
Williamsport, PA

May 30, 2014

9:00 am - 12:00 noon

Pennsylvania College of Technology, 1
College Avenue

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Patricia
Rumberger

I want to thank the LTC Commission Committee for giving me the opportunity to speak to you about something I am very passionate about and that is ensuring that the Area Agency on Aging retain their role as the Gatekeeper for assessing consumers needs, determining their appropriate level of care, managing their care and always respecting their choice in the process.

As a Area Agency on Aging employee for the past 30 years, the Director for 6 years and a senior citizen I am proud to be a part of the AAA family. They are the most trusted, credible and dedicated agency in the Commonwealth to assess the needs of seniors and people of all ages with disabilities.

The 52 AAA's know the seniors and their caregivers in their counties. They understand and relate to the different cultural nuances of each individual community in their counties. We need to continue to play a strong role and promote the development of a comprehensive LTC system in our communities.

AAA's have strong community support through extensive partnerships resulting in a system that empowers people to age at home, in their community, - where they want to be.

It is imperative that the Area Agency on Aging continue in their gatekeeper role to ensure seniors and people with disabilities have professionals assist them thru this maze of LTC.

The Aging Network is a well established system that is committed to helping older Pennsylvanians age in place, while maintaining their independence.

Thank you

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Pennsylvania Long-Term Care Commission Public Comment Session

Lycoming County – May 30, 2014

Good Morning, my name is Bill Farley, and I have had the good fortune to serve as the Director of the Area Agency on Aging for the counties of Bradford, Sullivan, Susquehanna, and Tioga for the past 25 years. My comments today will focus on a rural perspective in terms of the issues facing our Long Term Care Service Delivery System.

Pennsylvania's diversity between urban, suburban, and rural areas creates a unique quest for policy makers in designing programs for the good of the whole. And Pennsylvania's rural service delivery is impacted by issues such as limited number of Providers, distances between Consumers and service options, and a dependency on self- transportation (for both Consumers and Staff) that may not be concerns for our urban and suburban populations.

~~As the necessity for cost saving measures and consideration for Managed Care Models become realities, I can only hope that alternative service options will be included as solutions for rural service delivery. We need to make sure that consideration is given for all options available in Federal criteria, and for the Commonwealth's interpretations to provide maximum flexibility and not just a single model perspective.~~

The following are some examples of rural issues and possible solutions, from my perspective, having worked at a rural Area Agency on Aging for the past 31 years:

Thank you to Gov Corbett and the various Depts for the additional funding for services - especially W.L. & Aging MR to help our needy consumers, and the importance of continuing to pay for the \$ to maintain current service levels.

1. Programs such as the PACE/LIFE Program and Adult Day Care are wonderful service models for Consumers in urban areas, but in the current program format, these are not viable options in my rural area. An ~~alternative opportunity for rural Pennsylvania could be the expansion of Home Health Services with an acceptable reimbursement rate accompanied by expansion of Tele Med and Home Monitor Services.~~

The current Medical Assistance Reimbursement Rates do not cover the associated costs for most of our Home Health Providers and as we see more Hospital Mergers in rural areas, we are seeing fewer Home Health options. ~~Establishing realistic reimbursement rates in rural should increase the availability of In Home Nursing services allowing more Consumers the opportunity to receive this type of service and oversight at home.~~

2. Transportation almost always is identified as an unmet need in rural Pennsylvania. And our current Coordinated Transportation Providers are faced with regulatory obstacles that create difficulties in meeting the needs of our most vulnerable populations. Isn't it time to re visit some of the cumbersome regulations like the Shared Ride Program's prior day notification as well as the trip reimbursement rates? Could the Shared Ride and Medical Assistance Transportation Program regulations be modified to establish consistency and reimbursement flexibility that make sense in meeting service needs rather than just meeting some financial and or regulatory criteria?

