies for communicating the rationale for all regulatory, policy, and programmatic changes to the aging network partners and stakeholders.

We were also fortunate to receive valuable input on a wide variety of topics and services, which was vital in building and revising the plan. This input was used to make significant revisions to the objectives and strategies contained in the plan, which will ultimately ensure that the department is appropriately directing its efforts over the next four years.
OVER 55% of households in PA have someone age 60 or older living in them.

OVER 240,000 Pennsylvanians over the age of 60 live below the poverty line.
WHO WE ARE

THE DEPARTMENT OF AGING

The Department of Aging was created by Pennsylvania's Act 70 of 1978, which established “a cabinet-level State agency whose jurisdiction, powers, and duties specifically concern and are directed to advancing the well-being of Pennsylvania's older citizens.” It further established that PDA would “serve as an advocate for the aging at all levels of government.”

As such, the department serves as the State Unit on Aging for Pennsylvania and is formally charged by the Older Americans Act and the Pennsylvania General Assembly with representing the interest of older Pennsylvanians throughout the commonwealth.

In conjunction with administering Older Americans Act Titles III and VII and ACL Discretionary Grants, the department coordinates a comprehensive array of services through the network of 52 local Area Agencies on Aging. The department is also responsible for representing the state’s interests in the design, implementation, and continuous improvement of all long-term services and supports.

THE AGING SERVICES NETWORK

Aging services in Pennsylvania are carried out through a robust network made up of Area Agencies on Aging, senior community centers, adult daily living centers, and the PA Link to Aging and Disability Resources. This network is vital to ensuring the effective provision of services so that older Pennsylvanians receive the support and services they need.
The department and AAAs collaborate with other state agencies in the delivery of shared supports. These include Pennsylvania’s Department of Health on transition and diversion activities from nursing facilities to private residences, facilities licensing, and health and wellness initiatives; the Department of Transportation on coordinating transportation for older adults; the Department of Community and Economic Development and Pennsylvania Housing Finance Agency on housing and community development programs; the Department of Agriculture on nutrition programs; the Department of Human Services on home and community-based services, and coordination of long-term services and supports; and the Department of Labor and Industry on employment programs, direct care worker initiatives, and programs focused on independent living for persons with physical disabilities.

SENIOR COMMUNITY CENTERS

Senior community centers are a vital linkage in the distribution of aging services, promoting socialization, engagement, and a positive quality of life. Nearly 93,000 individuals participate in senior community center programming annually with an aggregate of more than 3.8 million annual visits.

Over the past three years, PDA has awarded over $6 million in state lottery-funded grants to senior community centers to update facilities or implement innovative programs to ensure that these vital resources can remain a focal point in the community. To preserve the viability of these resources, the department recognizes that it must not only promote existing services and enhance the quality of services, but also improve cultural competence to draw a larger, more diverse population that is fully inclusive.

ADULT DAILY LIVING CENTERS

PDA licenses 277 adult daily living centers, providing social, recreational, therapeutic, and nutritional support for more than 16,000 older Pennsylvanians. Adult daily living centers provide core services, including personal care, nursing services, therapeutic activities, social services, nutritional and therapeutic diets, and emergency care. 127 centers primarily serve older adults with dementia-related conditions, and 113 serve adults with developmental or intellectual disabilities.

Stakeholders said that adult daily living centers are vital not only for older individuals but also for caregivers who need this support and the respite it provides them. The state plan extends this support for individuals and their caregivers specifically though Objective 2.4, by exploring the viability of expanding access to adult daily living centers and increasing the number of centers throughout the state.

PA LINK TO AGING & DISABILITY RESOURCES

Pennsylvania’s Aging and Disability Resources Centers are known as PA Link. They are dedicated to improving access to long-term care supports, expanding the use of community-based solutions, promoting consumer-directed decision making through person-centered counseling, and improving the quality of services regardless of an individual’s age, physical or developmental disability, or ability to pay. PA Link functions are coordinated with other core Older Americans Act services and discretionary grants. Fifteen regional Links are made up of AAAs, Centers for Independent Living, county assistance offices, and other local partners.

ADVISORY COUNCILS

THE PENNSYLVANIA COUNCIL ON AGING

The Pennsylvania Council on Aging serves as an advocate for older individuals and advises the governor and the department on planning, coordination, and delivery of services to older individuals. The 21 members who make up the council (the majority of whom are required to be age 60 or older) are nominated by the governor and subject to senate confirmation. Five additional members of the council are chairs of the five regional councils.
THE PENNSYLVANIA LONG-TERM CARE COUNCIL

The Pennsylvania Long-Term Care Council consults with various departments and agencies to make recommendations on regulations, licensure, financing, or any other responsibilities of those departments or agencies relating to long-term care. The council’s scope includes institutional long-term care as well as home and community-based long-term care. The council replaces the Intergovernmental Council on Long Term Care and will begin its work in 2016.

THE CULTURAL DIVERSITY ADVISORY COUNCIL

The Cultural Diversity Advisory Council advises the department on developing an aging services network that is culturally sensitive, responsive, and inclusive of the diverse needs of Pennsylvania’s older adults. The council is made up of members from diverse backgrounds and perspectives.
AGING SERVICES

CAREGIVER SUPPORT

In fiscal year 2014-15, more than 5,500 caregivers received support through this service.

The Pennsylvania Caregiver Support Program reduces stress on primary, informal, unpaid caregivers. The program supports individuals who care for a spouse, relative, or friend who requires assistance due to disease or disability. The program also supports individuals age 55 and older caring for related children. The program provides coordinated support through an appointed care manager. Services may include caregiving assistance, education and counseling, and reimbursement for supplies used to provide care. Participation is projected to increase due to the broadening of enrollment eligibility.

On April 20, 2016, Governor Wolf signed the Caregiver Advise, Record, Enable Act (CARE) to ensure that caregivers receive the information and knowledge needed to safely care for their loved one after being discharged from a hospital.

Stakeholders advocated for increased support of caregivers during our community listening forums. The state plan extends this support specifically through the strategies in Objective 4.2.

EMPLOYMENT

Approximately 700 older adults participate in the Senior Community Service Employment Program (SCSEP) and other employment programs.

SCSEP helps unemployed, low-income adults age 55 and older with employment and training services. The department also connects older adults to the Commonwealth Workforce Development System and the Office of Vocational Rehabilitation.
Strategies for enhancing employment opportunities for older adults are included within Objective 4.1.

HEALTH & WELLNESS

Approximately 24,000 individuals participate annually in health and wellness services.

Every year, more than 80 different types of wellness programs are offered to individuals age 50 and older through AAAs, senior community centers, hospitals, physicians’ offices, community organizations, and educational institutions throughout the commonwealth. Programs include a wide array of options such as medication management, aquatic exercise, health screenings, nutrition classes, and more. The most widely available classes offered by the Department of Aging are:

- Chronic Disease Self-Management (CDSM) Workshops – Self-Management Skill Development
- “10 Keys” to Healthy Aging – Disease Prevention
- Healthy Steps for Older Adults – Falls Prevention
- Healthy Steps in Motion – Falls Prevention

In federal fiscal year 2016, PDA and the aging network will ensure that Title IIIID funds are utilized solely for health and wellness programming that meets the definition of “evidence-based” as prescribed by the Older Americans Act.

Stakeholders cited the effectiveness of these programs during community listening sessions but indicated that many older adults are either unaware of these services or have difficulty accessing them.

State Plan Objective 3.2 within Goal 3 expands and enhances preventive health promotion efforts to encourage older Pennsylvanians to develop healthier lifestyles.

HELP AT HOME

The Pennsylvania Department of Aging’s OPTIONS Program helps individuals age 60 and older to remain in their homes and communities. A comprehensive interview is conducted by the local Area Agency on Aging to determine eligibility and identify consumers’ needs. A Care Manager is assigned to work with the consumer to develop a plan of care, and coordinate and arrange for the provision of services. The Aging Waiver Program, which is administered by the Department of Human Services, as the state Medicaid agency, provides in-home services to consumers who are age 60 and older who meet both functional and financial eligibility requirements. Services may include adult day services, care management, counseling, emergency services, home-delivered meals, home health services, home modifications, home support services, personal care, personal emergency response systems, respite care, and transportation.

HOUSING

Over the course of the 2012-2016 state plan, PDA developed a housing strategy to address the growing need for safe, affordable, accessible housing and services for older adults so that they can remain in their communities and setting of choice. Initiatives focused on identifying housing needs and solutions in collaboration with AAAs, the PA Link, and other community partners, which included four housing technical assistance pilots in different parts of the state.

As a result, PDA developed and conducted a housing needs survey, hosted two regional housing summits targeted at developers to provide education and develop relationships, identified specific senior housing projects for development, developed a shared housing program called SHARE (Shared Housing and Resource Exchange) to help seniors remain in their homes, and developed protocols for cross-systems communication between AAAs, human services agencies, and public housing authorities.

In 2016, PDA was awarded a Money Follows the Person Rebalancing Demonstration Grant to address an
increasing need for affordable housing options for older adults and older adults with disabilities. The pilot of the program will be launched in three of Pennsylvania’s counties.

Stakeholders noted that older adults face significant challenges in maintaining their homes, finding affordable housing, and modifying existing housing to enable aging in place. Objective 2.6 addresses the role that PDA will serve in continuing to advocate and collaborate to create housing opportunities for older Pennsylvanians.

INSURANCE

Pennsylvania’s free health insurance counseling program, APPRISE, served approximately 295,000 of the commonwealth’s 2.5 million Medicare beneficiaries in calendar year 2015 through AAAs and a vast array of partnerships at the state and local level.

APPRISE is designed to empower Medicare-eligible individuals, their families, and caregivers through outreach, counseling, and training so they can make informed health insurance decisions that optimize access to care and benefits. Counselors are specially trained staff and volunteers who can answer questions about Medicare and provide older adults with objective, easy-to-understand information about Medicare, Medicare Supplemental Insurance, Medicaid, and Long-Term Care Insurance. APPRISE will have an important role leading up to and following the implementation of Community HealthChoices in July 2017 as the dual-eligible population will continue to rely on the APPRISE counselors as trusted resources for Medicare and Medicaid information.

Currently, there are 755 volunteers who support the program. Through local and state initiatives, over 7,000 outreach and educational events were held during 2015. The APPRISE program currently ranks seventh in the United States among state health insurance assistance programs.

In grant year 2015, PDA completed the Medicare Improvements for Patients and Providers Act, enrolling 6,541 individuals in low-income subsidy and 2,787 in Medicare supplement programs.

Although APPRISE is one of the aging services network’s most recognized programs, Objective 1.2 addresses increasing awareness of APPRISE among Medicare recipients and across diverse populations. Objective 1.5 focuses on outreach to increase enrollment in Medicare Part D and in the low-income subsidy among unenrolled individuals eligible for Medicare Part D.

LEGAL ASSISTANCE

In fiscal year 2014-15, PDA and its aging network partners provided more than 56,000 legal assistance sessions.

Pennsylvania’s Legal Assistance Program provides counseling through an attorney or non-lawyer advocate. The program also provides representation for eligible older adults, with priority to those with concerns related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination. Additionally, the legal service developer participates in state-level elder justice activities.

Stakeholders expressed frustration with how difficult it is to obtain legal services in some regions, and they called for greater advocacy and legal protections for all older Pennsylvanians, including LGBT and minority communities, veterans, and those with mental health issues.

Many of the objectives within the state plan support promotion and enhancement of legal services for older adults, and Objective 3.4 specifically focuses on improving the quality and consistency of guardianship services.
MEALS

In fiscal year 2014-15, PDA and its AAAs served 3,110,972 congregate meals and 5,581,225 home-delivered meals.

The Department of Aging provides nutritious meals at Senior Community Centers and through home-delivered meal programs to Pennsylvanians age 60 and older and their spouses. Meals are available free of charge or through an anonymous donation. The meals follow the Dietary Guidelines for Americans and are reviewed and approved by a dietitian to provide 1/3 of the Recommended Daily Allowances (RDAs). Nutrition education and counseling are available upon request for older adults found to be nutritionally at risk. PDA recognizes that nutrition services reduce hunger and food insecurity, promote socialization, and address the health needs of older adults.

PDA also participates in the Senior Farmers’ Market Nutrition Program (SFMNP) in collaboration with the Department of Agriculture so that eligible older adults can purchase locally grown, nutritious produce from participating farmers.

Food waste is a growing concern. In fiscal year 2014-15, 100,321 congregate meals and 69,032 home-delivered meals were prepared but not served. Pennsylvania is currently participating in the “What A Waste™” program through a pilot program with eight senior community centers that aims to reduce waste, reduce costs, improve senior nutrition program operations, and promote menu and purchasing modifications.

Objective 3.1 promotes the dissemination of best practices in the administration of existing and new nutritional support programs.

OMBUDSMAN

In fiscal year 2014-15, ombudsmen provided over 12,000 consultations with facility residents and their families.

Ombudsman advocate for and protect the rights of older adults receiving long-term care services. They receive confidential complaints from individuals living in long-term care settings and work to investigate and resolve these complaints. Ombudsmen services are confidential and free to individuals who receive long-term care services, reside in a long-term care facility, or attend an Older Adult Daily Living Center (OADL). Over the next four years, the Department of Aging will continue to focus our efforts on implementing the revised Older Americans Act requirements regarding the provision of ombudsman services.

Objective 2.3 seeks to increase awareness of and access to ombudsman services by examining evaluation protocols and evidence-based approaches. Objective 3.3 also addresses coordination between the Ombudsman’s Office and stakeholders to increase protection and improve the quality of care for consumers.

PRESCRIPTIONS

In fiscal year 2014-15, PACE provided pharmaceutical assistance to an average of 128,200 consumers each month; PACENET provided assistance to an average of 184,826 consumers monthly.

Pennsylvania’s Pharmaceutical Assistance Contract for the Elderly (PACE) and Pharmaceutical Assistance Contract for the Elderly Needs Enhancement Tier (PACENET) programs provide prescription drug coverage to individuals age 65 and older who meet the program’s income requirements. The PACE enrollment process also evaluates the eligibility of older adults for programs such as Medicare Part D, LIHEAP, and property tax and rent rebate assistance.

PACE and PACENET are perhaps the most recognized aging services. Building on this recognition, Objective 1.4 addresses targeting hard-to-reach populations to increase PACE and other program enrollments.
PROTECTIVE SERVICES

In fiscal year 2014-15, PDA (through the AAAs) received 20,133 reports of need for individuals age 60 or older and conducted 15,029 investigations.

The Older Adults Protective Services Act protects Pennsylvanians 60 years of age and older against physical, emotional, or financial abuse as well as exploitation, neglect, or abandonment. Reporting abuse is mandatory for employees and administrators of nursing homes, personal care homes, assisted living homes, domiciliary care homes, adult day services centers, home health care providers, and other facilities specified by their licensing body. For the general public, reporting of abuse is voluntary and can be anonymous. The law protects all reporters from retaliation and civil or criminal liability. Under this law, the Area Agencies on Aging receive reports of need for protective services 24 hours a day, 7 days a week, and are responsible for initiating an investigation within prescribed time frames (immediate, within 24 hours, or within 72 hours).

PDA is dedicated to raising awareness of and ultimately preventing elder abuse, neglect, and exploitation, an issue that impacts the lives of thousands of older Pennsylvanians. PDA is involved with the Supreme Court of Pennsylvania’s Advisory Council on Elder Justice in the Courts, along with other efforts that focus on education and prevention, while advocating for an adequate system of older adult protective services and access to justice for older victims of abuse.

In 2015, ACL awarded PDA a discretionary grant to enhance adult protective services statewide. PDA partners with many other advocacy organizations and offers ongoing training to protective service investigators. During fiscal year 2014-15, 15 courses were offered to a total of 658 protective service investigators. In addition, 1,142 professionals participated in training on elder abuse prevention and reporting and other elder-justice-related topics. Through PDA’s Institute on Protective Services at Temple University in Harrisburg, AAAs, and law enforcement, 11 arrests were made, a total of $568,359 in recoveries or court ordered restitution were realized, and $1.25 million in older adults’ assets were protected.

Objective 1.3 addresses improving awareness and collaboration in providing adult protective and referral services. Objective 4.1 focuses on standardized training for protective services investigators and other professionals.

TRANSPORTATION

In fiscal year 2014-15, Pennsylvanians age 65 and older received more than 38 million free or reduced-fare rides through the Pennsylvania Department of Transportation’s lottery-funded transit programs.

Area Agencies on Aging help coordinate transportation services and assist older adults in getting to and from senior community centers, medical facilities, and other essential destinations. The services utilized includes Pennsylvania’s Free Transit Program, which allows senior citizens to ride free on local fixed-route service, and the Shared-Ride Program, which enables older Pennsylvanians to use shared-ride, demand-responsive services and pay only a small portion of the regular shared-ride fare.

Stakeholders expressed a need for flexible, affordable, and reliable transportation, particularly in rural areas. Transportation is often a barrier to accessing services. Issues include affordability, scheduling, coordination of door-to-door and door-through-door transit, reliability, and flexibility. Objective 2.7 covers how PDA will work to address these needs.

FUNDING

Pennsylvania is the only state in the nation that dedicates its lottery revenue solely for programs and services that benefit older Pennsylvanians. These include property tax and rent rebates, free and reduced-fare transit services, PACE and PACENET low-cost prescription drug programs, nursing facility services, and an array of home and community-based services through the network of local Area Agencies.
Pennsylvania, like other states, must address budgetary constraints and competing priorities for funding. Within the state plan, a number of objectives and strategies address ways to maximize and leverage financial resources. These include developing a robust and diverse volunteer network across all program areas, promoting collaboration and communication across the entire aging network and among all stakeholders, implementing evidence-based and best practices to ensure a more effective delivery of new and existing services, securing sustainable grant funds that match our organizational capabilities and capacity, and eliminating redundancy in program administration through improved data and information collection and quality assurance protocols.

QUALITY MANAGEMENT & METRICS

The Department of Aging is committed to continuous quality improvement and has reaffirmed this value through our state plan development efforts. This commitment is shared by the aging network and is communicated on a regular basis in a variety of methods: monthly conference calls focused on improving our data systems and sharing of best data management practices, a presentation of a benchmark report and key performance measures during each quarterly meeting with the aging network, and rigorous efforts to validate data before it is reported as final.

At all levels, PDA is focused on transparency and open data, and recognizes the importance of ensuring that the public is aware of how federal and state dollars are being invested to better the lives of older Pennsylvanians. The use of data in our planning efforts is a requirement across all programs and services to ensure that the most prevalent needs are being addressed. The necessity of maintaining data in a secure way is emphasized at least annually to staff at the department through cyber security training and testing.

Through the state plan, the Department of Aging will continue to focus on continuous quality improvement, and stakeholders will be and must be engaged in and committed to this process. Training will be ongoing and developed to ensure alignment with both the department’s mission, foundation, and values as well as those of the Area Agencies on Aging.

OTHER INITIATIVES

COMMUNITY HEALTHCHOICES

Under Governor Tom Wolf’s leadership, the Department of Humans Services (DHS) and PDA are developing a new program for older Pennsylvanians and adults with physical disabilities called Community HealthChoices (CHC). CHC represents a major state initiative in reforming the delivery of long-term services and supports via a managed long-term care environment. The program will roll out in three phases over three years, beginning in July 2017. The commonwealth is committed to creating a system that allows Pennsylvanians to receive services in the community, preserves consumer choice, and ensures that consumers will have an active voice in the services they receive. The commonwealth plans to coordinate health and long-term services and supports through CHC managed care organizations (CHC-MCOs). Participants will have a choice of between two and five CHC-MCOs in each region. The CHC rate model will include value-based incentives to increase the use of home and community-based services and meet other program goals. CHC will use standardized outcome measures at both the program and participant level to assess overall program performance and improve the CHC program over time.
STATE PLAN FOR ALZHEIMER’S DISEASE AND RELATED DISORDERS

The Alzheimer’s Disease Planning Committee was established in 2013 by executive order. The purpose of the committee was to create a comprehensive plan for a thoughtful, integrated, and cost-effective approach to addressing the needs of people living with Alzheimer’s Disease and Related Disorders (ADRD). Twenty-six committee members, composed of legislators and stakeholders, were appointed for their expertise and leadership from across the ADRD care and research spectrum. Seven recommendations were made to the governor.

On September 24, 2014, the Department of Aging hosted the first ADRD Summit. The summit brought together over 150 stakeholders, including several government officials, Alzheimer’s Associations chapters, other advocacy groups, and leading academic researchers. The keynote speaker was Dr. Randi Chapman, Director of State Affairs for the National Alzheimer’s Association. Breakout sessions for each of the recommendations identified action steps for the implementation of the plan. A second ADRD Summit is planned for Fall of 2016.

GOVERNOR’S OFFICE OF TRANSFORMATION, INNOVATION, MANAGEMENT AND EFFICIENCY (GO-TIME)

The Governor’s Office of Transformation, Innovation, Management, and Efficiency was established in April of 2015 by Governor Tom Wolf in recognition of the need to be innovative and collaborative and to maximize the efficiency that working together across state agencies will provide to the residents of Pennsylvania. The Department of Aging participates in GO-TIME through an innovation team, which is responsible for implementing initiatives identified by our agency.

FOOD SECURITY INITIATIVE

In September 2015, Governor Tom Wolf announced an executive order that coordinates Pennsylvania’s food and nutrition programs and updates the Blueprint for a Hunger-Free PA, which was originally published in 2007. This executive order was announced at the 2015 Pennsylvania Food Security Summit at the Farm Show Complex in Harrisburg and was sponsored by the Departments of Aging, Agriculture, Education, Community and Economic Development, Health, and Human Services. These agencies have committed to working together and establishing public and private partnerships to address the issue of hunger across the commonwealth.

REAUTHORIZATION OF THE OLDER AMERICANS ACT

The Older Americans Act Reauthorization Act of 2016 reauthorizes programs for fiscal year 2017 through fiscal year 2019. It includes provisions that aim to protect vulnerable elders by strengthening the Long-Term Care Ombudsman program as well as elder abuse screening and prevention efforts. It also promotes the delivery of evidence-based programs, such as falls prevention and chronic disease self-management programs. PDA will work to implement the changes in the recent reauthorization within the aging network.

AFFORDABLE CARE ACT

Over the course of the 2016-2020 state plan, Money Follows the Person (MFP) program funding will help the department strengthen the state’s No Wrong Door infrastructure through education and outreach efforts aimed at strengthening relationships between community-based human service and health care organizations, and directing consumers to their local community resources. Additionally, MFP funds will assist us in building capacity for person-centered counseling, Certified Older Adult Peer Specialists, and piloting a shared housing match-up program aimed at addressing the need for affordable housing options and helping older Pennsylvanians remain in their homes and communities, reducing the need for long-term care placement.

Through the Balancing Incentive Program (BIP), the department is currently in the process of building a
public-facing website that will allow consumers and family caregivers access to information and resources that will provide the services and supports needed to remain as independent as possible for as long as possible in the setting of their choice.

The department will continue to encourage the development and continued expansion of Care Transitions efforts throughout the state by promoting collaborations with other community-based organizations, the sharing of best practices and the utilization of evidenced-based practices to increase successful transitions from hospital to home and reduce the need for readmission. The department is currently developing a Care Transitions Toolkit to support the AAA network in the development, expansion, and sustainability of Care Transitions programs.
GOALS, OBJECTIVES, STRATEGIES, AND PERFORMANCE MEASURES

The state plan includes four goals, each supported by objectives, strategies, and performance measures.

GOAL 1: PROMOTE EXISTING SERVICES

Part of our job at PDA is to ensure that services reach those who need them most, yet many Pennsylvanians are unaware of services that they qualify for. The objectives under Goal 1 expand promotion and outreach efforts to reach more consumers, especially those in the greatest need or in under-served populations.

OBJECTIVE 1.1

*Increase the knowledge and awareness of services supporting older Pennsylvanians among potential consumers, service providers, partners, and the public.*

STRATEGIES

*Promote aging services. Identify target markets for all aging services. Coordinate promotion with AAAs.*

*Collaborate with legislators on events related to aging services.*

*Collaborate with sister agencies to promote similar services or services that serve shared populations.*

*Collaborate with organizations representing diverse communities to promote aging services.*

*Develop and update publications. Publish them in multiple languages to reach target populations.*

*Develop a social media presence.*

*Rebrand services to be more comprehensible to consumers.*
Utilize the PA Link network to collaborate with social service and health care organizations.

Hold events in more underserved communities to better reach target populations.

**PERFORMANCE MEASURES**

Increase in number of communications vehicles with multiple language options

Increase in traffic and engagement with communication vehicles

Increase in number of consumer inquiries for Aging Services

**OBJECTIVE 1.2**

*Increase awareness of health insurance counseling and services available to all Medicare beneficiaries.*

**STRATEGIES**

Develop and implement a promotion strategy to connect target populations to APPRISE services.

Ensure APPRISE is aligned to the baby boomer lifestyle and technology.

Increase the number of trained APPRISE volunteers through targeted recruitment and training to serve targeted populations, including those with limited English proficiency, and meet the needs of the CHC rollout.

Conduct a needs assessment to determine the most effective means of connecting with Pennsylvania’s diverse populations.

**PERFORMANCE MEASURES**

Percent increase in consumer contacts in targeted populations over baseline established in 2018-2019

Percent increase in baby boomer consumer contacts over baseline established in 2016-2017

Percent increase in trained APPRISE volunteers per year over current baseline

**OBJECTIVE 1.3**

*Increase awareness of protective services and referral procedures by enhancing collaborations with federal, state, and local agencies.*

**STRATEGIES**

Work with federal partners to implement enhancements to the Social Assistance Management System (SAMS) and protective services tools.

Pursue a Pennsylvania Commission on Crime and Delinquency grant to train protective services workers on the availability of local victims’ services and train local law enforcement on protective services.

Partner with Pennsylvania’s Department of Banking and Securities to train attorneys on the provisions of the Older Adults Protective Services Act.

Standardize forms, training, and enrichment opportunities.

Collaborate with Pennsylvania’s Department of Health to align training relating to falls, neglect, and electronic notification, and to use data to better define and advocate for public policy priorities.
**PERFORMANCE MEASURES**

Number of collaborations with federal, state, and local agencies

Number of trainings held

### OBJECTIVE 1.4

*Expand outreach to hard-to-reach populations to increase enrollments in PACE and other services.*

**STRATEGIES**

Collaborate with trusted organizations, counties, and health systems. Deploy linguistically appropriate signage.

Expand outreach through established relationships.

Expand efforts of PACE to participate in community events and varied locations.

Collaborate with the Pennsylvania Medical Society to train physicians to connect individuals to PACE/PACENET.

Coordinate with AAAs to increase PACE enrollments.

Develop enrollment file-matching system to target PACE outreach.

Develop and implement outreach strategy in coordination with the department’s overall promotion strategy.

**PERFORMANCE MEASURES**

Percent increase in enrollment in PACE and other services per year

Number of community events PACE participated in per year

Percent increase in trained physicians per year

Percent increase in PACE/PACENET physician referrals per year

Percent increase in PACE/PACENET enrollment via AAA referrals per year

### OBJECTIVE 1.5

*Target outreach to increase enrollment in Medicare Part D and the Low Income Subsidy benefit among unenrolled eligibles.*

**STRATEGIES**

Work with the Centers for Medicare and Medicaid Services (CMS) and propose a strategy to use their data to focus outreach on the 500,000 Medicare Part D and Low Income Subsidy benefit-eligible but unenrolled individuals.

Use APPRISE and department information to focus outreach on the 500,000 Medicare Part D and Low Income Subsidy benefit-eligible but unenrolled individuals.

**PERFORMANCE MEASURES**

Percent increase in Medicare Part D and Low Income Subsidy benefit enrollment via PACE per year

Percent increase in Medicare Part D and Low Income Subsidy benefit enrollment via APPRISE outreach per year
GOAL 2: IMPROVE ACCESS TO SERVICES

Consumers often come up against barriers which prevent them from obtaining the services they need. PDA will make services more accessible by expanding volunteer services, expanding the scope and reach of the PA Link network, and improving access to ombudsmen and adult daily living centers.

OBJECTIVE 2.1

Increase the number of aging network volunteers.

STRATEGIES

Assess current volunteer capacity and establish a baseline for each program, then conduct a gap analysis comparing current capacity to projected need.

Develop and implement volunteer engagement approaches.

Develop and implement volunteer retention approaches.

Engage volunteers from diverse communities to serve as liaisons.

Leverage existing volunteer programs, retiree organizations, and trusted community groups to expand the pool of potential volunteers.

PERFORMANCE MEASURES

Percent increase over the baseline number of volunteers in programs

OBJECTIVE 2.2

Position the PA Link as the preferred coordinating entity for all aging and disability services at the local level.

STRATEGIES

Reevaluate the existing system structure to potentially transition from a loose association of organizations to a committed network of partners with the PA Link Office as its core. Explore the operations model of existing regional PA Link brick-and-mortar centers and other models that provide a personal advocate call-center approach.

Obtain formal partner agreements or memorandums of understanding within the PA Link structure both at the local level and within PDA and DHS in order to strengthen the PA Link infrastructure.

Minimize customer handoffs by empowering the first customer contact to assess and connect the individual with services.

Engage with community organizations to coordinate services and to promote PA Link as the main entry point to person-centered services.

Publish the PA Link program guide.

Finalize the design, development, and maintenance strategy for the website in coordination with the overall promotion strategy.

Document key processes and develop and implement staff orientation and training.
PERFORMANCE MEASURES

Number of trainings provided to community organizations in all 15 service areas

Percent increase in referrals to person-centered services

OBJECTIVE 2.3

Improve access to ombudsman services for long-term care consumers.

STRATEGIES

Collaborate with long-term care facilities to increase the number of ombudsman program representatives who advocate for the rights of the long-term care consumers.

Collaborate with local program entities to encourage increased visitation to long-term care facilities within their jurisdiction.

Provide enhanced training and tools to local program entities to ease documentation and data collection requirements and improve the consistency of data captured at facility visits.

Encourage resident participation in the Pennsylvania’s Empowered Expert Residents (PEER) program.

Conduct evidence-based analysis of PEER program.

PERFORMANCE MEASURES

Ombudsman staffing and volunteer to bed-count ratio

Percent increase in community education activities over current baseline

Percent increase in number of completed and received PEER monthly activity logs over current baseline

Increase in number of PEER facilities

OBJECTIVE 2.4

Improve access to older adult daily living centers.

STRATEGIES

Promote the services and benefits of adult daily living centers.

Collaborate with AAAs, managed care organizations, and other organizations to support the growth in capacity of adult daily living centers.

PERFORMANCE MEASURES

Increase in number of adult daily living centers

Increase in number of adult daily living center enrollees
OBJECTIVE 2.5

*Enhance person-centered counseling to enable individuals to age in place.*

**STRATEGIES**

- Develop a person-centered counseling program that trains and evaluates person-centered counselors in order to certify them.
- Identify specialists by population segment and provide specialized counseling.
- Enhance collaboration between benefits enrollment and aging network benefits.
- Provide training to PA Link staff and partners to integrate services into the counseling process.
- Raise awareness of cognitive, mental, and behavioral health issues among the aging network partners in coordination with the Bureau of Aging Services.
- Ensure the certification training process for all person-centered counselors and specialists contain elements addressing cultural competency.

**PERFORMANCE MEASURES**

- Full certification of all person-centered counselors
- Number of trainings provided in all 15 service areas

OBJECTIVE 2.6

*Improve access to affordable and accessible housing for older adults.*

**STRATEGIES**

- Develop and implement housing pilots.
- Collaborate with state agencies in order to align housing efforts.
- Advocate for housing models that allow older adults and persons with disabilities to age in place.
- Investigate ways to attract and retain domiciliary care providers.

**PERFORMANCE MEASURES**

- Number of housing matches facilitated
- Increase in number of domiciliary care providers

OBJECTIVE 2.7

*Improve transportation resources by collaborating with state and local government entities.*

**STRATEGIES**

- Advocate on behalf of the older adults most likely to have limited access to transportation.
- Collaborate with state and local government to facilitate the exchange of information regarding transportation resources.
- Determine number of rides utilized across various government services.
GOAL 3: ENHANCE QUALITY OF SERVICES

We can always improve our services. Goal 3 lays out PDA’s approach to enhancing the quality of our services. We will expand and improve services, collaborate with partners, provide training, define key measures, and utilize data to become more efficient and consistent. Only through continuous improvement can we meet the needs of the future.

OBJECTIVE 3.1

Identify and disseminate best practices to enhance aging services.

STRATEGIES

Survey stakeholders for best practices, then prepare and distribute a case study.

Pilot the identification and dissemination of best practices in a program.

Establish public-private partnerships to deliver services.

PERFORMANCE MEASURES

Percent increase in participation in aging services over the baseline

OBJECTIVE 3.2

Expand and enhance evidence-based preventive health promotion efforts.

STRATEGIES

Revise the bulletin for Title III-D and issue updated policy.

Increase number of implementation sites.

Increase frequency of workshop sessions with a focus on diverse populations.

Expand non-English program offerings.

Expand Chronic Disease Self-Management Programs (CDSMP) and Diabetes Self-Management Programs (DSMP).

Provide outreach and technical assistance to AAAs and senior community centers related to Affordable Care Act disease self-management.

Promote expansion of Healthy Steps for Older Adults (HSOA) in-state and out-of-state.

Update the Healthy Steps in Motion (HSIM) workbook.

Certify HSIM as evidenced-based by 2017.

Certify “10 Keys™” to Healthy Aging as evidence-based.

PERFORMANCE MEASURES

Percent increase in the number of CDSMP and DSMP implementation sites

Percent increase in the number of workshops conducted in rural or medically underserved areas over baseline year of 2016-2017
Percent increase in the number of non-Caucasian participants in workshops over baseline year of 2016-2017

Percent increase in the number of bilingual trainers recruited to conduct evidence-based programs over baseline year of 2016-2017

Percent increase in the number of AAAs and senior community centers certified to bill Medicare/Medicaid for self-management programs over baseline year of 2016-2017

Percent increase in the number of out-of-network providers that adopt HSOA within the state and outside of the state over baseline year of 2016-2017

Percent increase in the number of AAAs implementing HSIM programs over current baseline

Percent increase in the number of AAAs implementing “10 Keys ™” for Healthy Aging programs

OBJECTIVE 3.3

Enhance collaboration with entities responsible for various components of the long-term care system.

STRATEGIES

Enhance collaboration with Pennsylvania’s Department of Human Services and Department of Education.

Engage entities in cross-training and information exchanges to ensure consumer needs are met by ombudsmen, providers, regulators, and protective services.

Engage with entities and meet with them at least three times per year to discuss scope, limitations, and systems improvement.

Ensure that publications demonstrate collaborative activities and public information sheets describe issues of importance to long-term care consumers and their families.

Develop a departmental customer satisfaction survey for key programs and services in collaboration with PDA program areas and AAAs.

PERFORMANCE MEASURES

Number of times stakeholders are engaged

Number of informational communications developed and circulated

OBJECTIVE 3.4

Improve the quality and consistency of guardianship services for older adults.

STRATEGIES

Develop guardianship policies and procedures regarding documentation and standards of practice.

Develop and implement guardianship care program within SAMS to ensure availability of demographic information on individuals supported by PDA resources.

Develop and provide training on guardianship law, standards of practice, and newly developed policies and procedures to PDA and AAA staff responsible for guardianship program implementation.

Review, prioritize, and implement the recommendations of the Supreme Court of Pennsylvania’s Elder Law Task Force.

Implement biannual quality assurance monitoring on guardianship cases wherein PDA resources are used to support an older adult.
PERFORMANCE MEASURES

Number of guardianship trainings conducted to all appropriate PDA and AAA staff

OBJECTIVE 3.5

Evaluate the value and impact of PACE and PDA programs on the health and well-being of program enrollees through evidence-based research methods.

STRATEGIES

Identify programs to be evaluated in collaboration with PDA program areas.

Develop and implement research design and protocol using Medicare Part A and Part B data and information.

Survey individuals who receive PDA services to measure the perceived value and identify the need for other potential assistance.

Coordinate research efforts with AAAs. Match their enrollment files on specific programs and issues identified for improvement.

PERFORMANCE MEASURES

Number of individuals surveyed per year

OBJECTIVE 3.6

Support the success of local senior community centers and the quality of services they provide.

STRATEGIES

Engage with AAAs to evaluate the current role of senior community centers.

Provide access to senior community center grants intended to help modernize sites, improve programs, or both.

Advocate on behalf of senior community centers to stimulate additional funding.

Hold forums for senior community centers to share best practices.

Provide cultural competency training to create a welcoming environment.

Identify and implement a senior community center competency assessment tool.

PERFORMANCE MEASURES

Percent increase in enrollments over baseline year 2016-2017

Percent increase in training attendance

Percent of senior community center AAA partners provided cultural competency training

Level of senior community center competency

OBJECTIVE 3.7

Enhance senior legal service delivery systems with a focus on victims of elder abuse and exploitation.
STRATEGIES

Assess capacity of current legal service delivery system.

Develop a statewide legal service delivery, data collection, and reporting system.

Create new low-cost and no-cost legal service mechanisms targeted at the most underserved.

Create innovative outreach and targeting strategies for the most underserved.

Establish formalized partnerships with aging and elder rights networks for effective legal responses to abuse and exploitation.

Develop and implement a statewide legal training agenda for professionals and advocates.

Collaborate in the development of a guardianship bench book.

Increase partnerships with local bar associations.

Enhance education for judges and attorneys developed by the Administrative Office of Pennsylvania Courts (AOPC) and the Office of Elder Justice in the Courts (OEJC), focusing on creating uniformity in the guardianship process.

Adopt a volunteer monitoring program to assist the courts in their monitoring of guardianship matters. Collaborate with financial institutions to educate the public regarding financial fraud and financial exploitation of the elderly.

Facilitate efforts to increase the assistance of financial investigators to local prosecutors and AAAs.

PERFORMANCE MEASURES

Number of outreach activities directed at the most vulnerable senior victims of elder abuse, neglect, and financial exploitation

Number of formalized partnerships between aging/disability and elder rights networks

Post-training survey results regarding the quality, usefulness, and impact of training events

Number of formal collaborations between partner agencies

Percent compliance with delivery standards and guidelines

OBJECTIVE 3.8

Develop formal partner arrangements, including formal work plans that identify roles, responsibilities, resources, and timelines to address Alzheimer’s disease and related disorders.

STRATEGIES

Hold an Alzheimer’s Disease and Related Disorders (ADRD) Forum to convene stakeholders and partners.

Provide training and education for caregivers and those living with ADRD.

PERFORMANCE MEASURES

Number of formal partnerships

Increase the number of physicians using the physician app

Increase the number of physician referrals using the referral form tool
OBJECTIVE 3.9

Develop and implement a continuous quality improvement program within the aging network.

STRATEGIES

Develop an incentive system for high-performing AAAs. Evaluate options to transition the system to a performance-based pay structure.

Define key measures, quality targets, and minimum standards of compliance. Involve stakeholders in the process.

Establish a single measure of organizational performance.

Improve the funding and reporting module or create a new one to support data-driven decision-making.

Provide training aligned to continuous quality improvement efforts. Maintain program and operations manuals.

Communicate key performance measures to the aging network.

Engage AAA directors to ensure alignment with the direction of the department.

In collaboration with PDA program areas and AAAs, develop a departmental customer satisfaction survey for key programs and services.

PERFORMANCE MEASURES

Percent increase in continuous quality improvement program performance measures

Number of training held for PDA and AAA staff

OBJECTIVE 3.10

Improve data collection and integrity to better measure activity, performance, and quality.

STRATEGIES

Facilitate a development process to reach consensus on key data elements, definitions, collection and submission of essential data and information, and measures for programs. Collaborate with PDA program areas and aging network partners.

Identify data and information required to measure the value of aging network programs and services.

Identify data and information required to certify the evidence-based foundation of programs.

Develop and implement a strategy to secure important data and information from aging network partners.

Improve funding and reporting module to support data requirements.

Update and maintain the Aging Services Policy and Procedure Manual.

Develop and deliver training, educational materials, and technical assistance to AAAs.

PERFORMANCE MEASURES

Percent decrease in AAAs reporting data entry issues over baseline

Percent decrease in missing data for each National Aging Program Information Systems (NAPIS) data element

Percent decrease in errors in SAMS data by monitoring period
GOAL 4: EMPOWER THE WORKFORCE

A vast workforce serves older adults, ensuring that they have the quality of life they deserve. PDA must empower this workforce - paid and unpaid caregivers, researcher partners, health care providers, aging network staff, and more - in order for older adults to be able to age in place and secure justice in instances of elder abuse.

OBJECTIVE 4.1

**Improve the capabilities of protective services investigators and other professionals through standardized training.**

**STRATEGIES**

Develop and implement a standardized curriculum for protective services investigators and intake personnel based on national standards and minimums recommendations.

Expand training to nontraditional venues.

Enhance SAMs data by coordinating with the data improvement strategy.

Develop a research agenda regarding the transfer of learning from the classroom to the field. Coordinate with other program areas.

Align training with improved quality assurance methods and tools, SAMs data, policies and procedures, standardized national tools, and updated guidance documents.

Enhance case consultation guidance regarding neglect and financial exploitation.

**PERFORMANCE MEASURES**

Standardized curriculum training to all appropriate protective services investigators and intake personnel

Percent increase in training conducted over baseline year 2016-2017

Percent increase in number of compliance audits over baseline year 2016-2017

OBJECTIVE 4.2

**Foster career development and support for the workforce that serves older adults.**

**STRATEGIES**

Facilitate volunteer and internship connections for students as a path to a career in aging services.

Provide education to support direct care workers and caregiving career opportunities.

Create career opportunities for individuals as care providers by leveraging the Senior Community Service Employment Program (SCSEP), and partnerships with the Pennsylvania Department of Labor and Industry and local Workforce Investment Boards. Encourage SCSEP providers to train participants in the direct care field.

Advocate for paid and unpaid caregivers (in support of Executive Order 2015-05).

Identify and remove barriers to entering the direct care workforce. Promote incentives to entry.

Develop and deliver education and training targeted toward volunteer and family caregivers.

Collaborate with existing providers and organizations in developing, delivering, and promoting training for family and
volunteer caregivers.

Develop a promotion strategy to raise awareness of caregiver support and respite care.

**PERFORMANCE MEASURES**

Percent increase in SCSEP participant employment rate

Percent increase in the 6-month employment retention rate of SCSEP participants

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**OBJECTIVE 4.3**

*Enhance the capabilities of aging network volunteers through education and training.*

**STRATEGIES**

*Improve the management capacity of volunteer coordinators through education and training, dissemination of best practices, and on-site support.*

*Develop and implement a process for auditing the quality of local volunteer management programs.*

*Identify best practices of local volunteer management programs.*

*Provide cultural competency training for volunteers who will serve diverse communities.*

**PERFORMANCE MEASURES**

*Percent increase in the number of counties trained to conduct local program audits*

*Percent increase in the number of counties that implement the recommendations provided by volunteer audit teams*

*Percent increase in the number of volunteers that receive cultural competency training per program in each county*
FY 2015 State Plan Guidance Attachment A

STATE PLAN ASSURANCES AND REQUIRED ACTIVITIES
Older Americans Act, As Amended in 2006

By signing this document, the authorized official commits the State Agency on Aging to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2006.

Attachment A

ASSURANCES & REQUIRED ACTIVITIES

ASSURANCES

Sec. 305(a) - (c), ORGANIZATION

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.

States must assure that the following assurances (Section 306) will be met by its designated area agencies on agencies, or by the State in the case of single planning and service area states.

Sec. 306(a), AREA PLANS

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services:

(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer’s disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance;
and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—
(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;
(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and
(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—
(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;
(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and
(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and
(4)(A)(ii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall—
(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;
(II) describe the methods used to satisfy the service needs of such minority older individuals; and
(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on—
(I) older individuals residing in rural areas;
(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);
(IV) older individuals with severe disabilities;
(V) older individuals with limited English proficiency;
(VI) older individuals with Alzheimer’s disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and
(VII) older individuals at risk for institutional placement; and
(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:
in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;
(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.

(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as “older Native Americans”), including- (A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title; (B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and (C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency-- (i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and (ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and (B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(17) Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.
Sec. 307, STATE PLANS

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances that--
(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;
(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and
(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that area agencies on aging will--
(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;
(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and
(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.