- 3. The Area Agency on Aging Gate Keeper Role – hopefully this can be kept local, as a one stop shop for the over 60 and consideration for some of the under 60 programs (LINK/ADRC)? I wonder too, if the under 60 Nursing Home Transition program could become a function of rural AAAs, rather than organizations hours away from Consumers. Why Not Us?

From electronic applications, to Medicare Part D to Assessment, to Enrollment, and Care Management. I don't think enough importance is placed upon the need of our most vulnerable population to have trained social workers available in the community to assist with enrolling and accessing services, and assisting in dealing with Consumers day to day challenges in getting their service needs met. As a member of the PPL Transition Advisory Committee I watch and listen to the many Consumers who need the assistance of their Service Coordinators in navigating the electronic Consumer Directed Model.

- 4. In 1994 we had 39 licensed Personal Care Homes in our four county area, many of which accepted SSI Supplement Consumers. We now have a handful of Personal Care/Assisted Living Facilities catering to the Private Pay Consumers. Many low income Consumers in need of supervision and support are residing in Public Housing Buildings without the assistance they need. The Commonwealth needs to revisit this issue and develop realistic reimbursement rates and regulations and re establish the Personal Care Home component as a viable service option in the community.

42% reduction in SSI Supplement Consumers
in our 4 county area in the last 5 yrs

5. Recruitment of Personal Care Aides is and will continue to be one of the most significant challenges facing rural service delivery. Cost Control measures are affecting quality and availability. My experiences are that the first costs to be controlled by Providers are the wages paid to Personal Care Aides, and their travel expenses – limited paid travel time and reduced or no mileage reimbursement – when Aides have to use their own cars.

I would like to see unit costs indexed so that a fair portion of the rate paid to the Provider Agencies is applied to the Aides wages and expenses.

I would also like to see realistic career ladders established, such as part time LPN courses, so that Single Parent Aides can be afforded an opportunity to earn a living wage. I believe this could be achieved by some changes in our Work Force Investment Programs (WIBs) and advocating for part time vs full time criteria for the LPN programs. WIBs could and should be our connections for training and career ladders.

6. Care Transition and Nursing Home Transition – These are great programs helping Consumers return to and remain in their communities. These programs need to be expanded and have some Partnership Incentives established to enhance the opportunity for growth.

Waiting lists get in the way of Care Transitions, when this program should be emphasized for immediate service delivery upon discharge from a hospital, enhancing the opportunity for Consumers to be successful in their efforts to remain at home.

WIB will create possibility of many practitioners to be @ in the rural sector and not just

@ in facilities

7. Timeliness of Service Approval –Simplify and Speed up – This is a lawsuit waiting to happen. From the ISP review and approval process to the DME approval mystery to the Environmental Modification process. All take too long and are reasons for unnecessary placements and put Consumers at risk.

Grants for home approval DME approval & DME approval

8. Last but not Least – The Electronic Application Process – Those most in need will be challenged the most by this system. I understand the reasoning to do so, but the system needs to be accompanied by trained staff/advocates who can assist with the completion process so that needy Consumers don't fall by the wayside because they are not technologically savvy.

I want to thank you for this opportunity to provide my comments and applaud yours and the Governor's efforts to meet the needs of some of our most vulnerable population.

Bill Farley, Executive Director
B/S/S/T Area Agency on Aging

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**Long-Term Care Commission Public Hearing by the
Department of Public Welfare
Testimony of the Disability Rights Network of Pennsylvania
(DRN)**

Presented by:

**Deborah Delgado, Traumatic Brain Injury Project Director
May 30, 2014, Williamsport, PA**

Thank you for the opportunity to provide testimony on Pennsylvania's long-term services and supports system. This testimony is provided on behalf of Pennsylvanians with physical, sensory and developmental disabilities, which includes persons with acquired and traumatic brain injury.