(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging...
carrying out such services will conduct a program consistent with relevant State law and coordinated with
existing State adult protective service activities for--
(A) public education to identify and prevent abuse of older individuals;
(B) receipt of reports of abuse of older individuals;
(C) active participation of older individuals participating in programs under this Act through outreach,
conferences, and referral of such individuals to other social service agencies or sources of assistance
where appropriate and consented to by the parties to be referred; and
(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known
as a legal assistance developer) to provide State leadership in developing legal assistance programs for
older individuals throughout the State.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any
planning and service area in the State are of limited English-speaking ability, then the State will require the
area agency on aging for each such planning and service area—
(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who
are fluent in the language spoken by a predominant number of such older individuals who are of limited
English-speaking ability; and
(B) to designate an individual employed by the area agency on aging, or available to such area agency on
aging on a full-time basis, whose responsibilities will include--
(i) taking such action as may be appropriate to assure that counseling assistance is made available to such
older individuals who are of limited English-speaking ability in order to assist such older individuals in
participating in programs and receiving assistance under this Act; and
(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan
involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively
linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—
(i) older individuals residing in rural areas;
(ii) older individuals with greatest economic need (with particular attention to low-income older individu-
als, including low-income minority older individuals, older individuals with limited English proficiency, and
older individuals residing in rural areas;
(iii) older individuals with greatest social need (with particular attention to low-income older individu-
als, including low-income minority older individuals, older individuals with limited English proficiency, and
older individuals residing in rural areas;
(iv) older individuals with severe disabilities;
(v) older individuals with limited English-speaking ability; and
(vi) older individuals with Alzheimer’s disease and related disorders with neurological and organic brain
dysfunction (and the caretakers of such individuals); and
(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the
caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assur-
ances that the State will coordinate planning, identification, assessment of needs, and service for older
individuals with disabilities with particular attention to individuals with severe disabilities with the State
agencies with primary responsibility for individuals with disabilities, including severe disabilities, to en-
hance services and develop collaborative programs, where appropriate, to meet the needs of older indi-
viduals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the
coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older
individuals who--
(A) reside at home and are at risk of institutionalization because of limitations on their ability to function
independently;
(B) are patients in hospitals and are at risk of prolonged institutionalization; or
(C) are patients in long-term care facilities, but who can return to their homes if community-based ser-
vices are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).

(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall
(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made--
(A) to coordinate services provided under this Act with other State services that benefit older individuals; and
(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.

Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and
other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—
(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;
(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and
(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--
(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order

**FY 2015 State Plan Guidance Attachment A (Continued)**

**REQUIRED ACTIVITIES**

**Sec. 307(a) STATE PLANS**

(1)(A) The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and
(B) The State plan is based on such area plans.

Note: THIS SUBSECTION OF STATUTE DOES NOT REQUIRE THAT AREA PLANS BE DEVELOPED PRIOR TO STATE PLANS AND/OR THAT STATE PLANS DEVELOP AS A COMPILATION OF AREA PLANS.

(2) The State agency:
(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;
(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). Note: “Periodic” (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.

(5) The State agency:
(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;
(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and
(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

Signature and Title of Authorized Official

Date 8-1-16
FY 2016 State Plan Guidance

Attachment B
INFORMATION REQUIREMENTS

States must provide all applicable information following each OAA citation listed below. The completed attachment must be included with your State Plan submission.

Section 305(a)(2)(E)

Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

The primary mechanism is the Intrastate Funding Formula (IFF) which targets Older Americans Act (OAA) dollars to those in greatest economic and social need. The department’s Quality & Compliance Specialists and Fiscal Monitoring staff oversee AAAs to continuously monitor their implementation. The department has a Cultural Diversity Advisory Committee who advises the department in diversity and limited English proficiency issues. Target groups include: individuals over age 75, individuals over age 85, minority individuals over age 60, rurally isolated individuals over age 60, and individuals living in poverty over age 60.

Section 306(a)(17)

Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

The mechanism for disaster relief coordination is covered in our Area Plan Aging Program Directive, and it’s organized and coordinated through the Department’s Agency Representative to the Pennsylvania Emergency Management Agency (PEMA). Each AAA area plan must include a specific section on local emergency responsiveness and how the AAA will coordinate with the department and PEMA.

Disaster relief services during a declared disaster’s response phase are coordinated through the department’s representative to the PEMA Commonwealth Response Coordination Center (CRCC). This individual coordinates state level intra-agency and inter-agency responses for issues identified at the local level. During the recovery phase of a disaster, an ad hoc committee is created between the department and the AAA network to develop solutions related to remaining issues.

Section 307(a)(2)

The plan shall provide that the State agency will:
(C) Specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) (Note: those categories are access, in-home, and legal assistance). Provide specific minimum proportion determined for each category of service.

AAAs are required to provide a minimum proportion of funding to core services. The department, through its IFF, specifies a minimum proportion of the funds received by each AAA will be used to carry out part B requirements, including access, in-home, and legal assistance. Oversight for this is provided by the department’s fiscal (oversight) staff.

AAAs are required to meet established standards for funding services provided primarily to
individuals in their residence. For example, in FY 2015-16, they were required to spend a minimum of 60% of their designated funding (Block Grant, Block Grant Supplement, Caregiver Support, Nutrition Services Incentive Program, and Options Services) on these activities.

Section (307(a)(3))

The plan shall:
(B) with respect to services for older individuals residing in rural areas:
(i) provide assurances the State agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.
(ii) identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).
(iii) describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.

The state agency assures that it and AAAs will not spend less for each fiscal year of the plan than the amount expended for such services for fiscal year 2000. According to the allocation methodology utilized by the department and approved by AoA, the population of a AAA’s PSA, as noted by the latest approved census, is a weighted factor in calculating the Block Grant allocation for the agency. This calculation can and often is overridden by state law that contains a hold harmless provision requiring each AAA receive no less Block Grant funding than they received in the prior fiscal year.

Section 307(a)(10)

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

According to the allocation methodology utilized by the department and approved by AoA the population of an AAA’s PSA, as noted by the latest approved census, is a weighted factor in calculating the Block Grant allocation for the agency.

Section 307(a)(14)

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—
(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and
(B) describe the methods used to satisfy the service needs of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

From the US Census Bureau, of the 345,079 minority individuals age 60 and over in Pennsylvania, 106,383 are low income. Further, of the 345,079 minority individuals age 60 and over in Pennsylvania, 29,160 were low income and spoke English less than “very well.” This data comes from the 2014 American Community Survey 1-Year Public Use Microdata File. Individuals who are low income are those whose income is 150% of the federal poverty level and less.

The department’s Cultural Diversity Advisory Committee advises the department on both diversity and limited English proficiency issues. Some of the department’s publications are in Spanish, and AAAs have materials published in languages appropriate to their consumers’ languages.

Section 307(a)(21)

The plan shall:
(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs
and benefits provided under this title (title III), if applicable, and specify the ways in which the State agency intends to implement the activities.

There are no formal Native American tribes in Pennsylvania.

**Section 307(a)(29)**

The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.

Within the Area Plan Aging Program Directive there is a section requiring all Area Plans to include both their local emergency plan as well as how the AAA will coordinate their needs with the department. Periodically the department’s representative will review AAA plans and provide technical assistance as needed.

**Section 307(a)(30)**

The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.

The Secretary of the Department of Aging has been leading the department and its staff on all aspects of the State Plan on Aging, including the emergency preparedness plan. The secretary also routinely meets with other state cabinet secretaries, and the Departments of Health, Insurance, and Human Services on many matters, including emergency preparedness. Additionally, the secretary and the agency’s Representative to PEMA attend various exercises to ensure interdepartmental responses to anticipated activities are coordinated and planned.

**Section 705(a)(7)**

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:

(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6).

(Note: Paragraphs (1) of through (6) of this section are listed below)

In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:

(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;

(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;

(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;

(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;

(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);

(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3--

(A) in carrying out such programs the State agency will conduct a program of services consistent with
relevant State law and coordinated with existing State adult protective service activities for:
(i) public education to identify and prevent elder abuse;
(ii) receipt of reports of elder abuse;
(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and
(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;
(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or
(iii) upon court order

The department hosted seven Community Listening Forums in March and April 2016. Pennsylvanians were invited (via e-mail, the department’s website, newspaper announcements, and radio spots) to share their input on programs and priorities and to measure their awareness of services and supports. More than 230 individuals participated in the sessions and more than 400 individuals responded to surveys. A draft version of the plan was presented for review and comment on the department’s website and in three public hearings in May 2016.

Beginning in May of 2016 and lasting until May of 2017, the Commonwealth of Pennsylvania is participating in the NCI-AD National Core Indicators—Aging and Disability Consumer Survey (“NCI-AD Survey”). The commonwealth will interview a minimum of 400 consumers who are receiving long-term services and supports to assess quality of life, service satisfaction, and outcomes of service recipients. The commonwealth will use the NCI-AD Survey Data to improve the quality of services, communicate with service recipients, families, advocates and lawmakers, compare programs with the commonwealth and compare programs with other state programs nationally. The commonwealth plans to continue participating in the NCI-AD Survey in the future.

Pennsylvania’s State Health Insurance Assistance Program (APPRISE) will work in partnership with the Senior Medicare Patrol to extend fraud education efforts to include information on elder abuse. The APPRISE program will also disseminate information to beneficiaries through activities conducted as part of Medicare Improvements for Patients and Providers Act (MIPPA) outreach.

Through collaboration between both the Pennsylvania Department of Aging (PDA) and the 52 Area Agencies on Aging (AAA), the Older Adults Protective Services Act (OAPSA) is consistently implemented to ensure that older adults who lack the capacity to protect themselves and are at imminent risk of abuse, neglect, exploitation, or abandonment shall have access to and be provided with the services necessary to protect their health, safety, and welfare.

In accordance with this Act (35 P.S. §10225.101, et seq.), the Pennsylvania Department of Aging (PDA) works with the AAA network to increase public awareness regarding elder abuse, neglect, exploitation, and abandonment. This public outreach and education includes providing for an ongoing educational campaign regarding the causes and warning signs of elder abuse, profiles of victims and perpetrators and the voluntary and mandatory reporting requirements of Pennsylvania’s Older Adults Protective Services Act and Adult Protective Services Act. In addition, AAAs work tirelessly to employ prevention, identification, and abuse mitigation/elimination strategies.

PDA is responsible to administrative oversight, technical assistance, and quality oversight while the local AAAs are responsible for the intake, investigation, and resolution of elder abuse allegations. All information is maintained within strict confidentiality provisions although limited sharing of information between protective services, law enforcement, and service providers is permitted when appropriate. Release of confidential information does require either consent of the older adult or a court order.

PDA assures services are in accordance with the OAA, AAAs, ADRCs, and Long-term Care
Ombudsman programs are monitored for compliance and a plan for remediation is developed as necessary.

PDA assures there are no restrictions other than those included in Section 712(a)(5)(C)(i)-(iv), regarding the eligibility of entities for designation as local Ombudsman entities. All local Ombudsman entities shall follow Pennsylvania Department of Aging 71 P.S. §§581-1 et seq. and its Aging Program Directive 16-10-01 Long-term Care Ombudsman Program.

PDA assures it will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protections.
INTRASTATE FUNDING FORMULA AND BACKGROUND

Background

The current Intrastate Funding Formula or “allocation formula” was developed in 2004 and was implemented for the beginning with State Fiscal Year 2005-06 allocations. This same formula, with no changes, has been utilized through State Fiscal Year 2015-16 to calculate allocations to the Area Agencies on Aging.

Model Development

The department examined the current model, reviewed federal and state laws and regulations governing the intrastate allocation of funds, and gave due consideration to the Area Agencies on Aging recommendations. It researched available empirical data and conducted literature reviews to ascertain the impact of various subsets of the elderly population on the Area Agencies on Aging resources. The result of these efforts confirmed that clear differences exist on how the various demographic subsets of a population impact an agency’s resources.

The department’s overarching goal was to arrive at a model by which to optimize the allocation of state and federal funds to the Area Agencies on Aging while minimizing any adverse impact. The following objectives facilitated the achievement of this goal:

- The model must operate within the parameters established in state and federal laws and regulation
- The model must be populated with criterion variables for which data values are available from common, readily accessible and reliable sources
- Updates or changes to the model data, input variables, and decision variables must be easily accomplished
- The model must contain within its logic alternative decision points that will accommodate changes in state and federal laws and regulations
- The model must fit all possible foreseeable situations and provide accurate and reliable output

The Allocation Formula-Public Review and Comment Process

Interacting with the Area Agencies on Aging network, older adults, state legislators and numerous other interested providers, the department ensured all parties were given an opportunity to provide constructive input. These interactions included five listening forums and three public hearings across the state. With these sessions, all parts of the plan were discussed. As a result, no changes were made to the current intrastate funding formula.
Model Description

The model consists of two distinct parts: an allocation formula and a distribution methodology.

The first part, the formula, consists of selected factors, the factor weights, the values of the factors, census data, and calculated indices. The purpose of this part of the model is to determine the number of equivalent consumers within each Area Agency on Aging.

The formula composition and definition are as follows:
\[(w_1F_1 + w_2F_2 + \ldots + w_6F_6) = AAA \text{ Value}\]

Where \(w_1\) is the weight assigned to each of the factors. The weights were determined by the department with input from the Pennsylvania Association of Area Agencies on Aging. The weight provides the level of importance to the factor in relation to the other factors.

Where \(F_f\) is the factor. The factor, which can also be defined as an attribute of the consumer, is the level of demand or requirement placed on an Area Agency on Aging by a particular type of consumer. It is the census count of consumers of that type.

The department adjusted value is the sum of all Area Agency on Aging values and is the statewide number of equivalent consumers. One the statewide number of equivalent consumers is calculated each Area Agency on Aging value is divided by the statewide value providing an index number for each Area Agency on Aging. This index number is simply the Area Agency on Aging’s proportion of the statewide equivalent consumers.

The second part, the distribution methodology, consists of allocation decision variables. These determine how and when the formula is applied.

The model takes into account the following precepts from the law and regulations:

- The federal rules require that the model take into account the geographical distribution of older persons across the state, including the proportion of the older persons with the greatest economic and social needs. It must also pay particular attention to low-income minorities.
- The state rules require that the model take into account that the allocation must be weighted by the proportion of the older poor in each Planning and Service Area, or Area Agency on Aging, in relation to the total older poor in Pennsylvania. State law incorporates a “hold harmless” (state funding only) provision that specifies that no Area Agency on Aging may receive less state funding that it received in the preceding year.
The formula is a mathematical expression of the requirements/needs of the consumer population within each AAA in relation to all the Area Agencies on Aging. Different types of consumers have different needs and therefore require varying levels of resources. Consumer characteristics are represented within the formula as factors. Each factor represents a demographic subset of the overall sixty-plus population.

There are two criteria for considering a factor for inclusion in the formula. The first is that each factor must represent an exceptional or unique set of demands or requirements on an Area Agency on Aging’s resources. The second is that there is a disproportionate distribution of the factor (consumer type) among the various Area Agencies on Aging.

In all cases the formula was first applied to the available funds to calculate the index base amount by Area Agency on Aging. Then, parameters that affect the allocation (i.e. hold harmless (state only funding)) are applied. The difference between the preceding (base) year’s allocation and the current budget year index base amount is used to calculate the marginal indices.

This methodology permits a gradual shift, with both state and federal funds, in allocations preventing Area Agencies on Aging from taking a drastic loss in one year. Conversely it prevents other Area Agencies on Aging from receiving a disproportionately large gain in a single year. The change can be spread out over a period of years allowing Area Agencies on Aging to adjust and plan for changes in allocations. The rate at which the change occurs is a decision that can be made in conjunction with the Area Agencies on Aging and other stakeholders. Currently we are using the 2010 Census data.

Current Status

After full consideration of many factors and weights, including those discussed with the Area Agencies on Aging, the following factors and weights were chosen:

<table>
<thead>
<tr>
<th>Factor</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor (at or below 100% poverty)</td>
<td>25% (.25)</td>
</tr>
<tr>
<td>Rural</td>
<td>25% (.25)</td>
</tr>
<tr>
<td>Minority</td>
<td>20% (.20)</td>
</tr>
<tr>
<td>75 years old or older</td>
<td>20% (.20)</td>
</tr>
<tr>
<td>60 years old or older</td>
<td>10% (.10)</td>
</tr>
<tr>
<td>100%</td>
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</table>

To focus resources on targeted, at risk populations, the poor and rural factors were weighted most heavily, followed by minority and persons 75 years of age and older. To respond to overall shifts in the older population, persons age 60 and older were also included as a factor and weighted accordingly. In addition, the “hold harmless” (state only funding) provision in Pennsylvania state law requires that the state funds AAAs receive be at least equal to the amount received in the previous year further minimizing.
the losses to any single Area Agency on Aging. The chart below is the listing of data per AAA for the factors and weights.

As a matter of policy, the department will utilize the most recent census data available when it allocates dollars (both state and federal) annually based on funding levels.
## PDA EXAMPLE Allocation

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<td>weighted</td>
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<td>by 0.20</td>
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<tr>
<td></td>
<td>2010</td>
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<td>75+</td>
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<td>by 0.20</td>
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| 75+ | 1,509   | 338 | 68 | 19,062 | 2,741 | 1,365 | 341 | 6,536 | 0.00592423 | 438,829 |
| 75+ | 1,509   | 338 | 68 | 19,062 | 2,741 | 1,365 | 341 | 6,536 | 0.00592423 | 438,829 |
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| AAA | weight   |
|     | 0.20     |
| AAA | weight   |
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**Index**: AAA wt. divided by State WT. **Title III Funding**: 883,975
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Pennsylvania Department of Aging
Pennsylvania Association of Area Agencies on Aging
Pennsylvania Council on Aging
Annual Convention and Quarterly Review Meeting

Summary of State Plan on Aging Discussion

Wednesday, March 16, 2016
Introduction

Every four years, the Pennsylvania Department of Aging (PDA) prepares a strategic plan to steer its programming and delivery of services and supports for older adults, their families, and their caregivers. The 2016-2020 State Plan on Aging will articulate a clear and comprehensive direction for both the department and for those who serve and support our diverse and robust population of older Pennsylvanians.

The State Plan carries out the complementary objectives of the Older Americans Act, PDA, and the commonwealth in ensuring that all older Pennsylvanians are empowered to make informed decisions about their care in the setting of their choice.

The State Plan development process incorporates broad outreach, informed by local plans developed by the 52 Area Agencies on Aging (AAAs), PDA staff, aging services network partners, and consumers and the general public (via community listening forums, public hearings, and surveys).

In March 2016, PDA, the Pennsylvania Association of Area Agencies on Aging (P4A), and the Pennsylvania Council on Aging (PCoA) held their annual convention. One convention session was devoted to a facilitated discussion to solicit feedback (through polling, open-ended questions for discussion, and response cards) from these aging services network partners. The session also provided participants with an abbreviated preview of the content and format for upcoming community listening forums.

This report summarizes the input received in the session. It contains four sections, mirroring the primary themes that will guide the community listening forums (Hopes and Concerns, AAA Services and Supports, Senior Community Centers, and PDA Programs and Issues).

Within the report, data tables present the results for each polled item, indicating the percentage and number of participant responses by organization type. Bar graphs further illustrate the percentage of responses to most polled items, by organization type. Lastly, the bulleted points recap participants largely unedited comments, captured in the session’s open discussion and response cards (denoted in quotations).

The excellent feedback from these aging services network partners served in refining the content and format for the community listening forums. Perhaps more importantly, their thoughtful participation provided valuable insight on the issues and priorities PDA must consider in developing—and ultimately implementing—the State Plan.
Hopes and Concerns

The following summarizes the input provided during the discussion introducing the session.

Polling item: Growth of the older adult population by 2020

Overall, 50% of the respondents were correct that the population is anticipated to increase by 25% in the next four years.

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<tr>
<th>In 2010, Pennsylvania's population of those aged 60 and over was over 2.9 million. By 2020 this population is expected to increase by:</th>
</tr>
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<tbody>
<tr>
<td>Response</td>
</tr>
<tr>
<td>10%</td>
</tr>
<tr>
<td>15%</td>
</tr>
<tr>
<td>25%</td>
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</table>

Discussion question: What do Consumers say are their greatest hopes and concerns about aging for themselves or loved ones?

- Aging in place (staying in my home)
- Affording to stay in my home
- Getting the best results out of my health (take care of myself)
- Making sure that my parents age in place
AAA Services and Supports

Polling item: Participant awareness of services coordinated by AAAs

Awareness of AAA Programs and Services

More than two-thirds of participants overall were aware of all services. P4A participants were most familiar with these core services.

Please indicate all of the services you are aware of that AAAs provide or coordinate.

<table>
<thead>
<tr>
<th>Response</th>
<th>P4A</th>
<th>P4A %</th>
<th>PCOA</th>
<th>PCOA %</th>
<th>PDA</th>
<th>PDA %</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult day care</td>
<td>59</td>
<td>89%</td>
<td>23</td>
<td>79%</td>
<td>18</td>
<td>72%</td>
<td>100</td>
<td>83%</td>
</tr>
<tr>
<td>Home-delivered meals</td>
<td>60</td>
<td>91%</td>
<td>26</td>
<td>90%</td>
<td>22</td>
<td>88%</td>
<td>108</td>
<td>90%</td>
</tr>
<tr>
<td>Personal assistance and care services</td>
<td>59</td>
<td>89%</td>
<td>25</td>
<td>86%</td>
<td>19</td>
<td>76%</td>
<td>103</td>
<td>86%</td>
</tr>
<tr>
<td>Housing assistance and advocacy</td>
<td>56</td>
<td>85%</td>
<td>21</td>
<td>72%</td>
<td>21</td>
<td>84%</td>
<td>98</td>
<td>82%</td>
</tr>
<tr>
<td>Home modifications</td>
<td>59</td>
<td>89%</td>
<td>19</td>
<td>66%</td>
<td>18</td>
<td>72%</td>
<td>96</td>
<td>80%</td>
</tr>
<tr>
<td>Care management</td>
<td>59</td>
<td>89%</td>
<td>25</td>
<td>86%</td>
<td>20</td>
<td>80%</td>
<td>104</td>
<td>87%</td>
</tr>
<tr>
<td>Home health care</td>
<td>57</td>
<td>86%</td>
<td>20</td>
<td>69%</td>
<td>18</td>
<td>72%</td>
<td>95</td>
<td>79%</td>
</tr>
<tr>
<td>Caregiver support</td>
<td>60</td>
<td>91%</td>
<td>20</td>
<td>69%</td>
<td>18</td>
<td>72%</td>
<td>98</td>
<td>82%</td>
</tr>
<tr>
<td>Respite care</td>
<td>58</td>
<td>88%</td>
<td>19</td>
<td>66%</td>
<td>18</td>
<td>72%</td>
<td>95</td>
<td>79%</td>
</tr>
<tr>
<td>Employment</td>
<td>50</td>
<td>76%</td>
<td>15</td>
<td>52%</td>
<td>19</td>
<td>76%</td>
<td>84</td>
<td>70%</td>
</tr>
</tbody>
</table>
Polling item: Importance of programs in helping older adults age in place with dignity

The majority rated these programs as critically or very important.

![Importance of Programs](image)

### How important do you think these programs are in helping older adults age in place with dignity?

<table>
<thead>
<tr>
<th>Response</th>
<th>P4A</th>
<th>P4A %</th>
<th>PCOA</th>
<th>PCOA %</th>
<th>PDA</th>
<th>PDA %</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critically important</td>
<td>41</td>
<td>67%</td>
<td>16</td>
<td>61%</td>
<td>21</td>
<td>88%</td>
<td>78</td>
<td>70%</td>
</tr>
<tr>
<td>Very important</td>
<td>17</td>
<td>28%</td>
<td>8</td>
<td>31%</td>
<td>2</td>
<td>8%</td>
<td>27</td>
<td>24%</td>
</tr>
<tr>
<td>Important</td>
<td>3</td>
<td>5%</td>
<td>2</td>
<td>8%</td>
<td>0</td>
<td>0%</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>Somewhat important</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Not at all important</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>4%</td>
<td>1</td>
<td>1%</td>
</tr>
</tbody>
</table>

Discussion question: What types of services or supports are most important?

- Home delivered meals
- Home modifications
- Care management/navigation
- Caregiver support
- Home healthcare (waiver support and OPTIONS)
- Raising income eligibility limits
- Social support (bringing older adults together)
- *Keep in mind that that not all seniors today or in the future will ever need to or choose to access PDA/AAA services. The largest percentages of PA seniors are still active and productive in their own way.*
Polling item: Effectiveness of programs in allowing older adults to age in place with dignity.

In general, participants indicated that programs were effective but suggested that there is room for improvement (as no one rated them as “completely effective”).

Program Effectiveness

<table>
<thead>
<tr>
<th>Response</th>
<th>P4A</th>
<th>P4A %</th>
<th>PCOA</th>
<th>PCOA %</th>
<th>PDA</th>
<th>PDA %</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely effective</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Very effective</td>
<td>18</td>
<td>31%</td>
<td>5</td>
<td>18%</td>
<td>3</td>
<td>12%</td>
<td>26</td>
<td>24%</td>
</tr>
<tr>
<td>Effective</td>
<td>25</td>
<td>43%</td>
<td>10</td>
<td>36%</td>
<td>12</td>
<td>50%</td>
<td>47</td>
<td>43%</td>
</tr>
<tr>
<td>Somewhat effective</td>
<td>15</td>
<td>26%</td>
<td>13</td>
<td>46%</td>
<td>9</td>
<td>38%</td>
<td>37</td>
<td>34%</td>
</tr>
<tr>
<td>Not at all effective</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

Discussion question: How are we doing?
- Programs may be effective but older adults may not know about them
- Funding not keeping pace; fuel delivery of services, waiting lists
- Undertake more to encourage early planning for the move to assisted living (to avoid crisis management)

Discussion question: Which services and supports/issues are in the greatest demand?
- Transportation
- Protective services (financial exploitation, prescription drug problem)
- Accessible, safe, affordable housing
- Advertising what is available to older adults
- Crisis management (time consuming for case managers)
Senior Community Centers

**Polling item:** Participants’ awareness of the number of senior community centers in Pennsylvania

Overall, 64% knew that there are 530 senior community centers.

<table>
<thead>
<tr>
<th>How many Senior Community Centers are there in PA supported by counties, community organizations, faith-based organizations, and others?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Response</strong></td>
</tr>
<tr>
<td>65</td>
</tr>
<tr>
<td>150</td>
</tr>
<tr>
<td>285</td>
</tr>
<tr>
<td>530</td>
</tr>
</tbody>
</table>

**Polling item:** Significant barriers to older adult participation in senior community center programs

Nearly four-fifths of respondents cited “not perceiving themselves as seniors” as the most significant barrier. P4A participants in particular cited this barrier.

**Significant Barriers to Senior Community Center Participation**

![Bar chart showing significant barriers to senior community center participation]
What do you consider significant barriers to older adults participating in Senior Community Center programs?

<table>
<thead>
<tr>
<th>Response</th>
<th>P4A</th>
<th>P4A %</th>
<th>PCOA</th>
<th>PCOA %</th>
<th>PDA</th>
<th>PDA %</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not perceiving selves as seniors</td>
<td>58</td>
<td>97%</td>
<td>17</td>
<td>59%</td>
<td>18</td>
<td>72%</td>
<td>93</td>
<td>78%</td>
</tr>
<tr>
<td>Lack of transportation to centers</td>
<td>39</td>
<td>65%</td>
<td>18</td>
<td>62%</td>
<td>16</td>
<td>64%</td>
<td>73</td>
<td>61%</td>
</tr>
<tr>
<td>Mobility difficulties</td>
<td>32</td>
<td>53%</td>
<td>10</td>
<td>34%</td>
<td>10</td>
<td>40%</td>
<td>52</td>
<td>43%</td>
</tr>
<tr>
<td>Lack of awareness</td>
<td>41</td>
<td>68%</td>
<td>22</td>
<td>76%</td>
<td>16</td>
<td>64%</td>
<td>79</td>
<td>66%</td>
</tr>
<tr>
<td>Inconvenient locations/hours</td>
<td>27</td>
<td>45%</td>
<td>13</td>
<td>45%</td>
<td>9</td>
<td>36%</td>
<td>49</td>
<td>41%</td>
</tr>
<tr>
<td>Already maintaining active lifestyle</td>
<td>46</td>
<td>77%</td>
<td>19</td>
<td>66%</td>
<td>12</td>
<td>48%</td>
<td>77</td>
<td>64%</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>28%</td>
<td>6</td>
<td>21%</td>
<td>8</td>
<td>32%</td>
<td>31</td>
<td>26%</td>
</tr>
</tbody>
</table>

Discussion question: What are the barriers/opportunities to enhance senior centers?

- Look at other states (e.g., Summit, Grand Prairie, TX—multigenerational, lifelong learning, progressive “community center”)
- Update programming to reflect community desires (e.g., exercise programs)
- Address difficulties in programming, as we are at a crossroads with two (or more) different populations of older adults
- Address inconsistencies in programming—but focus should be on attracting “talent”
- Challenge older adults to find the senior center or programming that fits their needs/desires
- Provide more staff training to create new attitudes and programming
- Encourage creativity in hours of operation (variety in programming is dependent on funding)
- Establish new connections—not through a specific location, but through activities, connecting points (e.g., golf clubs)
- Create a directory of all senior centers and their programs to facilitate choice, raise awareness of what is available
- Guide leadership on migrating from a “social club” to a “community club”—potential shift to a new business model
- Eliminate snobbery among attendees
- Pool resources of senior centers with other community groups
- Adequately compensate senior center directors and staff
- *You need to add senior centers (or as we call them, “Centers for Healthy Aging”) to the list for discussion. They provide meals, health screenings, exercise programs, many activities, and socialization. Many more seniors are served in senior centers than adult day care. You cannot equate the two. They are much different. Senior centers are preventive care.
PDA Programs

How would you describe the ideal interaction between consumers and the PDA or its partners?

**Discussion question:** How do we encourage interaction between consumers and PDA and its partners?
- Provide better meals
- Promote better communication; still no clearinghouse for information
- Ensure accessible locations
- Tailor to the needs of the community; reach out, leveraging advisory committees

**Polling item:** Participant awareness of the PDA-administered APPRISE program

Although the community listening forums will explore perceptions on a number of PDA-administered programs, the APPRISE program was offered as an example of a programmatic topic for a facilitated discussion. Nearly two-thirds of participants overall were aware of the program. However, P4A participants were more than twice as aware when compared to PCoA and PDA participants.

### Awareness of the APPRISE Program

<table>
<thead>
<tr>
<th>Not aware at all</th>
<th>Aware, but not clear of its purpose</th>
<th>Aware that APPRISE provides insurance counseling</th>
<th>Received services</th>
</tr>
</thead>
<tbody>
<tr>
<td>P4A</td>
<td>3%</td>
<td>9%</td>
<td>6%</td>
</tr>
<tr>
<td>PCOA</td>
<td>3%</td>
<td>18%</td>
<td>8%</td>
</tr>
<tr>
<td>PDA</td>
<td>13%</td>
<td>68%</td>
<td>78%</td>
</tr>
<tr>
<td>Total</td>
<td>6%</td>
<td>89%</td>
<td>78%</td>
</tr>
</tbody>
</table>

Prior to today, what was your level of awareness of the APPRISE program?

<table>
<thead>
<tr>
<th>Response</th>
<th>P4A</th>
<th>P4A %</th>
<th>PCOA</th>
<th>PCOA %</th>
<th>PDA</th>
<th>PDA %</th>
<th>Total</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not aware at all</td>
<td>2</td>
<td>3%</td>
<td>2</td>
<td>9%</td>
<td>2</td>
<td>13%</td>
<td>6</td>
<td>6%</td>
</tr>
<tr>
<td>Aware, but not clear of its purpose</td>
<td>2</td>
<td>3%</td>
<td>4</td>
<td>18%</td>
<td>2</td>
<td>13%</td>
<td>8</td>
<td>8%</td>
</tr>
<tr>
<td>Aware that APPRISE provides insurance counseling</td>
<td>51</td>
<td>89%</td>
<td>12</td>
<td>55%</td>
<td>11</td>
<td>68%</td>
<td>74</td>
<td>78%</td>
</tr>
<tr>
<td>Received services</td>
<td>3</td>
<td>5%</td>
<td>4</td>
<td>18%</td>
<td>1</td>
<td>6%</td>
<td>8</td>
<td>8%</td>
</tr>
</tbody>
</table>
Polling item: Likelihood of recommending the APPRISE program

Nearly three-quarters of participants who are aware of the program would recommend it to consumers.

Discussion question: What about the quality of APPRISE?
- Rethink program titles (of programs in general as well as APPRISE); not always indicative of or clear about services provided
- Enhance communication; public unaware of how good APPRISE is
- Use ambassadors to spread the word to the public, no eligibility requirements
Polling item: Participation of eligible consumers in APPRISE

Overall, 72% were correct that out of more than 2 million Medicare beneficiaries eligible for APPRISE services, 350,000 Pennsylvanians participate.

| Of the more than 2 million Medicare beneficiaries eligible for APPRISE services, how many participate? |
|---|---|---|---|---|
| Response | P4A | PCOA | PDA | Total |
| 350,000 | 36 | 18 | 15 | 69 |
| 750,000 | 14 | 6 | 2 | 22 |
| 1,500,000 | 1 | 0 | 2 | 3 |
| 2,000,000 | 1 | 0 | 1 | 2 |

Polling item: Population of older adults age 85 or older by 2020

Overall, 81% were correct that 350,000 Pennsylvanians will be age 85 or older by 2020.

| Today, the number of Pennsylvanians age 85 or older is about 330,000. By the year 2020, how many Pennsylvanians will be age 85 or older? |
|---|---|---|---|---|
| Response | P4A | PCOA | PDA | Total |
| 335,000 | 1 | 0 | 0 | 1 |
| 340,000 | 5 | 1 | 1 | 7 |
| 345,000 | 6 | 2 | 3 | 11 |
| 350,000 | 43 | 23 | 15 | 81 |

Discussion question: What will the aging of the population mean for older adults and communities?

- Addressing concerns related to a lack of facilities
- Creating more services
- Holding forums on chronic disease self-management, exercise programs
- Fixing property taxes to prevent homelessness
- Creating services for older adults who do not have children residing nearby (with a suggestion on viewing Independent Fiscal Office presentation)
- Providing workforce training to address needs of seniors
- Encouraging financial planning to promote less dependence on public funding, reduce intergeneration competition for funds
- Ensuring transportation and affordable housing
Discussion question: How do we increase awareness of programs?
- Use volunteers to reach out to seniors in their communities, especially if programs are marketed
- Post information on Facebook page
- Institute multimodal 211 system (use and improve existing systems)
- Do more to understand cultural backgrounds of seniors (beyond language)
- Educate the average person
- *We need to figure out ways to tap into healthy, active seniors as a home grown resource to help address the very concerns being discussed here today.
- *PDA should advertise services on TV. You can use the script for some limited English-speaking groups.
- *Use TV for two-minute info for seniors; combine with PA lottery, other commercials within programs seniors watch (Jerry Springer, Wheel of Fortune, Jeopardy, Dancing with the Stars). You will reach thousands of seniors.

Discussion question: How do we encourage volunteers?
- Hold volunteer “pep rallies”
- Coordinate with, rather than compete with, other agencies that recruit volunteers
- Use advisory councils; AAA directors do not always want to engage
- Explore/emulate models that publicly collaborate on their senior volunteer efforts
- Reach out to high schools and colleges
- Work with religious leaders and the faith-based community
- Teach people how to volunteer; eliminate confusion
- Promote flexible scheduling of volunteers; rigid schedules make people balk, results is short stint
- Enhance communication among regional CoAs, PCoA, and governor’s office
- *Involve the Rotary, chambers of commerce, and other community organizations to raise awareness of PCOA and need for volunteers.
- *We need to stop treating volunteers like employees; too many demands, requirements, initiatives for volunteers to complete!
- *Provide tax credits for volunteers.

Discussion question: What else should we know?
- PDA Community Listening Forums are too far away—help local AAAs do locally (Kirsten then addressed website, survey, and other means for community input)
- Need to engage other partners, particularly hospitals
- *State Plan on Aging should attempt to incorporate the Alzheimer’s Plan and Elder Justice Plan recommendations in an effort to track and promote progress of each as their activities proceed.
- *Investigate EMPOWER Center for Health (Patrick G. Reilly, 814-317-5063): Unique program to help improve care of seniors with chronic illness and decrease the cost and frequency of hospital admissions.
- *The entire aging network has a great responsibility to impart a change in the way society views aging. We need to educate Pennsylvanians about the needs
of older adults. We need to teach people how to care for their neighbors again, look out for each other, cook an extra meal, and shovel a driveway. Even saying "hello" with a smile can change a person's whole day and outlook on life.

- *The state should be more flexible with regard to meals and menu nutrition so the meals can be more enjoyable, more what seniors want. The meal should not be for the purpose of training persons to change their eating habits at age 80+. A meal should be an attractive, enjoyable.

*Indicates comments from response cards
Pennsylvania Department of Aging

Summary of Community Listening Forums

April, 26 2016
Introduction

Every four years, the Pennsylvania Department of Aging (PDA) prepares a strategic plan to steer its programming and delivery of services and supports for older adults, their families, and their caregivers. The 2016-2020 State Plan on Aging will articulate a clear and comprehensive direction for both the department and for those who serve and support our diverse and robust population of older Pennsylvanians.

The State Plan carries out the complementary objectives of the Older Americans Act, PDA, and the commonwealth in ensuring that all older Pennsylvanians are empowered to make informed decisions about their care in the setting of their choice.

The State Plan development process incorporates broad outreach, informed by local plans developed by the 52 Area Agencies on Aging (AAAs), PDA staff, aging services network partners, and consumers and the general public (via Community Listening Forums (CLFs) public hearings, and surveys).

In March and April 2016, PDA convened seven CLFs throughout the state (Erie County [Erie]; Washington County [California]; Lehigh County [Bethlehem]; Lancaster County [Manheim Township]; Tioga County [Mansfield]; Blair County [East Freedom]; and Lackawanna County [Scranton]). These forums provided concerned stakeholders with an opportunity to tell PDA what they thought about the programs and services they provide, are they benefitting older Pennsylvanians, or are they not effective; what do they think is being done well or what needs to be improved. The input obtained will validate the developing components of the State Plan on Aging.

Over 230 individuals participated in the sessions, offering a wide variety of perspectives and adding legitimacy to the State Plan development process. Participants included:

- Consumers of services
- AAA and Senior Community Center staff professionals
- Home health care, nursing home, adult day center, transportation, housing, and legal services providers
- Advocates for various groups or constituencies, including the Alzheimer’s Association, AARP, and LGBT representatives
- County government officials, including agency managers and elected commissioners
- State legislators and their staff
- One federal Department of Health and Human Services regional official
Each CLF featured an introduction by PDA Secretary Teresa Osborne, followed by a facilitated session. The session provided participants with an opportunity to respond to polling and open-ended questions, designed to gauge their awareness of and perceptions about the programs and services supported by the department and its aging network partners. In addition, facilitated conversation allowed participants an open forum in which to discuss critical concepts and ideas related to these programs and services.

This report summarizes the input received in the sessions, organized in a manner reflecting the structure of the CLFs. The report also briefly highlights some of the broader implications related to participant input that will impact the State Plan on Aging objective and strategy refinement. Lastly, polling results (for both the entire CLF population and by individual CLF) are illustrated in bar graphs at the end of the report.

The information received in the CLFs reflects the unique and varied perspectives of consumers, partners, and other stakeholders from communities throughout the commonwealth. These thoughtful and engaged participants also provide PDA with valuable insight on the issues and priorities the department should consider in developing, and ultimately implementing, the State Plan on Aging.

CLF Session Summary

Discussion question: What are your hopes and concerns about aging for you or a loved one?

The most prevalent hopes among forum participants were to have the health and financial security to stay in their homes, and to live vibrantly and independently as they age. However, they also expressed a number of concerns that may serve as barriers to aging in place. The most common of these often interrelated concerns included:

- Isolation, where opportunities for engaging in their communities may be limited.
- Affordable, high-quality, geriatric-centered health care, both in the home and in the community.
- Care for individuals with Alzheimer’s disease and related disorders, as well as support for their caregivers.
- Qualified, trustworthy, culturally competent and compassionate in-home caregivers.
- Adequate housing, in terms of availability, affordability, and maintenance.
- Flexible, affordable, and reliable transportation, particularly in rural areas.
- Financial security, with the resources (either personal or state-subsidized) to maintain independence.
- Physical safety.
- Protection from exploitation and access to legal and protective services.
• Provision of services in a manner sensitive to every individual’s unique circumstances, ensuring that all older adults have equal access and protections.

Polling item: Awareness of AAA core programs

There is concern that older adults—and those soon to be—are not aware of programs and supports to assist them in preparing to age in place with dignity. Polling demonstrated that programs provided primarily through the AAAs were at least recognizable to over a majority of all CLF participants, as illustrated below:

- Home-delivered meals (80%)
- Personal assistance and care services (76%)
- Home health care (74%)
- Adult day care (71%)
- Care management (71%)
- Housing assistance and advocacy (68%)
- Home modifications (65%)
- Caregiver support (64%)
- Respite care (60%)
- Employment (56%)

Discussion question: Which of these services or supports are most important to you?

Although participants generally agreed that all of the programs and supports offered by AAAs are important, the majority considered personal assistance, meals, home health care, and care management as the most critical (see graph Which of these services or supports are most important to you on page 16).

Polling item: How effective are these programs in allowing older adults to age in place with dignity?

Most forum participants agreed that these programs are effective when consumers can access them and when resources are available. Participants cited common barriers to effectiveness, including:

- Overall awareness of the spectrum of services and supports.
- Eligibility and income limitations.
- Communication gaps between partners in the aging services network (including AAAs, services providers, and medical professionals).
Polling item: Are you aware of senior community centers in your area?

Overall, 97% of forum participants were aware of senior community centers.

Discussion question: Are senior community centers a service you or your family member would be interested in? Why or why not?

In general, participants cited the value of senior community centers in promoting socialization, engagement, and a positive quality of life. Many commended the centers in their communities for their programming, including recreational and continuing education activities, meals and nutritional support, and health and wellness offerings.

However, most participants recognized that there are many older adults who are reluctant to, not interested in, or not able to participate in senior community center activities. Specific reasons for a lack of participation included:

- The perception among some that centers are for “old people,” not them.
- Little interest in perceived or traditional programming, such as Bingo and cards.
- Scheduling conflicts, particularly among active seniors, working older adults, and those who care for their grandchildren or spouse.
- Lack of reliable transportation.
- Feeling unwelcome (especially among those in the LGBT and disability communities).

In turn, participants offered suggestions for drawing individuals to senior centers. The most prevalent of these was to develop programming reflecting the diverse interests of the community’s older adults. Other suggestions included:

- Promoting an inclusive environment, where all individuals feel welcome.
- Creating opportunities for active and/or younger seniors, such as walking programs, adventure clubs, music programs and rock concerts.
- Promoting senior centers as multi-generation, multi-faceted community centers, with lifelong recreational and educational programming.
- Expanding hours to facilitate evening and weekend activities.
- Advertising senior center activities through traditional and social media outlets.
- Jointly program with senior advocacy groups (such as AARP), state agencies, social workers, health care providers, and other partners to enhance education on and access to essential services.
Polling item: Are you aware of adult day centers in your community?

Overall, 71% were aware of adult day centers.

Discussion question: Are adult day centers a service you or your family member would be interested in? Why or why not?

Participants recognized that adult day centers are vital. Many cited specific examples of the respite these centers provide for caregivers, as well as the quality of care provided to those they care for.

Yet, many voiced their concerns. In particular, participants noted that:

- The cost can be prohibitive for consumers, especially those who do not qualify for assistance. For providers, operational expenses constrain viability.
- Transportation is often a challenge. Issues include weather, affordability, distance, scheduling, and coordination of door-to-door/door-through-door transit.
- Not all regions of Pennsylvania have adult day centers, with resultant gaps in access despite need.

Participants suggested that expanding center hours and exploring social and medical models may help alleviate some of these concerns.

Polling item: Are you aware of transportation services for older Pennsylvanians in your communities?

Over 93% of the participants were aware of the transportation services available.

Discussion

Forum participants identified transportation as a major concern for those who do not drive, live in rural areas, or need to rely on public transportation to get to medical appointments, work, or shopping. Some commented on the lack of fixed route public transportation in many areas, but most of the input related to shortcomings in the Shared Ride program as it serves older Pennsylvanians. In particular, participants stated that:

- Reserving rides 24 hours in advance is inconvenient or impractical.
- Riders may have to dedicate an entire day for a single ride to an appointment, given pick-up windows and traveling distances.
- Service is unreliable, causing riders to miss scheduled medical appointments while remaining responsible for the fare.
- Scheduled timing of trips is incompatible with medical appointment schedules, such as afternoon appointments for surgeons.
- Service is often not available on weekends or government holidays.
• Travel is often restricted to within one's home county.
• Service is limited to curb-to-curb, making it difficult for riders who need assistance.
• Drivers often do not know where they are going.
• Drivers are insensitive to their passengers.