~~The Disability Rights Network of Pennsylvania (DRN) supports full availability of home and community-based supports and services. People with disabilities should have access to the full range of home and community-based services in integrated settings of their choice. Therefore, new State funding should only be used for home and community-based services, and funding should be maximized through initiatives such as Money Follows the Person and the Balancing Incentive Program. In addition, State policies, including intake, enrollment and planning procedures, must be designed and implemented to ensure prompt access to all needed home and community-based services.~~

Pennsylvania must maintain and expand opportunities for shifting funding from institutional services to home and community-based services. DRN strongly encourages the Department to partner with stakeholders in maximizing the use of the Balancing Incentive Program federal dollars to expand home and community-based services and to improve intake, enrollment and planning procedures. DRN also recommends that the Department continue and expand the use of the Money Follows the Person (MFP) program. Stakeholders should be more involved in identifying and developing strategies to eliminate barriers that prevent the use of Medicaid funds only in home and community-based settings. The Department should assess the current MFP program and determine how to expand it to move more

people can make informed choices about available programs, services, and service delivery models.

In addition, the eligibility and enrollment process must include a procedure for expediting enrollments, including timely development and approval of individual service plans, for people who are at imminent risk of institutionalization. Expedited enrollments are needed to prevent the unnecessary institutionalization of people into nursing facilities and other institutions, so that they can instead receive services in the most integrated setting. This procedure for expediting enrollments could be similar to the Community Choice process previously used to expedite enrollments for people at risk of being institutionalized within 72 hours in the absence of home and community-based services, or for people already in institutional settings. The procedure for expediting enrollments must be standardized, statewide, and shared with people with disabilities, service coordinators and other stakeholders so that there is an awareness of how to access expedited home and community-based services when needed.



The Department must maximize Medicaid dollars for home and community-based services, which will save money and protect persons with disabilities' rights under Medicaid law and the Americans with Disabilities Act. Thank for you the opportunity to provide these comments on the need for rebalancing and on access barriers to home and community-based services.

Contact:

Kelly Whitcraft, Policy Coordinator



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Good Morning. My name is Pat McGee from Susquehanna Health Home Care & Hospice and Palliative Care. Thank you for providing me with an opportunity to talk about home care and hospice as part of the continuum of care.

I would like to address care coordination. Care coordination from the hospital or between post acute providers, such as the nursing/rehab facility, home care or hospice or other areas. I have seen improvement in our communication, specifically when liaisons are in place to communicate with providers and patients, but more work is needed.

Providers recognize a disconnect and most important, patients are frustrated and confused by our lack of adequate care coordination. A patient may experience an encounter involving the emergency department, ICU, medical floor and receive a variety of ancillary services prior to discharge to home with home care or hospice. They are likely to receive a number of follow up calls, and discharge instructions typically asking the same or similar questions. A common response from our patients is, "don't you talk to each other?"

Another complicating factor seems to be "other providers" moving into the home environment in place of or along side home care staff. Although I applaud diversifying a business model and a focus on post-acute care it seems it is in our best interest to work together, instead of creating alternate home visitors, which may include EMT's, paramedics, navigators, or care managers from a variety of areas that create confusion and fragmentation for providers and patients.

Our current home care and hospice model works with proven outcomes. Home care and hospice services should be provided by experienced home care providers. We are licensed, have the established relationship, years of experience, knowledge and expertise and most important, we are a trusted friend and caregiver for our patients. Our program, which is similar to many PA provide service to patients in 11 counties from two locations, serving 900 patients as our average daily census. Working together to coordinate care seems to be the best answer for our industry and patients.

One model with proven positive outcomes involves a monthly meeting of providers - hospital or health system care coordinators, care managers, nursing/rehab facility, home care & hospice, palliative care, pharmacy services, aging services, senior centers, and behavioral health and primary care services. The team works together with the goal of improving access to care and care coordination and there are key projects, such as establishing a single transfer and referral form to be used by all providers and evidence-base practice protocols to address readmission diagnoses.

Another useful project involved developing a self-management calendar for patients with alerts to direct the patient when to call the healthcare provider. All projects contribute to improved care coordination and access to care and a decrease in visits to the emergency department and hospitalization.