Some participants, however, were optimistic about the potential of new options, such as Uber and community-based membership service groups that offer transportation.

Other PDA-Administered Programs

The following chart shows the percentage of individual respondents mostly unaware ("not aware" and "aware but not clear of its purpose") and those knowledgeable ("aware of the purpose of the program" or "utilized the service") of other PDA-administered programs.

<table>
<thead>
<tr>
<th>Program</th>
<th>Mostly Unaware</th>
<th>Knowledgeable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance - APPRISE</td>
<td>44%</td>
<td>56%</td>
</tr>
<tr>
<td>Prescriptions – PACE</td>
<td>21%</td>
<td>79%</td>
</tr>
<tr>
<td>Caregiver Support</td>
<td>47%</td>
<td>53%</td>
</tr>
<tr>
<td>Legal Assistance</td>
<td>42%</td>
<td>58%</td>
</tr>
<tr>
<td>Ombudsman Program</td>
<td>25%</td>
<td>75%</td>
</tr>
<tr>
<td>Protective Services</td>
<td>15%</td>
<td>85%</td>
</tr>
<tr>
<td>Health and Wellness – PrimeTime Health</td>
<td>47%</td>
<td>53%</td>
</tr>
</tbody>
</table>

Discussion: Health Insurance

Many forum participants were highly complimentary of the APPRISE program. They cited it as a tremendous benefit in navigating health insurance programs and praised the knowledge and dedication of APPRISE counselors in general.

They also offered suggestions on how to improve access to the program, such as:
• Renaming the program so that individuals can better recognize what the program offers.
• Recruiting more counselors, as current volunteer staff is often overbooked.
• Promoting the program through mailings and traditional marketing means, as well as through social media and aging services network partners.
Discussion: Prescriptions

Perhaps for more than any other program, forum participants touted the value of PACE and PACENET. They also shared their experiences and familiarity with the programs’ benefits.

Nevertheless, they had a few suggestions for enhancing the program, including:

- Increasing income eligibility ceilings.
- Providing assistance in completing enrollment or applications.
- Enhancing program promotion through pharmacies and other healthcare outlets.

Discussion: Caregiver Support

Polling item: Are you, or have you ever been a caregiver?

Overall, 65% of participants indicated they were at least at one time a caregiver.

Discussion question: What kind of help do you need as a caregiver?

The most prevalent responses related to the constant stress placed on a caregiver. This stress is multi-dimensional, with layers of constant change, financial worry, emotional distress, and depression. The act of care giving is constant.

Caregivers concerns also included the need for:

- Education and training on basics, such as how to give a shot, administer salve or lotions, or bathe the individual receiving care.
- Emotional care, with an emphasis on self-care.
- Greater financial support through the Caregiver Support program.
- Trustworthy hired caregivers.

Forum participants offered a number of comments related to the Caregiver Support program. Perhaps the most prevalent was that it provides such minimal reimbursement for care and supplies, it is not worth the effort of maintaining and submitting receipts. Yet, some added that knowing the support services were available was a comfort, whether or not a caregiver tapped into the program. Further, one participant noted that home modifications are the best part of the program.

They also suggested:

- Reviewing income guidelines that limit participation.
- Marketing the program to working-age individuals, especially those dealing with children and parents.
Discussion: Legal Assistance

Most participant comments related to how to access legal services, indicating that there may be a need to more strongly promote these services.

Participants also remarked:
- Individuals find it difficult to get legal assistance in certain regions.
- Legal aid offices are overtaxed and hard to get to.

Discussion: Ombudsman Program

In general, participants feel that the program is successful, with competent and responsive ombudsmen.

However, they offered a few suggestions for program improvement, including:
- Encouraging consistency in service delivery throughout Pennsylvania.
- Ensuring that individuals understand what the ombudsman sign means.
- Fostering partnerships with nursing homes, as an opportunity for synergy between ombudsman and nursing home transition programs.

Discussion: Protective Services

Participants recognized the criticality of these services in protecting some of Pennsylvania’s most vulnerable older adults. They also noted difficulties in resolving cases of abuse and neglect, not the least of which is the stigma attached to seeking help.

In turn, they offered a number of suggestions to address these concerns, such as:
- Refocusing AAAs on protective services for older adults.
- Ensuring that there will be care for the abused individual once their abuser can no longer care for them.
- Increasing public awareness of what constitutes abuse.
- Increasing awareness of protective services, through Lottery advertising, media outlets, and educational mailings, and in coordination with other aging services network programs.
- Strengthening partnerships with district attorneys, police departments, and healthcare providers toward reporting and pursuing cases.
- Exploring how other commonwealth agencies approach abuse issues.
Discussion: Health and Wellness

Forum participants cited the effectiveness of these programs and how well they are received, particularly the Healthy Steps and “10 Keys™” to Healthy Aging programs. However, they also noted that many older adults are not aware of or have difficulty accessing these services.

To address these issues, participants suggested:
- Promoting programs through partnerships with hospitals, YMCA, AARP, and community and faith-based organizations.
- Partnering with specific communities, such as the LGBT and minority communities, to dispel wariness of “mainstream programs” and to ensure inclusiveness.
- Coordinating offerings with the State Health Improvement Plan.
- Expanding access beyond daytime hours.
- Establishing aggressive goals for participation, encouraging aging services network partners (AAAs in particular) to help meet these goals.

Discussion question: How can the Department of Aging increase awareness of services?

There was consensus among participants in all of the sessions that PDA and its partners must raise awareness of programs. They offered a number of suggestions to this end, including:
- Leveraging the televised Lottery drawing to promote services.
- Advertising through television, given that older Pennsylvanians watch a significant amount of television.
- Providing a comprehensive toll-free 1-800 number and expanding PDA’s website.
- Including program information with home delivered meals.
- Pursuing more on-site visits to senior centers and other sites in spreading the word about programs and services.
- Partnering with numerous organizations (including but not limited to the Alzheimer’s Association, AARP, food banks, faith-based organizations, housing authorities, nursing homes and their affiliates [e.g., PHCA, LeadingAge], and casinos) to provide information and promote services.
- Partnering with legislators to promote services for older adults and those who care for them.
- Engaging leaders in the state’s diverse communities, such as the LGBT and minority communities, as a means to disseminate information and build support for programs.
• Targeting marketing to caregivers and family members through traditional outlets, social media, and community pages.
• Working with pharmacies and health care providers to market programs like PACE, APPRISE and PrimeTime Health, where there are mutual benefits.
• Partnering with employer human resource professionals to provide information and increase awareness of support available for older workers and employees supporting older family members.
• Spearheading a PDA campaign (to enhance AAA marketing efforts), highlighting how services and support enable a higher quality of life.

Discussion question: How should the Department of Aging and local communities encourage individuals to volunteer for services that aid older Pennsylvanians?

Many programs, such as Apprise and Ombudsman, are reliant upon volunteers. In addressing PDA’s query on recruiting volunteers, forum participants stated that individuals often want short-term but meaningful projects, as well as to be part of autonomous teams to manage those projects. Key objectives include getting volunteers involved in activities they are passionate about or for which they have a talent. Participants also noted that potential volunteers sometimes simply need to be asked to do something productive.

Participants suggested ways to recruit volunteers, including:
• Conducting a marketing campaign on how to get involved in supporting older Pennsylvanians.
• Partnering with other volunteer entities, such as AARP and other retiree organizations, strengthening ties with the tens of thousands of current volunteers.
• Advertising in community sections of local newspapers.
• Recruiting in-place (such as in senior centers); a lot of people want to help but do not know how.
• Creating a state-funded clearinghouse or crowd-sourcing site for volunteers.
• Recognizing and rewarding volunteers (even through tax credits).

Participants also noted that the knowledge and training required for volunteers, particularly for APPRISE and Ombudsman programs, as well as mandatory and onerous background checks, may be significant deterrents.
Discussion question: What needs of older Pennsylvanians are not currently being addressed?

Participants stated that older Pennsylvanians need:

- More geriatric professionals, including doctors, and training for these professionals (particularly for those treating individuals with Alzheimer’s disease and related disorders).
- Integrated care for the entire person (physical and behavioral health), with better medical management and service reconciliation.
- Greater education of direct care providers.
- More on-call provider staffing.
- Extended eligibility for programs and services, including sliding scales.
- Greater personal outreach to consumers in ensuring their daily well-being.
- Extended programs hours (e.g., evenings and weekends).
- Higher subsidies for nutritional and caregiver support.
- Greater advocacy and legal protections for all older Pennsylvanians, including but not limited to the LGBT and minority communities, veterans, and those with mental health issues.
- Increased cultural competency among all aging network service partners.
- Enhanced self-care for caregivers and services for their families.
- Greater attention to Pennsylvania’s guardianship laws to better protect older adults.
- Education and assistance on advanced directives.
- Better coordination between AAAs and publicly- and privately-subsidized organizations and community partners.
- Outreach to employers for those seeking jobs.

Discussion question: What other suggestions do you have to help shape the State Plan on Aging and address the needs of older Pennsylvanians?

Forum participants offered the following suggestions:

- PDA and its aging services network should be the voice for consumer choice.
- Emphasize the role of PA LINK.
- Ensure that services are tailored to the individual.
- Integrate the goals and objectives of the State Plan for Alzheimer’s Disease and Related Disorders.
- Increase accessibility to services and supports accessibility for those with mental illness.
- Reduce or eliminate property taxes for older adults.
- Conduct outreach to chambers of commerce and business association.
- Do not allow implementation of managed care to overshadow the importance of local understanding of service needs.
Implications for State Plan Objectives and Strategies

- Given that those who participated in the CLFs were, for the most part, more engaged in public programs to assist older Pennsylvanians than the general public, one would expect a greater level of awareness of programs. Yet, polling demonstrated that the level of program awareness may not have been as high as anticipated. Although most participants recognized all the programs, a very high percentage was unaware of programs and services basics. Awareness was greatest for Protective Services and PACE.

- Awareness was greatest for Protective Services and PACE, suggesting that the marketing of these programs might serve as a model or be leveraged for raising awareness of other programs.

- Participants validated the need for additional volunteers, identifying baby boomers as a significant resource. However, Pennsylvania’s onerous requirements for volunteers may be a barrier. Participants also mentioned the need for volunteer coordinators, as well as strategies to keep volunteers engaged.

- In several sessions, AAA representatives expressed that case loads are significantly more than they can adequately handle; given demographic projections, caseloads will continue to grow. Consequently, any additional administrative or programmatic requirements placed upon AAAs may incite some resistance.

- Similarly, participants stated that if it is difficult to meet the demand for services now, promoting benefits and services will increase demand with no anticipated increase resources or viable means of meeting that demand. As a result, service will suffer, waiting lists will grow, and consumers will be disappointed.

- Participants discussed the challenges faced by, and the complexity of the needs of, older adults, along with the belief that it is extremely difficult for individuals and families to navigate the health and human services system alone. Care managers, counselors, or navigators would be of great benefit in helping individuals to connect with the services they need.

- Participants recognized the need and value of adult day centers. However, many participants suggested that the current model is not financially viable, due to reimbursement rates, participation rates, or other factors. As a result, a number of centers have closed in recent years.

- Participants expressed the desire for a single point of objective information for aging services.
Polling Results

How many miles did you travel to get here?

![Bar chart showing polling results for different mile ranges and locations.]

There are over 2.9 million Pennsylvanians over the age of 60. By 2020 this population is expected to increase by:

![Bar chart showing the expected increase in population by 10%, 15%, and 25% for different locations.]

13
Please indicate all of the services you are aware of.

- Adult day care
- Home-delivered meals
- Personal assistance and care services
- Housing assistance and advocacy
- Home modifications
- Care management
- Home health care
- Caregiver support
- Respite care
- Employment

Please select the services you are aware of for the following locations:

- Erie
- California
- Bethlehem
- Lancaster
- Mansfield
- Blair
- Lackawanna
- All Locations
How effective are these programs in allowing older adults to age in place with dignity?
Which of these services or supports are most important to you?

- Adult day care
- Home-delivered meals
- Personal assistance and care services
- Housing assistance and advocacy
- Home modifications
- Care management
- Home health care
- Caregiver support
- Respite care
- Employment

Data was not collected for this question at the Erie and California forums.
Are you aware of Senior Centers in your area?

- Yes: 91%, 98%, 100%, 94%, 95%, 100%, 95%, 97%
- No: 9%, 2%, 6%, 5%, 5%, 3%

Are you aware of Adult Day Centers in your community?

- Yes: 64%, 69%, 87%, 82%, 69%, 71%
- No: 36%, 31%, 13%, 11%, 18%, 31%, 29%
Are you aware of transportation services for older Pennsylvanians in your community?

Prior to today, what was your level of awareness of the APPRISE program?
Prior to today, what was your level of awareness of the PACE program?

- Not aware at all
  - Erie: 7%
  - California: 3%
  - Bethlehem: 5%
  - Lancaster: 5%
  - Mansfield: 3%
  - Blair: 5%
  - Lackawanna: 6%
  - All Locations: 3%

- Aware, but not clear of its purpose
  - Erie: 18%
  - California: 61%
  - Bethlehem: 43%
  - Lancaster: 65%
  - Mansfield: 66%
  - Blair: 9%
  - Lackawanna: 3%
  - All Locations: 9%

- Aware that PACE provides prescription drug assistance
  - Erie: 21%
  - California: 13%
  - Bethlehem: 35%
  - Lancaster: 40%
  - Mansfield: 35%
  - Blair: 18%
  - Lackawanna: 8%
  - All Locations: 7%

- Utilized this service
  - Erie: 16%
  - California: 9%
  - Bethlehem: 16%
  - Lancaster: 16%
  - Mansfield: 18%
  - Blair: 81%
  - Lackawanna: 9%
  - All Locations: 7%

Are you, or have you ever been a caregiver?

- Yes
  - Erie: 50%
  - California: 73%
  - Bethlehem: 56%
  - Lancaster: 69%
  - Mansfield: 74%
  - Blair: 65%
  - Lackawanna: 57%
  - All Locations: 57%

- No
  - Erie: 50%
  - California: 27%
  - Bethlehem: 43%
  - Lancaster: 27%
  - Mansfield: 31%
  - Blair: 26%
  - Lackawanna: 35%
  - All Locations: 43%
Prior to today, what was your level of awareness of the Pennsylvania Caregiver Support Program?

- Not aware at all: 23% (Erie), 21% (California), 22% (Bethlehem), 25% (Lancaster), 22% (Mansfield), 22% (Blair), 27% (Lackawanna), 25% (All Locations)
- Aware, but not clear of its purpose: 8% (Erie), 12% (California), 18% (Bethlehem), 18% (Lancaster), 22% (Mansfield), 41% (Blair), 69% (Lackawanna), 48% (All Locations)
- Aware that PA provides caregiver assistance: 6% (Erie), 37% (California), 14% (Bethlehem), 35% (Lancaster), 57% (Mansfield), 50% (Blair), 33% (Lackawanna), 48% (All Locations)
- Utilized this service: 4% (Erie), 3% (California), 6% (Bethlehem), 14% (Lancaster), 9% (Mansfield), 5% (Blair), 9% (Lackawanna), 5% (All Locations)

Prior to today, what was your level of awareness of Legal Assistance services?

- Not aware at all: 31% (Erie), 53% (California), 26% (Bethlehem), 26% (Lancaster), 26% (Mansfield), 19% (Blair), 15% (Lackawanna), 14% (All Locations)
- Aware, but not clear of its purpose: 13% (Erie), 10% (California), 18% (Bethlehem), 18% (Lancaster), 16% (Mansfield), 32% (Blair), 33% (Lackawanna), 37% (All Locations)
- Aware that legal counseling may be available: 46% (Erie), 61% (California), 44% (Bethlehem), 43% (Lancaster), 37% (Mansfield), 37% (Blair), 37% (Lackawanna), 55% (All Locations)
- Utilized this service: 14% (Erie), 5% (California), 6% (Bethlehem), 6% (Lancaster), 11% (Mansfield), 6% (Blair), 6% (Lackawanna), 6% (All Locations)
Prior to today, what was your level of awareness the Ombudsman Program?

- Not aware at all
- Aware, but not clear of its purpose
- Aware that there is assistance for long-term care complaints
- Utilized this service

Prior to today, what was your level of awareness of Protective Services?

- Not aware at all
- Aware, but not clear of its purpose
- Aware that there is assistance to report cases of abuse
- Utilized this service

Data was not collected for this question at the California forum.
Prior to today, what was your level of awareness of PrimeTime Health?

- Not aware at all
- Aware, but not clear of its purpose
- Aware that there are health education programs
- Utilized this service

Data was not collected for this question at the California forum.
Which of the following programs are effective?

- APPRISE
- PACE
- Pennsylvania Caregiver Support Program
- Legal Assistance
- Protective Services
- Ombudsman Program
- Primetime Health
- Have not utilized these services

Data was not collected for this question at the California forum.
Pennsylvania Department of Aging
Summary of Public Hearings
May 27, 2016
Introduction

Every four years, the Pennsylvania Department of Aging (PDA) prepares a strategic plan to steer its programming and delivery of services and supports for older adults, their families, and their caregivers. The 2016-2020 State Plan on Aging will articulate a clear and comprehensive direction for both the department and for those who serve and support our diverse and robust population of older Pennsylvanians.

The State Plan carries out the complementary objectives of the Older Americans Act, PDA, and the commonwealth in ensuring that all older Pennsylvanians are empowered to make informed decisions about their care in the setting of their choice.

The State Plan development process incorporates broad outreach, informed by local plans developed by the 52 Area Agencies on Aging (AAAs), PDA staff, aging network partners, and consumers and the general public (via Community Listening Forums [CLFs] public hearings, and surveys).

In May 2016, PDA conducted three public hearings. The hearings provided concerned stakeholders with an opportunity to tell PDA what they thought about the goals, objectives and strategies within the draft State Plan on Aging and the implied direction and priorities. In addition, attendees and all stakeholders were encouraged to submit comments in writing to the department for consideration, even if they did not publicly testify. The input obtained will validate and help refine the developing components of the State Plan.

Twenty-eight individuals publicly testified in the three hearings and a number of others offered written testimony for the record. Those testifying, including AAAs, advocacy associations (AARP, Alzheimer’s Association, and the lesbian, gay, bisexual, and transgender [LGBT] community), providers (e.g. home health, adult day), legal services, and individuals, represented a variety of perspectives. The testimony provided recommendations specific to certain draft objectives and strategies, as well as overall general suggestions relative to the State Plan.
Each public hearing featured an introduction by PDA Secretary Teresa Osborne, followed by scheduled testimony limited to five minutes per testifier. This report summarizes the input received in the hearings, organized according to affinity groupings. The report also briefly highlights some of the broader implications related to participant input that will impact State Plan objective and strategy refinement.

The information received in the public hearings reflects the unique and varied perspectives of consumers, partners, and other stakeholders from communities throughout the commonwealth. These thoughtful and engaged participants also provide PDA with valuable insight on the issues and priorities the department should consider in developing, and ultimately implementing, the State Plan on Aging.

Public Hearings Summary

Hearing participants offered many suggestions intended to strengthen the State Plan on Aging.

In general

- The plan lacks vision and demographic and data justification for actions or priorities.
- Performance measures should be specific.
- Important services are missing (e.g., legal, housing, transportation, veterans, LGBT)
- OAA reauthorization allows for oral health screenings, which is not addressed in plan.
- OAA funding cuts are not addressed in plan.
- Long-term care reform (Community Health Choices) is not addressed in plan.
- The financial security of seniors is critical to coping with an aging population in a fiscally responsible manner.
- Help Pennsylvanians save for retirement through workplace deductions.
- Acknowledge in the State Plan that there is a seat at the table for older Pennsylvanians when the future is being debated.
- PDA must demonstrate it will be a catalyst for stimulating additional funding.
Caregiver Support

- Ensure that family caregivers can continue in their role without becoming so exhausted or frustrated that they jeopardize their own health.
- Increase opportunities for respite services for caregivers.
- Support the Plan’s initiative to expand adult day center opportunities.
- Increase awareness of caregiver support programs.
- Include navigators to support kinship care
- Support senior sandwich generation.

Participants expressed support for objectives 4.1, 2.4, 1.1, 1.4, 1.5, 2.1 and 3.4 and focusing on caregiver support.

Diversity

- Identify and meet the service needs of those from various cultural backgrounds, including those with limited English proficiency (LEP).
- Explicitly mention LGBT older adults and those living with HIV/AIDS.
- Compel AAAs to pay more attention to existing and growing Asian refugee and immigrant populations.
- Include policies to hold AAAs accountable for investing in programming to properly reach and serve linguistically and culturally isolated senior communities.
- Develop procedures to ensure language access throughout the entire spectrum of service delivery (e.g., interpreters, translators, language line technology).
- Ensure AAAs maintain sustained financial investments and program partnerships with smaller agencies that have linguistic and cultural expertise with difficult to reach ethnic populations.

Person-Centered Planning.

- Amend intake forms so that transgender individuals are not forced to check a box for “Male” or “Female” that may lead them to forego services altogether.
- Advocate for improved coordination of care, especially between medical and non-medical services. Review strategies of how services are provided and aggressively enforce accountability.

- Require a dedicated funding stream.
- Increase resources, specifically for psychologists.
- Consider Elder Justice Guardians and Counsel Committee recommendation for the lottery as a funding source.
- Make guardianship representation, oversight and statewide best practices a priority of the plan.
- Expand strategy to develop and provide training for PDA and AAAs on guardianship law, policies and procedures to include mediation and alternatives to guardianship.
- Clarify the strategy to implement quality assurance monitoring for guardianship cases, to specifically define to which cases it would apply.

Data Collection and Continuous Quality Improvement (Support for Objectives 3.1 and 3.7)

- Establish a Joint Committee on Quality Metrics and Measurements with the Pennsylvania Association of Area Agencies on Aging (P4A).
- Explore grants and other funding opportunities for providers to enhance electronic data collection and exchange.
- Improve AAA access to data collected and improve usage of Social Assistance Management System (SAMS) database.
- Allow individuals to self-identify gender in data collection activities.
- Establish and describe a stakeholder and feedback process to be used in developing policies and requirements. Ensure that the process is transparent, uses technology such as webinars, and that all website updates are easily identifiable.

Consider a Specific Objective to Improve Access to Transportation Services.

- Establish a task force with PennDOT to address necessary service enhancements, improve infrastructure, and make administrative updates.
- Incorporate transportation discussion in the State Plan.
- Direct increased resources to transportation.


- Prevent interruption of services under the OPTIONS program.
Home and Community Based Services

- Create a streamlined process for those individuals obviously not eligible for MA because of assets to bypass the CAO approval process and be considered for OPTIONS services.
- Expand community care options by advocating for a revision to current income limits and the disparity between nursing home and homecare.
- Increase funding flexibility and in-home support parameters.

Awareness and Promotion

Participants supported objectives related to increasing awareness of services.

- Participants cautioned on the need to provide adequate funding to support current service and increase capacity to meet increasing need.

Participants supported the State Plan’s first goal of increasing awareness of programs and provided the following suggestions:

- Target outreach (e.g., marketing materials, collaborations with LGBT community organizations), programming, funding and support to LGBT individuals inherently recognized as vulnerable. Prioritize aging network attention and support toward older adults living with HIV.
- Ensure that sexual orientation and gender identity are included in the definition of diversity.
- Include licensed insurance professionals in communications network to get the word out about services for older adults.
- Amplify education and outreach for APPRISE, ombudsman and guardianship programs.
- Include a specific strategy for Community Health Choices (CHC) and the changing role of AAAs.
- Expand education about and awareness of veterans benefits.

APPRISE

- Change the heading of objective 1.2 to “Increase awareness of APPRISE consumer education on services available to all Medicare beneficiaries throughout diverse populations” to differentiate the role of professional insurance producers and APPRISE volunteer counselors.
- Consider adding the following to the objective: “Utilizing licensed insurance producers as a training resource for APPRISE volunteers and as technical support to assist APPRISE in its educational efforts.”
- Add a strategy that calls for cross-training of APPRISE counselors on elements of CHC.
• Add a strategy that addresses monitoring the transition to CHC and training APPRISE counselors to assist individuals in choosing a CHC health plan that works best with their Medicare plan.
• Rename APPRISE

Consider retaining objective 1.4 in the 2012-2016 State Plan on Aging which states, “Build on existing programs (both public and private) that educate the public on the necessity for planning for their long-term care and health care needs.”

Protective Services
• Support objectives relating to protection against financial exploitation.
• Use existing resources, such as Consumer Financial Protection Bureau recommendations and PCA’s Financial Exploitation Task Force.
• Recommend more specifics on how objective 1.3 will be carried out in terms of trainings (e.g., content, target, mandates).
• Ensure that measures do not exclude those who do not go through the protective services system.

Ombudsman
• Support expanding program but also include additional resources.
• Suggest access to an “independent” ombudsman.

Legal Representation for Our Older Population
• Explicitly mention legal services and state Legal Assistance Developer.
• Back up this statement with adequate funding.
• Consider restating objective 4.2 from the 2012-2016 State Plan on Aging, “to strengthen the safety net through promotion of a comprehensive elder justice system, elder abuse prevention and response, and state legal assistance development.”
• Ensure the State Plan meets its statutory requirement to specify a minimum proportion of the funds received by each AAA be dedicated to providing legal assistance.
• Reference and address recommendations related to elder abuse, exploitation and civil justice made by the Supreme Court’s Elder Law Task Force.
• Partner with the Pennsylvania Commission on Crime and Delinquency (PCCD) to support increased Victims of Crime Act (VOCA) funding for older adult victims.
• Incorporate key components of the strategic plan (Blue Print) for the delivery of legal services and justice for older adults.
• Recognize the mandate of the OAA to make legal assistance and elder rights and justice a priority, and set minimum funding requirements.
- Tailor the plan to focus on those older adults with greatest social and economic need.
- Strengthen and expand legal services to ensure all older Pennsylvanians can access legal services to help with various issues, such as those related to health, housing, accessing services, income, elder abuse, and guardianship.
- Legal assistance developer should provide statewide leadership on advocacy issues.
- Consider adding an elder justice objective incorporating key strategies from the Model Approaches initiative including: 1) assessing the capacity of the current legal assistance delivery system for older adults to meet priority needs; 2) developing and implementing statewide standards to ensure high quality/high impact legal services delivery to those in greatest social or economic need; 3) developing statewide data collection and reporting systems to measure program outcomes; 4) establishing collaborations with aging/disability and elder rights networks to enhance legal responses to abuse and neglect; and 5) establishing a statewide legal training agenda focusing on priority issues.
- Recognize those with dementia as a particularly vulnerable population.
- Educate the legal system that the threshold for abuse of those with neurological disorders who are unable to report abuse needs to be the same as is offered for children.

Criminal Background Checks for Direct Care Workers

- Require all caregivers, regardless of employment status, to comply with the criminal history provisions of the Older Adult Protective Services Act (OAPSA).
- Consider a strategy relating to fixing the law to provide guidance on how to proceed when an applicant shows a prior conviction (in light of a recent Supreme Court decision declaring certain provisions of the OAPSA unconstitutional).

Volunteers

- Participants supported objectives to maximize use of volunteers.

Alzheimer’s Disease and Related Disorders

- Participants supported objective to convene a summit on Alzheimer’s Disease and Related Disorders (ADRD).
- Partner with aging network to support current workforce.
- Coordinate efforts with the implementation efforts of the state plan on ADRD.
- Develop strategies to help ensure consumers can access capable dementia care.
Senior Community Centers

- Support additional resources devoted to sustaining a strong senior community center network.
- Within the State Plan, affirm that senior community centers are a vital and integral part of the aging network. Senior community centers could be referenced in objectives 2.1, 2.2, and 3.4.
- Encourage AAAs and senior community centers to improve cultural competence and adopt policies and procedures that are inclusive of older LGBT adults, to ensure programs and service offerings are more welcoming.
- Hold AAAs and senior community centers accountable for providing linguistically appropriate services to LEP consumers, including training center personnel on how to work with cultural and linguistically diverse populations.
- Direct funds and support to valuable services provided by senior community centers.
- Clearly define the role of senior community centers in all aspects of the plan and ensure they receive the dedicated support needed to carry out the tasks to meet the objectives.

Housing

- Recommend LINKs work with housing authorities and local housing coalitions to ensure access to affordable housing resources.
- Deliver services where people live.
- Develop senior housing alternatives.
- Seek dedicated funding for senior housing.
- Pilot the identification and training of volunteers to carry out low/no cost home repairs for older Pennsylvanians and perhaps partner with organizations like Habitat for Humanity.
- Ensure person-centered counselors are aware of a variety of housing options.
- Disseminate best practices information (e.g., shared housing, Elder Cottage Housing Opportunity [ECHO], cluster housing, limited equity cooperatives).
- Coordinate with the Department of Human Services (DHS) on the implementation of its Statewide Housing Strategy.
- Strengthen partnerships with DHS, the Department of Community and Economic Development, and the Pennsylvania Housing Finance Agency on affordable housing issues.
- Support the current grant for non-traditional housing, pilot of shared housing match-up program in Northeastern Pennsylvania.
- Advocate for the older homeless.
- Incorporate advocacy goals for housing.
Direct Care Workers/Aging Network

- Prioritize employees throughout the aging network, creating opportunities for students and entry-level employees to develop and advance in aging services.
- Train all police, fire, EMT, and ambulance and public transportation drivers on interactions with those with Alzheimer’s disease.
- Attract and retain professional caregivers and increase capabilities for caring for those with dementia.
- Provide or require dementia-specific training for anyone providing care to someone with a progressive neurodegenerative disorder.
- Utilize online mode for training PDA and AAAs.

Advance Directives

- Include a section on Advance Directives for Health Care.

Prevention

- Focus on prevention. Objective 3.4 could be expanded beyond emphasis on healthier lifestyles to include issues such as personal finance, volunteering, pursuing educational opportunities, and community involvement.
- Consider including programming relating to healthy sexuality and safety in relationships.

Submitted Comments and Testimony

In addition to those who testified at the public hearings, 15 individuals submitted testimony and another 18 offered comments through the department’s website. Most of the submitted testimony and comments were in three primary areas: housing, senior community centers and Community Health Choices.

Those who submitted testimony related to housing expressed concern that the State Plan, as presented (through the published objectives and strategies), does not address housing for older individuals. They noted that older adults face significant challenges in maintaining their homes, finding affordable housing, and modifying existing housing to enable aging in place.

Others were disappointed that senior community centers were not referenced and suggested that the department recognize the vital role senior community centers play in enhancing the quality of life of older Pennsylvanians.
Commenters consistently mentioned the need to define and clarify the link between aging services and CHC. The ACL guidelines require states to articulate the relationship between aging programs and state long-term care reform efforts.

A number of comments were framed in a manner similar to those presented by the Pennsylvania Coalition Against Domestic Violence, indicating that domestic violence is a significant health concern for people aged 60 years and older and should be recognized in the State Plan.

Those who commented suggested refinements to strategies relating to reaching diverse populations, and included offers by community organizations to help make connections. One individual suggested that the State Plan encourage naturally occurring retirement communities (NORCs).

**Implications for Further State Plan Development**

As noted throughout this summary, many of those who commented in the public hearing process consistently stated that the State Plan failed to adequately address a number of programs including legal assistance, senior community centers, caregiving, housing and transportation. It is possible that their perceptions might be attributable to the fact that only objectives and strategies, without the supporting narrative, were posted for comment.

Nevertheless, the narrative should clarify that the objectives and strategies outlined in the State Plan represent strategic initiatives above and beyond current steady state day-to-day operational programmatic support. The narrative should also explain the trends, data, or input that support the overall direction and priorities of the plan.

The performance measures were criticized as not being specific enough. Within the Plan, PDA might clarify that many of the performance measures will be further refined through a systematic process, working with key stakeholders. Further, the department might note that over the four year period of the plan, the intent is to translate output measures to outcome measures.

The Department has an opportunity to consider the validity of each of the comments offered during the public hearing process and determine if they should be addressed: 1) in the narrative, 2) as an objective, 3) as a strategy, or 4) as an issue for some other venue.
The following observations may assist PDA in determining how the comments might be addressed:

- The AAA representatives who testified expressed support for improving data use and integrity. This provides an opportunity for the department to lead a collaborative process to develop consensus on key data elements and process for capturing and maintaining information.

- Transportation consistently emerges as a major barrier to accessing services. Given the consistency of input across the CLFs and public hearings, not including strategies relating to transportation could appear as a significant gap in the plan.

- Housing also emerged as an important issue, and could be supported with strategies (if not through a stand-alone objective).

- Similarly, individuals expressed disappointment that there was no mention of legal assistance in relation to elder justice. If the department is planning to move forward with model approaches to elder rights and legal services (regardless of whether or not it is awarded a federal grant in this area), this may be worthy of an objective or strategy.

- The published draft objectives and strategies did not include references to particular cultural or diversity groups. Advocates interpreted this as a lack of attention to particular populations. The department may want to consider including references to particular targeted populations (e.g., Asian, LEP, LGBT) in the objectives and strategies as appropriate. Or, include the more detailed spreadsheet of objectives and strategies as an appendix with the targets identified.

- Many of those who commented raised the integration of the State Plan on Aging with CHC, the Long-Term Care Commission recommendations, ADRD Commission recommendations and the Supreme Court’s Elder Law Task Force recommendations. Where appropriate, PDA should establish linkages between State Plan objectives and strategies and those recommendations. The ACL guidelines require an explanation of state long-term care reform efforts and aging services.

- There were a number of specific programmatic recommendations. If the Department is already moving in support of those suggestions, they could be reinforced and articulated in the State Plan.
COMMUNITY HEALTH CHOICES CONCEPT PAPER
2016-2020 STATE PLAN ON AGING | ATTACHMENT G
Your feedback is requested.

This document contains the commonwealth’s design for Community HealthChoices (CHC). The commonwealth invites feedback on this document from participants, advocacy organizations, providers, managed care organizations, care coordination agencies, legislators, family members, and other interested members of the public. Feedback received will be used to finalize the program design and issue a Request for Proposals (RFP) in November 2015.

Feedback is due by 5:00 p.m. on Friday, October 16, 2015.

Please submit your written feedback by mail or e-mail.

By mail, please address to:

April Leonhard  
Office of Long-Term Living  
Bureau of Policy and Regulatory Management  
P.O. Box 8025  
Harrisburg, PA 17105-8025

By e-mail, please send your comments to:

RA-MLTSS@pa.gov and include “Community HealthChoices” in the subject line.

This document is available in alternative formats.

To request an alternative format, please call the Department of Human Services, Office of Long-Term Living at (717) 783-8412.

Persons with a disability who require an auxiliary aid or service may submit comments using the Pennsylvania AT&T Relay Service at (800) 654-5984 (TDD users) or (800) 654-5988 (voice users).
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1. Introduction

Under Governor Tom Wolf’s leadership, the Pennsylvania Departments of Human Services (DHS) and Aging (PDA) are developing a new program for older Pennsylvanians and adults with physical disabilities called Community HealthChoices (CHC). The program will roll out in three phases over three years, beginning in January 2017.

As described in this concept paper, the commonwealth is committed to creating a system that allows Pennsylvanians to receive services in the community, preserves consumer choice, and allows consumers to have an active voice in the services they receive.

This concept paper describes the features of CHC and is intended to gather feedback from stakeholders.

The commonwealth chose the name Community HealthChoices for two reasons. The first is that CHC will allow the commonwealth to serve more Pennsylvanians who need long-term services and supports in the community. The second is that CHC will build on the values and processes of the HealthChoices program that has successfully served millions of Pennsylvanians since its inception in 1997. In fact, many of the tenets of the program described below mirror the processes that have proved to be successful in the HealthChoices program.

1.1 Summary of CHC

The commonwealth plans to coordinate health and long-term services and supports (LTSS) through CHC managed care organizations (CHC-MCOs). Participants will have a choice of two and five CHC-MCOs in each region. The CHC rate model will include value-based incentives to increase the use of home and community-based services (HCBS) and meet other program goals. CHC will use standardized outcome measures at both the program- and participant-level to assess overall program performance and improve the CHC program over time.

Measures to ensure ongoing improvements to the CHC model will include stakeholder engagement to provide participant input.
CHC will serve an estimated 450,000 individuals, including 130,000 older persons and adults with physical disabilities who are currently receiving LTSS in the community and in nursing facilities. CHC-MCOs will be accountable for most Medicaid-covered services, including preventive services, primary and acute care, LTSS (home and community-based services and nursing facilities), prescription drugs, and dental services. Participants who have Medicaid and Medicare coverage (dual eligible participants) will have the option to have their Medicaid and Medicare services coordinated by the same MCO.

1.2 Background

This initiative builds on the commonwealth’s past success in implementing the country’s most extensive network of Programs of All-inclusive Care for the Elderly (called LIFE, Living Independence for the Elderly, in Pennsylvania), which will continue to be an option for eligible persons, and five HCBS waiver programs, which will be replaced by CHC.¹ It also builds on the commonwealth’s experience with HealthChoices, a statewide managed care delivery system for children and adults. Behavioral health services will continue to be provided through the Behavioral Health Services HealthChoices (BH-MCOs). CHC-MCOs and BH-MCOs will be required to coordinate services for individuals who participate in both programs.

The current LTSS system is expanding community options, but not rapidly enough to keep up with growing demand. Pennsylvania has made progress on reforming its LTSS system. The percentage of LTSS funding spent on HCBS increased from 37.3 percent in 2011 to 41.9 percent in 2013.² However, Pennsylvania still lagged significantly behind the national average of 51.3 percent spent on HCBS in 2013, ranking it 37th among states. Furthermore, the LTSS system operates separately from the Medicare and Medicaid physical health systems, leaving participants to navigate these complex programs on their own. Between 2002 and 2014, these challenges were documented by stakeholders in 10 significant planning groups, study commissions and work groups on LTSS. The following recommendations have consistently emerged over more than a decade of public discourse.³

¹ The six waiver programs that will be combined in CHC are: Aging, Attendant Care, AIDS, CommCare, Independence and OBRA. These waiver programs are currently managed by the DHS Office of Long-Term Living. In this paper, they will be referred to as the OLTL Waivers.
• Expand community LTSS options, and streamline and standardize the way people access them;
• Develop new models of care that integrate care coordination, service delivery, and financing;
• Innovate in the LTSS sector with creative housing and other supports, greater use of technology, and new strategies to recruit and retain direct care workers;
• Strengthen the focus on quality measurement, including both quality of life and quality of care, in order to achieve better outcomes; and
• Ensure long-term sustainability of the system as demand for LTSS grows.

In February 2015, Governor Wolf directed DHS and PDA to develop managed long-term services and supports to act on these longstanding recommendations. Following a national review of best practices, the commonwealth outlined the basis for CHC in a public discussion document. In June and July, officials from DHS and PDA received verbal feedback at six public forums held across Pennsylvania, attended by over 800 stakeholders, and through written feedback. Comments were received from 316 organizations and individuals at the forums and via mail and e-mail. This concept paper takes into consideration the feedback on the discussion document.

The commonwealth plans to coordinate health and long-term services and supports through CHC managed care organizations. Participants will have a choice between two to five CHC-MCOs in each region. The CHC rate model will include value-based incentives to increase the use of home and community-based services and meet other program goals. CHC will use standardized outcome measures of both program- and participant-level outcomes to assess overall program performance and improve CHC over time.

1.3 Program Vision and Goals

The vision for CHC is an integrated system of physical health and long-term Medicare and Medicaid services that supports older adults and adults with physical disabilities to live safe and healthy lives with as much independence as possible, in the most integrated settings possible.

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The goals of CHC are as follows:

1. **Enhance opportunities for community-based living.** There will be improved person-centered service planning and, as more community-based living options become available, the ability to honor participant preferences to live and work in the community will expand. Performance incentives built into the program’s quality oversight and payment policies will stimulate a wider and deeper array of HCBS options.

2. **Strengthen coordination of LTSS and other types of health care, including all Medicare and Medicaid services for dual eligible individuals.** Better coordination of Medicare and Medicaid health services and LTSS will make the system easier to use and will result in better quality of life, health, safety and well-being.

3. **Enhance quality and accountability.** CHC-MCOs will be accountable for outcomes for the target population, responsible for the overall health and long-term support for the whole person. Quality of life and quality of care will be measured and published, giving participants the information they need to make informed decisions.

4. **Advance program innovation.** Greater creativity and innovation afforded in the program will help to increase community housing options, enhance the LTSS direct care workforce, expand the use of technology, and expand employment among participants who have employment goals.
5. **Increase efficiency and effectiveness.** The program will increase the efficiency of health care and LTSS by reducing preventable admissions to hospitals, emergency departments, nursing facilities and other high-cost services, and by increasing the use of health promotion, primary care and HCBS.
2. Participant Considerations

2.1 Community HealthChoices Population

The estimated total statewide enrollment of dual eligibles, older persons, and adults 21 and older with physical disabilities for CHC is 450,000. The CHC population will include individuals with Medicaid-only coverage who receive or need LTSS, and individuals with full Medicare and Medicaid coverage (dual eligible), including those with and without LTSS needs.\(^5\) The CHC population will not include Act 150

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\(^5\) Full Medicare and Medicaid dual eligible participants are those with Medicare coverage and the full package of Pennsylvania Medicaid benefits.
participants, individuals receiving their services through the lottery-funded Options program, persons with intellectual/developmental disabilities (ID/DD) who receive services through the DHS Office of Developmental Programs, or residents of state-operated nursing facilities, including the State Veterans’ Homes.

Eligibility of CHC Population

The CHC population will include the following:

- Adults age 21 or older who require Medicaid LTSS (whether in the community or in private or county nursing facilities) because they need the level of care provided by a nursing facility or an intermediate care facility for individuals with other related conditions (ICF/ORC);
- Current participants of DHS Office of Long Term Living (OLTL) waiver programs who are 18 to 21 years old; and
- Dual eligibles age 21 or older whether or not they need or receive LTSS.

Persons included in the CHC population will be required to enroll in CHC. However, persons who are eligible for the LIFE program will not be enrolled into CHC unless they specifically ask to be enrolled.

Financial Eligibility for CHC

The DHS Office of Income Maintenance will continue to administer the Medicaid financial eligibility process through the County Assistance Offices. Persons who are already financially eligible when CHC starts will not need to go through a different or

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6 The Act 150 Program is a state-funded program that provides personal assistance and other ancillary services to individuals with physical disabilities 18 to 60 years of age who do not have Medicaid coverage. The OPTIONS program is a Lottery-funded program that provides personal assistance and ancillary services to individuals over the age of 65 who do not have Medicaid coverage.
additional financial eligibility process prior to enrollment in CHC. New applicants will still need to be determined financially eligible for the program.

To facilitate continuous eligibility of CHC participants, the commonwealth will provide CHC-MCOs with eligibility renewal date information so CHC-MCOs can assist participants with the regular eligibility renewal process.

Level of Care Process

Persons who are clinically eligible for LTSS when CHC starts will not need to go through a new level of care assessment prior to enrollment in CHC. Persons who are seeking LTSS services for the first time will have a level of care assessment as part of the overall eligibility determination process.

The commonwealth will develop a standardized level of care tool to replace what is currently in use across the OLTL LTSS programs. The tool will be developed to be in compliance with all federal and state statutory and regulatory requirements. The commonwealth will contract with an entity to perform LTSS level of care determinations and redeterminations. The entity selected to perform this function will not be permitted to be a provider of service.

2.2 Enrollment

Persons who are included in the CHC population will be required to enroll in one of the CHC-MCOs operating in the region unless they choose to enroll in a LIFE program. The commonwealth will select an independent enrollment entity (IEE) through a competitive procurement process to advise CHC participants of their options and to help them with the enrollment process.
Initial Enrollment into CHC

Approximately three months prior to the implementation of CHC in a region, the IEE will notify all eligible participants of their upcoming transition into CHC and their enrollment options. The IEE and other resources (such as the PDA APPRISE program) will be available to provide information and counseling to eligible CHC participants regarding their enrollment choices. Eligible participants will receive several notifications regarding their need to choose one of the enrollment options.

The IEE will notify persons who become eligible for CHC after the initial implementation date (e.g. persons who are 21 and older and become dual eligibles for Medicare and Medicaid) of their enrollment options.