This same model also helps to direct the patient to the right level of care or the preferred level of care, taking into account all needs. In the home care and hospice environment we believe it is very important

for the patient to remain in the home if possible, which is also the lower cost and preferred option by the patient.

As a future consideration, let's keep our eye on new models of care that include ACO's, bundling and population health management.

Thank you.

Patricia McGee, RN, MSN, NE-BC, CCP

Executive Director

Susquehanna Home Care & Hospice, Palliative Care

LONG TERM CARE COMMISSION MEETING

VERBAL TESTIMONY

WILLIAMSPORT, PA

MAY 30, 2014

Good Morning Commission Members. My name is Caryn Plessinger and I am the President of Hub's Home Oxygen & Medical Supplies and CressCare Medical. Our corporate office is located right here in Williamsport, Pennsylvania. We service rural central Pennsylvanians with ~~durable medical equipment, supplies and services and have done so for almost 60 years.~~ I am here today speaking on behalf of my companies as well as those from across the entire state belonging to PAMS (The Pennsylvania Association of Medical Suppliers) of which I currently serve as Chairman of the Board. I would like to thank the Governor for appointing each of you to this commission and for your participation in fulfilling his commitment to improve the long-term care system here in Pennsylvania.

Facts about long-term care in Pennsylvania tell us 1.7 million live with physical disabilities needing assistance with self-care, mobility, and independent living in their communities. This is a huge undertaking for the state not just from a financial standpoint but also from an operational one and my hope is that these public meetings and comments give the commission the information they need to implement change and improve access to those services.

~~DME providers like me are providing medical equipment, supplies and services across the long term care continuum.~~ While all places of care require the use of items such as oxygen, power wheelchairs, urological and incontinence products, the focus should be on providing those items in the most appropriate place for that care. The most cost effective and preferred place remains the home and we encourage your support and funding of community and home based care initiatives when appropriate. We as providers are extremely concerned over certain parts of the Healthy PA plan that places monetary caps on medical

needed. Proper reimbursement levels are needed to maintain strong networks for all types of providers. Continuation of decreasing fee schedules creates decreased product quality and services relating to those items. Last month at one of these meetings, a father of a severely handicapped adult child shared a story with you concerning the quality of incontinence products. He revealed due to cheaply made incontinence products, he and his son were awoken every few hours due to wetness. The fee schedule for these products has been cut on multiple occasions to the point that providers must seek inferior products to cover their costs. He commented that higher quality products allowed them both to sleep through the night dry. As the product quality decreased, the son needed changing more frequently to reduce risk of breakdown. Because he needed more changing, he was using more product than he was authorized for. His insurance continued to authorize more and more product but everyone missed the point. Neither the consumer nor the caregiver is getting the opportunity to sleep through the night and the consumer is being placed at a significant risk for developing skin breakdown and urinary tract infection. For those of you that know what that means, you know it hurts, it's costly and unnecessary. There must be common sense used when establishing coverage criteria for equipment and services and it should be a balanced approach between quality, savings and outcomes. In this case, providing a lower quantity of a higher quality product makes sense and will decrease the likelihood of expensive, senseless consequences.

As a respiratory therapist, I know that treating chronic respiratory and other chronic conditions require a team approach. In all settings, mismanagement of chronic illness is extremely costly. Quality measures should be developed across the entire long term care continuum that promotes adherence to care plans by providers and consumers. We must prevent readmissions and we must make it a priority to eliminate breaks in service to those with chronic disease. It should be noted, that DME companies don't just deliver equipment and supplies. We are an intricate part of the care continuum. My companies' employee clinical staff consisting of Respiratory Therapists, Nurses, and Occupational Therapy Staff that are responsible for treatment plans, education and expertise that promotes