The IEE will assist individuals to voluntarily select one of the available CHC-MCOs in the region, or a LIFE program. If an eligible individual does not select either one of the CHC-MCOs or a LIFE program prior to an established deadline (e.g. 30 days prior to implementation), he or she will be automatically assigned to one of the CHC-MCO plans in the region and the individual will be notified by the IEE. The commonwealth will use an intelligent assignment approach that matches participants with the CHC-MCO that best meets their needs. Current enrollees in a Medicare Dual Eligible-SNP will be automatically enrolled in the CHC-MCO affiliated with that D-SNP, if available, although they will be allowed to switch to a different CHC-MCOs at any time. CHC will be the default enrollment option for program participants.

The commonwealth is seeking input from stakeholders regarding factors it should consider for making “intelligent assignments” of participants who do not voluntarily select one of the CHC-MCOs or a LIFE program.

CHC-MCO Transfers

CHC participants may elect to switch from their current CHC-MCO to a different CHC-MCO in the region at any time. The effective date of the transfer will either be the 15th day of the month, or the 1st day of the month depending on when they request the change in CHC-MCO. Also, the IEE will annually notify all CHC participants of their option to switch from their current CHC-MCO to a different CHC-MCO, or to a LIFE program.
2.3 Covered Benefits

**Physical Health Care Benefits**

The CHC benefit package will include all physical health benefits specified in the Medicaid State Plan. For dual eligibles, Medicare will continue to be the first payer for benefits covered under both programs. For CHC participants who are not eligible for Medicare Part D pharmacy benefits, CHC will provide Medicaid pharmacy benefit coverage through a formulary consistent with the State Plan.

**LTSS**

The CHC benefit package will include nursing facility services and HCBS currently covered in the Aging, OBRA, Independence, COMMCare, AIDS, and Attendant Care waiver programs.

These benefits will be available to participants who meet the LTSS criteria.

CHC-MCOs may choose to provide LTSS to participants who are in need but do not meet the LTSS criteria or to offer additional LTSS benefits beyond those required in the CHC benefit package. The costs associated with these additional LTSS benefits will not be included in calculating the capitation payment made to the CHC-MCOs.

The commonwealth may add additional LTSS benefits not currently covered in the OLTL waivers.

See Appendix A for more detail on LTSS services that are proposed to be included in the CHC benefits package.
Behavioral Health Services

Participants will have access to behavioral health services through the existing HealthChoices BH-MCOs in each county. CHC-MCOs and BH-MCOs will be required to coordinate services for members they have in common.

Home Modifications

Home modifications to support HCBS will be a covered benefit under CHC. CHC-MCOs will contract with the entities that the commonwealth has chosen to act as brokers and to ensure that CHC participants have appropriate access to these services.

Participant-Directed Personal Assistance Services

CHC-MCOs will offer the choice of three different delivery models for personal assistance services to participants determined to need LTSS. First, participants will have the option to receive personal assistance services through a traditional agency model, in which the service coordinator arranges with a licensed agency enrolled with the CHC-MCO to provide the services in accordance with the person-centered services plan. Second, participants may elect to receive personal assistance services through a participant-directed employer authority model, in which the participant employs his or her own personal assistance provider, who can be a family member, a friend, a neighbor or any other qualified personal assistance worker.

Third, participants may choose Services My Way, which is a budget authority model. In this model, the participant develops a spending plan to purchase needed goods and services based on their service plan budget. Participants in this model may elect to receive personal assistance through an agency and/or to employ their own personal assistance providers.

Personal assistance workers employed by participants under the self-directed model will become qualified and receive payment through a financial management services (FMS) vendor, which processes timesheets, makes payments, and manages all required tax withholdings. The commonwealth will have agreements with three statewide FMS entities, and CHC-MCOs will be required to contract with these entities to ensure personal assistance workers receive timely and appropriate payment for services rendered.
Nursing Home Transition Services

CHC-MCOs will offer Nursing Home Transition (NHT) services to participants residing in nursing facilities who express a desire to move back to their homes or other community-based settings. CHC-MCOs will contract with NHT providers to identify NHT-appropriate participants and coordinate their NHT services.

2.4 Coordination of Benefits

CHC will include participants with a broad range of needs, from relatively healthy dual eligible participants to people with multiple chronic conditions and LTSS needs.

Needs Screening and Needs Assessment

Each CHC-MCO will submit to the commonwealth for approval its plan and methods for regular needs screening of all participants. Methods may include, but are not limited to, telephone-administered needs screens and analysis of participant utilization. Participants found to be in need of supports and services through the screening process will be offered a comprehensive needs assessment based on a standardized tool approved by the commonwealth. The tool will be used to identify the participants’ goals and preferences and addresses physical, social, psychosocial, environmental, LTSS, and other needs, as well as the availability and needs of participants through the support of unpaid caregivers.
Person-Centered Service Planning for LTSS and Others at Risk

All individuals in need of or receiving LTSS will have a service coordinator. The service coordinator will conduct a comprehensive needs assessment and assemble and monitor a person-centered service plan. Service coordinators will develop the service plan during a face-to-face meeting with the individuals and others who are invited to participate based on the needs and preferences of the participant. The service coordinator will update the plan annually or more frequently based on the needs of the participant.

The plan must identify the needs, preferences, and goals of the participant and specify how the participant’s physical health, LTSS, social, psychosocial, housing, and environmental needs will be met.

The person-centered service plan must be documented in a standardized, electronic form designated by the commonwealth. The plan must identify the needs, preferences, and goals of the participant and specify how the participant’s physical health, LTSS, social, psychosocial, housing, and environmental needs will be met. If behavioral health needs are identified, the plan will include steps to coordinate appropriate behavioral health services with the BH-MCO. The plan must address preferences in where the participant lives, control and choice about schedule, and desired life activities. The CHC-MCO must also address needs of participants through support of their unpaid caregivers. The plan will serve as an authorization for the services outlined.

The service coordinator will monitor the person-centered service plan to ensure that authorized services are delivered, and will coordinate those services as needed. With consent of the participant, the service coordinator will share the person-centered service plans and related information with the participant’s provider(s) and unpaid caregiver(s).

CHC-MCOs will be permitted to provide service coordination directly or through community partners, as long as expertise can be demonstrated. CHC-MCOs will be required to demonstrate that the service coordinators have expertise with the conditions of the target population, which include physical disability, brain injury, dementia, and a broad range of chronic conditions.

Service coordinators must be available and required to respond to all calls from participants in their caseloads during regular business hours. The CHC-MCO must have a system in place for redirecting and responding to participant calls made to service coordinators after business hours.
Service Coordination and Care Transitions

A major goal of CHC is to improve the coordination of services across providers and settings of care. In addition to providing service coordination for participants in need of LTSS, CHC-MCOs may provide service coordination to other participants identified through the risk screening process, or whose needs are otherwise identified by the participant, caregivers or the CHC-MCO. The need for service coordination may be indicated by the presence of one or more chronic conditions, use of multiple specialists, use of emergency departments or admissions to hospitals.

CHC-MCOs will be required to implement care transition protocols whenever participants are admitted to or discharged from hospitals, nursing facilities or residential settings.

CHC-MCOs will submit to the commonwealth for approval their plans for identifying the need for service coordination and care transition, and their plan for meeting those needs.

Coordination of Medicare for Dual Eligible Participants

Over 90 percent of CHC participants are expected to have Medicare and Medicaid coverage. CHC-MCOs will be required to offer companion D-SNPs for dual eligible participants. Participants who choose the companion D-SNPs will have all their benefits seamlessly coordinated by one MCO, and may also receive supplemental Medicare benefits offered by the MCO.

Dual eligibles who do not wish to enroll in a companion D-SNP will not be required to do so. They will continue to have all the Medicare choices offered in their regions, including original Medicare. CHC-MCOs will be required to coordinate with the participant’s Medicare health plan or the original Medicare Fee-for-Service program. CHC-MCOs will also be required to work with the Medicare Fee-for-Service providers to coordinate care for the participants.

A major policy objective of CHC is to improve the coordination of benefits across the Medicare and Medicaid programs for dual eligible participants. The commonwealth requests stakeholder input on how best to accomplish this goal.
2.5 Provider Networks

Provider network standards for CHC will mirror those of the existing HealthChoices program for hospitals, specialty clinics, trauma centers, facilities for high-risk deliveries and neonates, specialists, dentists, orthodontists, physicians, pharmacies, emergency transportation services, rehabilitation facilities, nursing facilities, home care providers, home health providers, certified hospice providers and durable medical equipment (DME) suppliers. For covered LTSS services, including nursing facility services, the CHC-MCO must demonstrate a sufficient network to allow participants a choice of providers that are accessible to them and have expertise in LTSS.

If a CHC-MCO is unable to provide necessary covered services to meet the needs of a participant, the CHC-MCO must cover the services out-of-network.

CHC-MCOs must demonstrate that the providers in their network are knowledgeable and experienced in providing services to participants with special needs of all types, including the need for LTSS, and that provider offices and facilities comply with the accessibility standards of the Americans with Disabilities Act.

The provider network of each CHC-MCO must reflect the needs and service requirements of its culturally and linguistically diverse participant populations. Both CHC-MCOs and their providers must demonstrate cultural competency. Each CHC-MCO will be required to describe the cultural competency of its provider network in its network management plan, which is submitted annually to the commonwealth.

Additional network management requirements are included in Section 3.1.
 Assistance for Participants within Provider Network

Each CHC-MCO must have a participant services department and toll-free telephone line to provide assistance, as needed, to participants. The staff of the participant services department should reflect the cultural diversity of the CHC-MCO’s participants. If no one is available in the participant services department to speak with a participant in his or her native language, translation services will be made available. A CHC-MCO which operates multiple health plans in Pennsylvania may integrate its CHC participant services department with those of other plans, but the CHC-MCO must demonstrate sufficient capacity and cultural diversity to meet the needs of CHC participants.

Nurse Hotline

Each CHC-MCO must offer a nurse hotline that operates and accepts calls 24 hours per day, 7 days per week. The participant services department staff must be trained to recognize when CHC participants should be connected to the nurse hotline.

Participant Informational Materials

The CHC-MCO must ensure that all marketing materials and other participant materials are written at no higher than a fourth grade reading level and include, at a minimum, the information required by the commonwealth. All materials and participant information must be made available as needed in alternative languages and formats. Informational material must, at a minimum, be available upon request in Braille, large print, audio tape, compact disc (CD), and DVD, and must be provided in the format requested by the person with a visual impairment.

2.6 Continuity of Care

CHC will include provisions to help maintain continuity of care and avoid interruptions of service for participants when they are first enrolled in CHC, and when they choose to switch from one CHC-MCO to another.
Continuity of Care Requirements during CHC Implementation

Continuity of care for CHC also includes continuity of LTSS providers. Each CHC-MCO must initially include in its networks all willing and qualified LTSS service providers in the CHC-MCO service regions that are currently enrolled in the Medicaid program to provide HCBS services in the OLTL waiver programs or nursing facility services. A willing and qualified provider is one that agrees to meet the CHC-MCO quality standards and accept the CHC-MCO payment rate. This requirement will apply during the first six months of each phase of implementation.

Waiver participants enrolling in CHC as part of the transition into managed care will continue to have access to all services and providers authorized in their service plan that were in effect the day before CHC enrollment. This continuity of care authorization will last for 180 days or until a new person-centered service plan is developed, whichever comes later. The CHC-MCO may increase the level of LTSS services during the continuity of care period in response to increased participant needs, but may not reduce services. Any new person-centered service plan developed by the CHC-MCO that proposes to reduce any one service by more than 25 percent must be approved by the commonwealth prior to implementation.

Participants residing in a nursing facility on the date of initial program implementation may continue to reside at that nursing facility indefinitely, as long as they continue to meet LTSS criteria.

Similar to the existing HealthChoices continuity of care rules, participants may continue to use physical health providers with which they had existing relationships for the first 60 days of their enrollment in CHC.

Continuity of Care Upon Transition between CHC-MCOs

If a participant chooses to transfer from one CHC-MCO to another CHC-MCO, the participant will continue to have access to all existing LTSS providers and must continue to receive any LTSS services in his or her service plan for 60 days from the date of the transfer or until a new person-centered service plan is developed by the new CHC-MCO, whichever is later. CHC-MCOs are required to transfer existing person-centered service plans when a participant moves from one plan to another within five business days of the participant’s enrollment in the new plan.

Participants may continue to use physical health providers with whom they had existing relationships for the first 60 days after the transfer from one CHC-MCO to another.
Continuity of Care if an LTSS Provider Drops Out of the CHC-MCO Network

If an LTSS provider chooses to drop out of a CHC-MCO’s network, any participant receiving services from that provider will continue to receive services from that provider until an alternative LTSS provider in the network can be identified. CHC-MCO agreements with LTSS providers must include provisions that guarantee the continuation of services and payment until a replacement provider is found, should a provider elect to drop out of the network.

2.7 Quality Assurance for Participants

Quality services are a central component of CHC. Participants will benefit from quality management programs through which the CHC-MCOs will be required to demonstrate their ability to provide and improve accessibility, availability, and quality of care in their networks.

The components of the quality management program will include at a minimum:

- MCO quality management leadership, staffing, quality improvement committee and other infrastructure;
- Member feedback mechanisms, including participant surveys and focus groups, and the presence of a participant as a full member of the CHC-MCO’s internal quality improvement committee;
- Provider monitoring;
- Mechanisms for tracking receipt of services;
- Critical incident reporting;
- Risk assessment and mitigation;
- Performance measure reporting;
- Performance improvement projects (PIPs);
- MCO involvement in External Quality Review Organization (EQRO) activities;
- Care coordination requirements related to maximizing the health and welfare of members;
- Quality-related financial incentives; and
- Quality reporting to the commonwealth.

Additional information about CHC-MCOs’ quality requirements are included in Section 3.2.

Additional information about participant rights and protections are included in Appendix B.

### 2.8 Comprehensive Services

CHC will be designed to encourage CHC-MCOs to offer a comprehensive approach to LTSS. The commonwealth is requesting input to initiatives that will support these goals.
Specifically, the commonwealth seeks stakeholder input methods and opportunities to:

- Increase access to affordable and accessible housing to support community living;
- Expand access to community-based integrated employment;
- Develop an expanded and skilled LTSS workforce; and
- Expand the use of technology supporting community-based LTSS services and the integration of services across the entire continuum.
3. Managed Care Organization Components

3.1 Network Requirements

Every CHC-MCO must develop and maintain a network management plan. The network management plan must be submitted to the commonwealth and reviewed during readiness review activities. Annual updates to the network management plan must be submitted to the commonwealth.

The network management plan must address the following areas:

- How the CHC-MCO will communicate and negotiate with network providers regarding contractual, continuity of care, and program changes and requirements before updating the provider manual annually;
- How the CHC-MCO will monitor network provider compliance with policies and rules of CHC, including compliance with all policies and procedures related to the grievance and appeal processes while ensuring the participant’s services are not interrupted during the grievance and appeal processes;
- How the CHC-MCO will evaluate the quality of services delivered by network providers;
- How the CHC-MCO will provide or arrange for medically necessary covered services when one or more network providers terminate their participation in the network;
- How the CHC-MCO will monitor the adequacy, accessibility, and availability of its provider network to meet the needs of its participants, including the provision of care to participants with limited English proficiency;
- How the CHC-MCO will recruit, select, credential, re-credential, and contract with providers in a manner that incorporates quality management, utilization, office audits, and provider profiling;
- How the CHC-MCO will provide training for its providers and maintain records of such training;
- How the CHC-MCO will track and trend provider inquiries, complaints and requests for information and take systemic action as necessary and appropriate; and

Highlights

- Network Requirements
- Quality Assurance
- Contract Administration
- Information Technology
• How the CHC-MCO will ensure that providers are returning calls within three business days of receipt.

**Network Changes/Provider Terminations**

All material changes in the CHC-MCO's provider network must be approved in advance by the commonwealth. A material change to the provider network is defined as one which affects, or can reasonably be foreseen to affect, the CHC-MCO's ability to meet the performance and network standards as described in the CHC agreement. It also includes any change that would cause more than 5 percent of participants in the region to change the location where services are received or rendered. The CHC-MCO must submit to the commonwealth a request for approval of a material change in its provider network, including a draft notice to affected participants before the notice is sent. The request must include a description of any short-term gaps identified as a result of the change and the alternatives that will be used to fill them.

All material changes in the CHC-MCO’s provider network must be approved in advance by the commonwealth.

The CHC-MCO must have procedures to address changes in its network that impact participant access to services.

**Provider Services**

Every provider in the CHC-MCO’s network is assigned a provider representative, who will be the first point of contact for that provider to address any issues the provider may have in meeting the needs of participants.

The CHC-MCO must operate provider services functions at a minimum during regular business hours (9:00 a.m. to 5:00 p.m., Monday through Friday). Provider services functions include, but are not limited to, the following:

• Assisting providers with questions concerning the eligibility or enrollment status of CHC participants;
• Assisting providers with the CHC-MCO's prior authorization and referral procedures;
• Assisting providers with claims payment procedures and handling provider disputes regarding outstanding claims;
• Facilitating transfer of participant medical records among medical providers, as necessary;
• Providing all providers with a monthly list of participants who are under their care, including the identification of new and discontinued participants; and

• Coordinating the administration of out-of-network services.

Provider Manuals

The CHC-MCO must keep its network providers up-to-date with the latest policies and procedures that govern CHC. The key to maintaining this level of communication is the publication and maintenance of a CHC provider manual. The CHC-MCO must work with the commonwealth on the development of the provider manual. Copies of the provider manual must be distributed in a manner that makes them easily accessible to all network providers. The provider manual must be updated annually. The commonwealth may grant an exception to this annual requirement upon written request from the CHC-MCO provided there are no major changes to the manual.

Provider Education and Training

The CHC-MCO must demonstrate that its provider network is knowledgeable and experienced in treating CHC participants with diverse needs. Within its network management plan, the CHC-MCO must submit an annual provider education and training plan to the commonwealth which includes its process for measuring training outcomes, including the tracking of training schedules and provider attendance.

At a minimum, provider training must address, as appropriate, the following areas:

• Identification of and appropriate referral for mental health, drug and alcohol, and substance use services;

• Sensitivity training on diverse and special needs populations such as persons who are deaf or hard of hearing, including how to obtain sign language interpreters and how to work effectively with sign language interpreters;

• Cultural competency, including the right of participants with limited English proficiency to engage in effective communication in their language, how to obtain interpreters and how to work effectively with interpreters;

• Provision of services to special needs populations, including the right to treatment for individuals with disabilities, and the requirements of the Americans with Disabilities Act;

• Administrative processes that include, but are not limited to, coordination of benefits, recipient restriction program, encounter data reporting and dual eligible issues;

• Issues identified by provider relations staff in response to calls or complaints by providers;
• Issues identified through the quality management process;
• Prevention and detection of fraud, waste, and abuse; and
• Participant-directed services.

A CHC-MCO may collaborate with other CHC-MCOs to develop and implement provider training and education. Any collaborative activities must be specified in the CHC-MCO’s provider training and education plan.

3.2 Quality Assurance and Performance Improvement

The CHC-MCO must provide for the delivery of quality physical health care and LTSS with the primary goal of improving the health and functional status of participants as well as preventing deterioration or decline. The CHC-MCO must work in collaboration with providers to actively improve the quality of care and services provided to participants, consistent with quality improvement goals required by the commonwealth. The CHC-MCO must provide mechanisms for participants and providers to offer input into quality improvement activities.

DHS will administer the quality management (QM) and utilization management (UM) components of this program. The CHC-MCO must comply with the QM and UM program standards and requirements established by DHS relating to external quality review, QM/UM deliverables, CHC-MCO pay for performance program, provider pay for performance program and community-based care management program. The CHC-MCO must comply with all QM and UM program reporting requirements and must submit data in formats to be determined by the commonwealth.

In collaboration with the CHC-MCO, the commonwealth may determine and prioritize QM and UM activities and initiatives based on areas of importance to DHS and CMS.

Quality Management and Performance Improvement Structure

The CHC-MCO will maintain QM and performance improvement processes and structures. The CHC-MCO will execute processes to assess, plan, implement, evaluate, and, as mandated, report QM and performance improvement activities.

The CHC-MCO must have a QM department that is separate from any other units or departments within the CHC-MCO organizational structure, including medical management, service coordination, or UM. The CHC-MCO must designate a senior executive responsible for the QM program, and the medical director must have substantial involvement in QM and performance improvement program activities. At a
minimum, the CHC-MCO must ensure that the QM structure is organization-wide, with clear lines of accountability within the organization, and includes a set of functions, roles, and responsibilities for the oversight of QM and performance improvement activities that are clearly defined and assigned to appropriate individuals.

The CHC-MCO must establish and maintain distinct policies and procedures regarding LTSS and must specify the responsibilities and scope of the authority of service coordinators in authorizing LTSS and in submitting authorizations to providers. This includes having in place an authorization process for covered LTSS and for cost-effective alternative services that is separate from, but integrated with, the CHC-MCO’s prior authorization process for covered physical health services.

The CHC-MCO will execute processes to assess, plan, implement, evaluate, and as mandated, report QM and performance improvement activities.

The QM structure must also ensure that for transitioning participants who are receiving LTSS as of the date of implementation, the CHC-MCO will be responsible for continuing to provide the LTSS previously authorized for the participant in accordance with continuity of care provisions.

The CHC-MCO QM and UM programs must be designed to assure and improve the accessibility, availability, and quality of care being provided to participants. The CHC QM and UM programs must, at a minimum:

- Contain the written program description, work plan, evaluation, and policies and procedures that meet requirements specified by the commonwealth;
- Allow for the development and implementation of an annual work plan of activities that focuses on areas of importance as identified by the CHC-MCO in collaboration with DHS;
- Be based on statistically valid clinical and financial analysis of encounter data, member demographic information, Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Pennsylvania performance measures, and other data that allow for the identification of prevalent medical, behavioral, and LTSS needs, barriers to care, and racial or ethnic disparities to be targeted for quality improvement and other initiatives;
- Allow for the continuous evaluation of CHC-MCO activities and adjustments to the program based on the evaluations;
• Demonstrate sustained improvement of clinical performance over time;
• Allow for the timely, complete, and accurate reporting of encounter data and other data required to demonstrate clinical and service performance; and
• Include processes for the investigation and resolution of individual performance or quality of care issues, whether identified by the CHC-MCO or the commonwealth, which allow for the tracking and trending of issues on an aggregate basis pertaining to problematic patterns of care, and allow for submission of improvement plans, as determined by and within time frames established by the commonwealth.

For standards related to CHC-MCOs’ QM and UM programs, see Appendix C.

**Provider Profiling**

The CHC-MCO will conduct Primary Care Physician (PCP) and other provider profiling activities at least annually. The CHC-MCO must describe the methodology it will use to identify which and how many providers to profile and to identify measures to use for profiling the providers. The CHC-MCO must:

• Use the results of its provider profiling activities to identify areas of improvement for PCPs and other providers;
• Establish provider-specific quality improvement goals for priority areas in which a provider or providers do not meet established CHC-MCO standards or performance improvement goals;
• Develop and implement incentives, which may include financial and non-financial incentives, to motivate providers to improve performance on profiled measures; and
• At least annually, measure and report to DHS on the provider network and individual providers’ progress, or lack of progress, towards the improvement goals.

**Performance Improvement Projects (PIPs)**

The CHC-MCO will perform at least two clinical and three non-clinical PIPs as determined by the commonwealth in conjunction with the CHC-MCO. Clinical PIPs include projects such as prevention and care of acute and chronic conditions, high-volume services, high-risk services, LTSS, and continuity and coordination of care. Non-clinical PIPs include projects such as availability, accessibility, and cultural competency of services, interpersonal aspects of care, and appeals, grievances, and complaints.

The CHC-MCO must follow CMS protocols for PIPs and demonstrate its steps in meeting those protocols.
The CHC-MCO must identify benchmarks and set achievable performance goals for each of its PIPs. The CHC-MCO must identify and implement intervention and improvement strategies for achieving the performance goals set for each PIP and promoting sustained improvements.

The CHC-MCO must report on PIPs. The CHC-MCO will submit one PIP summary report that includes region-specific data and information to DHS, including improvement strategies as required by CMS.

After three years, the CHC-MCO must, using evaluation criteria established by the commonwealth, determine if one or all of the PIPs should be continued.

**NCQA Accreditation**

CHC-MCOs must be accredited by the National Committee for Quality Assurance (NCQA). CHC-MCOs will also have to meet expanded accreditation standards that specifically address LTSS, which are currently under development.

**Pay for Performance Program (P4P)**

The commonwealth will include a P4P program in CHC to provide financial incentives to CHC-MCOs that meet quality goals. One of the P4P strategies under consideration is the CHC-MCO's performance on diverting persons from institutional placements, both hospitals and nursing facilities, through person-centered service plans that identify areas of need. The P4P program for CHC-MCOs will include identification of the target population, the interventions by the service coordinator for persons in need, documentation of the interventions, and incremental results reporting.

The CHC-MCOs will be required to develop P4P programs for providers. All provider P4P programs must target improvements in the quality of or access to services for participants and may not limit the appropriate use of services by participants. The CHC-MCO must develop and submit a proposal to the commonwealth for review prior to implementation.

**QM and UM Program Reporting Requirements**

The CHC-MCO must comply with all QM and UM program reporting requirements and time frames. DHS will, on a periodic basis, review the required reports and make changes to the information, data, and formats requested based on the changing needs of CHC. The CHC-MCO must comply with all requested changes to the report information and formats.
The CHC-MCO must audit a sample of the person-centered service plans as part of its QM and UM programs. The CHC-MCO must use a protocol approved by DHS to select the sample. Audit results must be submitted to DHS.

The CHC-MCO must submit HEDIS® data to the commonwealth annually.

The CHC-MCO must submit CAHPS data to the commonwealth. In addition, the commonwealth is monitoring the availability of nationally-validated experience of care surveys for HCBS populations and plans to require the use of such surveys when they become available.

**External Quality Review**

The CHC-MCO will be required to cooperate fully with any external evaluations and assessments of its performance conducted by the commonwealth’s contracted External Quality Review Organization (EQRO) or other designee. Independent assessments will occur at least annually and will include, but not be limited to, any independent evaluation required or allowed by federal or state statute or regulation.

**Delegated UM Functions**

Compensation and payments to individuals or entities that conduct UM activities may not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any participant.

**Confidentiality**

The CHC-MCO must have written policies and procedures for maintaining the confidentiality of medical records, participant information, and provider information that comply with the provisions set forth in Section 2131 of the Insurance Company Law of 1921, as amended, 40 P.S. 991.2131; 55 Pa. Code Chapter 105; and 45 CFR Parts 160 and 164 (Standards for Privacy of Individually Identifiable Health Information).

The CHC-MCO must ensure that provider offices and sites have implemented mechanisms that guard against unauthorized or inadvertent disclosure of confidential information to persons outside the CHC-MCO.

The CHC-MCO must obtain advance written approval from DHS before releasing data to any third party unless the release is for the purpose of individual care and coordination among providers, the release is authorized by the participant, or the release is required by court order, subpoena or law.
DHS Oversight

The CHC-MCO and its network providers and other subcontractor(s) will be required to make available to DHS and other oversight agencies upon request, data, clinical, and other records and reports for review of quality of care, access and utilization issues, including but not limited to activities related to external quality review, HEDIS, encounter data validation, program evaluation, and other related activities.

The CHC-MCO must submit a corrective action plan, in accordance with the time frames established by DHS, to resolve any performance or quality of care deficiencies identified through ongoing monitoring activities or any independent assessments or evaluations requested by DHS.

The CHC-MCO must obtain advance written approval from DHS before participating in or providing letters of support for QM or UM data studies or any data-related external research projects related to CHC.

3.3 Contract Administration

The CHC-MCOs must have in place the organizational, operational, managerial, and administrative systems capable of fulfilling all CHC requirements. This includes, at a minimum, employee screening, subcontractor oversight, employing sufficient staff, ability to work with the commonwealth on urgent issues, and identification of key staff qualified to serve the population.

3.4 Information Technology

The CHC-MCOs will be required to accept and transmit standard transaction data sets with the commonwealth which will include, but not be limited to:

- Eligibility transactions (834);
- Encounter transactions (837);
- Capitation payment transactions (820); and
- Quality assurance and incident management transactions.

See Appendix D for an overview of information technology requirements.
4. Stakeholder Engagement Process

The CHC initiative has had and will continue to have a robust and extensive stakeholder engagement process throughout the development and implementation of the program. Stakeholder input is key to the overall success of the program, and the commonwealth is committed to eliciting stakeholder input through a variety of channels, as follows.

Pennsylvania MLTSS Stakeholder Engagement Process

4.1 Public Forums

As noted above, stakeholder engagement began formally in June 2015 with the call for comments on the commonwealth’s discussion document. The input received on the discussion document and related public meetings was analyzed and considered in the preparation of this document.
4.2 CHC Advisory Committee

In August 2015, after seeking nominations from interested parties, the commonwealth established the Managed Long-Term Services and Supports System Subcommittee (MLTSS SubMAAC) as a subcommittee of the Medical Assistance Advisory Committee (MAAC) to advise the commonwealth on the design, implementation, oversight, and improvement of CHC. Fifty percent of the Committee’s members are LTSS participants or caregivers. The MLTSS SubMAAC’s initial role is to provide advice on the design of the CHC program. The MLTSS SubMAAC will continue to meet throughout development and implementation of CHC and will provide ongoing advice on program improvement in the post-implementation period. All meetings of the MLTSS SubMAAC are open to the public and governed by MAAC bylaws. CHC-MCOs will be required to provide information to the MLTSS SubMAAC as needed.

4.3 Third Thursday Webinars

The commonwealth is holding public webinars, currently on the third Thursday of every month, to provide updates on the progress of the CHC program development and to take questions from the public. The webinars are a direct response to feedback provided by participants, who requested virtual meetings to make attendance and participation more accessible. Information about past and upcoming webinars can be found on the DHS-CHC website at:

http://www.dhs.state.pa.us/foradults/managedlongtermsupports/index.htm

4.4 Stakeholder Input on Key Program Documents

The commonwealth will continue to seek feedback from stakeholders on key program documents.

4.5 CHC Mailbox

The commonwealth maintains a mailbox that stakeholders can use at any time to ask questions or make comments about CHC. The mailbox address is: RA-MLTSS@pa.gov.

4.6 Webinar Consultations on Topics of Special Interest

In addition to the regularly scheduled webinars, the commonwealth will hold webinars on topics of special interest regarding CHC design features for which stakeholder input is needed. For example, the commonwealth may hold a webinar that addresses what types of counseling and information should be made available to prospective CHC participants at the point at which they are being asked to select a CHC-MCO. The
schedule for webinars on topics of special interest will be posted on the DHS Community HealthChoices website.

4.7 Topic-Specific Advisory Groups

The commonwealth will also form topic-specific advisory groups on issues that are of strong concern to specific groups of stakeholders and are technical in nature. For example, the commonwealth plans to form groups of CHC-MCOs and LTSS providers to formulate a common credentialing application process and common billing process across all LTSS providers for consistency and simplicity.

4.8 CHC-MCO Participant Advisory Committees

Each CHC-MCO will be required to establish and maintain a Participant Advisory Committee that reflects the diversity of participants enrolled in the CHC-MCO. The commonwealth will require CHC-MCOs to report on the membership and activities of their Participant Advisory Committees. The CHC-MCOs will also be required to report on how they have responded to concerns raised by their Participant Advisory Committees.
Pennsylvania will issue a RFP for CHC-MCOs in November 2015 and will make tentative awards in March 2016, contingent upon successful readiness reviews and negotiations. MCOs may elect to submit proposals on any number of the five HealthChoices regions (see figure below). The commonwealth intends to award a minimum of two and a maximum of five CHC-MCO agreements in each region. The number of agreements awarded in each region will depend on the number of quality proposals submitted and the number of eligible persons in the region.

HealthChoices Regions
CHC will be implemented in three phases through one RFP. The program will go live in the Southwest region in January 2017, the Southeast region in January 2018, and the Northwest, Lehigh-Capital and Northeast regions in January 2019.

MLTSS Timeline

Table 1 presents the preliminary schedule for the procurement and implementation of CHC.

Table 1. Preliminary Procurement and Implementation Schedule

<table>
<thead>
<tr>
<th>Milestone Description</th>
<th>Date</th>
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<tbody>
<tr>
<td>Deadline for submission of comments on this document</td>
<td>October 16, 2015 (5:00 pm)</td>
</tr>
<tr>
<td>Release of RFP for CHC-MCOs</td>
<td>November 16, 2015</td>
</tr>
<tr>
<td>Technical questions on RFP due to the commonwealth</td>
<td>November 25, 2015 (5:00 pm)</td>
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<tr>
<td>Pre-proposal conference</td>
<td>December 2, 2015</td>
</tr>
<tr>
<td>Answers to technical questions provided by the commonwealth</td>
<td>December 11, 2015</td>
</tr>
<tr>
<td>Deadline for submission of proposals</td>
<td>January 15, 2016 (5:00 pm)</td>
</tr>
<tr>
<td>Qualified Offerors respond to written questions and make oral presentations as requested by commonwealth</td>
<td>January-February 2016</td>
</tr>
<tr>
<td>CHC-MCOs notified of selection (all regions)</td>
<td>March 2016</td>
</tr>
<tr>
<td>Agreement negotiations for Phase 1 CHC-MCOs</td>
<td>March-June 2016</td>
</tr>
<tr>
<td>Readiness reviews for Phase 1 CHC-MCOs</td>
<td>March-December 2016</td>
</tr>
<tr>
<td>Phase 1 CHC participants receive enrollment notices</td>
<td>October 2016</td>
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<tr>
<td>Implementation of Phase 1 (Southwest region)</td>
<td>January 2017</td>
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<tr>
<td>Implementation of Phase 2 (Southeast region)</td>
<td>January 2018</td>
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<tr>
<td>Implementation of Phase 3 (Northwest, Lehigh-Capital and Northeast regions)</td>
<td>January 2019</td>
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Appendix A. Long-Term Services and Supports

The CHC benefit package will include the following LTSS services for CHC participants who meet LTSS criteria:

- Adult Daily Living
- Adult Daily Living Enhanced
- Assistive Technology
- Behavior Therapy
- Cognitive Rehabilitation Therapy
- Community Integration
- Counseling
- Home Adaptations
- Home Delivered Meals
- Home Health Aide
- Home Health – RN
- Home Health – LPN
- Home Health – Physical Therapy
- Home Health – Occupational Therapy
- Home Health – Speech and Language Therapy
- Non-Medical Transportation
- Nursing Facility Services
- Nutritional Counseling
- Personal Assistance Services
- Personal Emergency Response System
- Prevocational Services
- Residential Habilitation
- Respite
- Service Coordination
- Specialized Medical Equipment and Supplies
- Structured Day Habilitation
- Supported Employment
CHC-MCOs may choose to provide LTSS to participants who are at risk but do not meet the LTSS criteria or to offer additional LTSS benefits beyond those required in the CHC benefit package.

The commonwealth is interested in receiving stakeholder input on additional HCBS services that might be covered under CHC, with an emphasis on services that would be most effective in helping to delay or avoid nursing home placements for CHC participants.
Appendix B. Participant Rights and Protections

Participant Rights and Protections

The commonwealth’s agreements with CHC-MCOs will specify participant rights and responsibilities, and will require CHC-MCOs to notify participants of their rights and responsibilities in writing.

Grievance and Appeal Processes

All participants will have access to grievance and appeal processes that provide the same protections afforded in HealthChoices. The commonwealth is exploring ways to streamline Medicare and Medicaid grievance and appeal processes for dual eligibles. The participant handbook must provide clear information to participants regarding the preparation and filing of grievances and appeals.

Protection from Abuse, Neglect, and Exploitation

CHC-MCOs will be required to adopt policies to protect against and detect abuse, neglect, and exploitation. CHC-MCOs will be required to train their network providers in mandatory reporting requirements for any instance of abuse, neglect or exploitation. CHC-MCOs will also be required to notify Adult Protective Services and Older Adult Protective Services of any situations that are reportable to those systems under their respective statutes. CHC-MCOs will also be required to comply and ensure that their staff and providers comply with applicable laws, regulations, and policies surrounding abuse and criminal background checks.

CHC-MCOs will be required to implement a critical incident reporting and management system for incidents that occur in LTSS delivery settings including nursing facilities and community-based settings. CHC-MCOs will be required to track and analyze critical incidents to identify and address potential and actual quality of care and/or health and safety issues, identify trends and patterns, identify opportunities for improvement, and develop and implement strategies to reduce the occurrence of incidents and improve the quality of services. CHC-MCOs will be required to report all critical incidents to the commonwealth.

Critical incidents include, but are not limited to, incidents listed on page 43 in connection with Enterprise Incident Management.
Appendix C: Standards for the Quality Management and Utilization Management Programs of CHC-MCOs

- **Standard I**: Comprehensive scope of program
- **Standard II**: Systematic monitoring, measurement, and evaluation
- **Standard III**: Appropriateness and cost-effectiveness of care and services
- **Standard IV**: Integration of LTSS with disease and health management programs
- **Standard V**: Seamless continuum of care
- **Standard VI**: Standards for credentialing providers
- **Standard VII**: Quality management and utilization management programs
- **Standard VIII**: Provider appeals and provider disputes
- **Standard IX**: Actions taken as a result of quality management and/or utilization management programs
- **Standard X**: Drug utilization review
- **Standard XI**: Medical record keeping
- **Standard XII**: Cultural competency
- **Standard XIII**: Written descriptions for quality management and utilization management programs
Standard I: The scope of the programs must be comprehensive, allow for improvement and be consistent with the commonwealth’s goals related to access, availability, and quality of care. Distinct policies and procedures regarding LTSS services must specify the responsibilities and scope of the authority of service coordinators in authorizing LTSS.

Standard II: The programs must include methodologies that allow for objective and systematic monitoring, measurement, and evaluation of the quality and appropriateness of care and services.

Standard III: The programs must objectively and systematically monitor and evaluate the appropriateness and cost-effectiveness of care and services provided to participants through utilization review activities with a focus on identifying and correcting instances and patterns of overutilization, underutilization, and misutilization.

Standard IV: The program must have mechanisms for integration of LTSS with disease and health management programs that rely on wellness promotion, prevention of complications, and treatment of chronic conditions for participants.

Standard V: The programs must ensure that participants receive seamless, continuous, and appropriate care throughout the continuum of care, by means of coordination of care, benefits, and quality improvement activities.

Standard VI: The programs must have standards for credentialing and recredentialing providers to determine whether physicians, other health care providers, and other LTSS providers who provide services in the commonwealth and are under contract with the CHC-MCO are qualified to perform their services.

Standard VII: The programs must contain policies and procedures that describe the scope of the QM and UM programs, mechanisms, and information sources used to make determinations of medical necessity.

Standard VIII: The CHC-MCO must have a mechanism in place for provider appeals and disputes.

Standard IX: The CHC-MCO must ensure that findings, conclusions, recommendations and actions taken as a result of QM and UM program activities are documented and reported to appropriate individuals within the plan for use in other management activities.
**Standard X:** The CHC-MCO must have written policies and procedures for conducting prospective and retrospective drug utilization review (DUR) that meet DHS DUR guidelines and federal requirements.

**Standard XI:** The CHC-MCO must have written standards for medical record keeping.

**Standard XII:** The QM and UM programs must demonstrate a commitment to ensuring that participants are treated in a manner that is culturally competent, acknowledges their defined rights, and respects and honors personal choices.

**Standard XIII:** The CHC-MCO must maintain systems, which document implementation of the written QM and UM program descriptions.
Appendix D. Information Technology Requirements Overview

Information technology (IT) requirements will be consistent with those in HealthChoices and will include, but are not limited to, the following:

**Eligibility Reporting**

The commonwealth will provide a Monthly 834 Benefit Enrollment and Maintenance file for each CHC-MCO on the second to last Saturday of the month, which will be sent to the CHC-MCOs by Monday at 6:00 a.m. The file will contain the MA Eligibility Period, CHC-MCO coverage, BH-MCO coverage and other participant demographic information. It will contain only one record for each managed care participant where the member is both MA and CHC Managed Care eligible at some point in the following month. The CHC-MCO must reconcile this membership file against its internal membership information and capitation payment file and notify the commonwealth of any discrepancies found within 30 business days, in order to resolve problems. Participants not included in this file will still be the responsibility of the CHC-MCO until their MA and MCO termination date.

The commonwealth will provide to the CHC-MCO a Daily 834 Benefit Enrollment and Maintenance File that contains record(s) for each managed care participant where data for that participant has changed that day. The file will contain add, termination and change records. The record can contain demographic changes, eligibility changes, enrollment changes, members enrolled through the automatic assignment process, and third party liability (TPL) information. A separate record for CHC-MCO and BH-MCO will be created and sent as needed. The MCOs must process this file within 24 hours of receipt and prior to any Daily 834 file received after.

**Encounter Data Reporting**

The CHC-MCO must record for internal use and submit to the commonwealth encounter data. Encounter data consists of a separate record each time a participant has an encounter with any provider including medical and LTSS providers, and including participant-directed services. A service rendered under the agreement is considered an encounter regardless of whether or not it has an associated claim. The CHC-MCO shall only submit encounter data for participants enrolled in the CHC-MCO on the date of service and not submit any duplicate records. The CHC-MCO must maintain appropriate systems and mechanisms to obtain all necessary data from its providers to ensure its ability to comply with the encounter data reporting requirements. The failure
of a provider or subcontractor to provide the CHC-MCO with necessary encounter data does not excuse the CHC-MCO’s noncompliance with this requirement.

The CHC-MCO will be given a minimum of 60 days notification of any new edits or changes that the commonwealth intends to implement regarding Encounter Data.

Encounter data files must be provided in the following HIPAA transactions:

- 837 – Professional
- 837P – Drug
- 837I – Inpatient
- 837I – Outpatient
- 837I – Long Term Care
- 837I – Outpatient Drug
- 837 – Dental
- NCPDP batch files

All encounter records except pharmacy transactions must be submitted and determined acceptable by the commonwealth on or before the last calendar day of the third month after the payment/adjudication calendar month in which the CHC-MCO paid/adjudicated the claim. Pharmacy transactions must be submitted and approved in PROMISe™ within 30 calendar days following the adjudication date.

Encounter records that are denied due to commonwealth edits are returned to the CHC-MCO and must be corrected. Denied encounter records must be resubmitted as “new” encounter records if appropriate and within the timeframe referenced above.

Encounter submissions, corrections and resubmissions sent to the commonwealth are considered acceptable when they pass all commonwealth edits.

The CHC-MCO must adhere to the file size and format specifications provided by the commonwealth. CHC-MCOs must also adhere to the encounter file submission schedule provided by the commonwealth.

The encounter data system must have a mechanism in place to receive and process the U277 and NCPDP response files; and to store the PROMISe™ ICN associated with each processed Encounter Data record returned on the files.
Capitation Payment Transactions

The 820 transaction will be used for fund transfers associated with capitation payments.

Enterprise Incident Management (EIM)

CHC-MCOs and their network providers and subcontractors will be required to submit critical events or incidents via a standard file transaction that will be incorporated into the Enterprise Incident Management System. The following are considered critical incidents:

- Death (other than by natural causes);
- Serious injury that results in emergency room visits, hospitalizations, or death;
- Hospitalization except in certain cases, such as hospital stays that were planned in advance;
- Provider and staff misconduct, including deliberate, willful, unlawful, or dishonest activities;
- Abuse, which includes the infliction of injury, unreasonable confinement, intimidation, punishment, mental anguish, or sexual abuse of a participant. Types of abuse include, but not necessarily limited to:
  - Physical abuse, defined as a physical act by an individual that may cause physical injury to a participant;
  - Psychological abuse, defined as an act, other than verbal, that may inflict emotional harm, invoke fear, and/or humiliate, intimidate, degrade or demean a participant;
  - Sexual abuse, defined as an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a participant; and
  - Verbal abuse, defined as using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a participant;
- Neglect, which includes the failure to provide a participant the reasonable care that he or she requires, including, but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm. Seclusion, which is the involuntary confinement of an individual alone in a room or an area from which the individual is physically prevented from having contact with others or leaving, is a form of neglect;
- Exploitation, which includes the act of depriving, defrauding, or otherwise obtaining the personal property from a participant in an unjust, or cruel manner, against one’s will, or without one’s consent, or knowledge for the benefit of self or others;
• Restraint, which includes any physical, chemical or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual’s body. Use of restraints and seclusion are both restrictive interventions, which are actions or procedures that limit an individual's movement, a person’s access to other individuals, locations or activities, or restricts participant rights;

• Service interruption, which includes any event that results in the participant’s inability to receive services that places his or her health and or safety at risk. This includes involuntary termination by the provider agency, and failure of the participant’s back-up plan. If these events occur, the provider agency must have a plan for temporary stabilization; and

• Medication errors that result in hospitalization, an emergency room visit or other medical intervention.