My name is Carmela Green. I'm a 51 year old taxpayer, mother of 2 healthcare workers, 1=Home Care 2=Nursing Homes. Taking care of others is difficult. You have to be able to give all of yourself (whether routine or random), but I guess it's in our blood to make the best out of 24 hours as we best can. This is the same for financial also. We must be able to manage money or at least attempt to stretch our and our consumers money. Minimum wage is 7.25 per hour. I've earned 450.00 bi-weekly, but bring home 378.00 per check. I'm a 2 person no dependents household. On paper it'd state that I make too much to be eligible for food stamps, financial applications, (public Assistance), and don't qualify for utilities offered to the public. I'm paying a mortgage and like most, Electric, water & sewage, phone and trash removal. I have an automobile, so that makes me responsible for Gas, Car Insurance, Car payments, and Car maintenance of repairs which are unpredictable and often. Being paid bi-weekly predicts my whole life style because I find myself living from check to check. I've worked as a PCA (Personal Care Aide), for over 33 years and today I'm still working without Doctor or Dentist insurance because I have no healthcare but that's a whole different story! In this summary of bills paid, I haven't even mentioned food yet! Food prices vary depending on what time of the month it is! The beginning of the month there's a lot of shopping of condiments=mayo, mustard, etc; You don't even start shopping for anything with substance until the middle of the month. Nursing Homes are getting paid 15.00 per hour. They usually get from 15.00 to 16.00 on weekends. Personal Care Aides are making 8.00 to 10.00 per hour, some 11.00 on weekends and we are struggling, I speak from experience! We have no room for emergencies or set-backs, no holidays or sick days. I don't say this as a complainer but as an observer of how anyone can be living off of 7.25 per hour or should I be saying the word "surviving!" I'm speaking across the board and not only for healthcare workers, but this very important job that's leaving us with only half of our necessities and asking "How can we continue as prices and taxes go up to continue to give our all before burdens get the best of our 24 hours.

**Testimony for the
Pennsylvania Long-Term Care Commission
Williamsport, PA
May 30, 2014**

Presented by Frederick Shrimp, Aging Director
STEP Office of Aging
Lycoming Clinton Counties Commission for Community Action (STEP) Inc.



Greetings to Secretary of Aging, Brian Duke and the Secretary of Public Welfare, Beverly Mackereth and distinguished members of the Long-Term Care Commission. Thank you for bringing a public comment session to Williamsport. I will use a broad definition of long term care that includes those with disabilities of all ages and all levels of need and not just those in need of a nursing home level of care. I will concentrate my comments on service to those ages 60 and over (seniors) as that is the main focus of an Area Agency on Aging but the same issues often affect people with disabilities of all ages.

Before we look at services for those with functional limitations that limit a person's ability to participate in activities outside of the home, let's take a look at aiding people to stay well. Senior community Centers can fill this role. Every study I have read about successful aging or how to live a long and healthy life contains three main elements. Those three elements are good nutrition, exercise and socialization. I believe senior centers should provide nutritious meals and nutrition education, exercise programs, health screenings and health education and socialization. Senior centers that operate in this manner provide a preventative health service within the long-term care system.

STEP also serves 400 seniors per day with home-delivered meals or meals-on-wheels. The meals are prepared by a contractor but delivered Monday through Friday by 74 volunteers each day. I mention this because I want to talk about the importance of personal contact with the frail and disabled. In the month of April we had 5 instances of what I call meals-on-wheels rescues. The meals-on-wheels volunteers found the older person ill or fallen and summoned help through emergency contacts and ambulance services. Two of the five people had medical alert systems but did not activate them. Many Area Agencies on Aging have changed to frozen meal delivery once a week or once every two weeks due to cost cutting measures. These rescues would likely not have happened in that system.

How many more hours or days would they have been on the floor before they were found? Many frail and disabled individuals do not want to be a bother to anyone. They may need to see a physician for new or worsening symptoms, but since they have an appointment in a few weeks, they will wait for that appointment. That person may reveal the problem to a caseworker, service coordinator, personal care aid or a volunteer that makes contact with them, but will not initiate the contact. I understand the constraints of available funding, but when possible we need to find ways to have personal contact with frail and disabled individuals.

The increased funding for in-home services through the AAAs this fiscal year for the first time in six years was a godsend to thousands of seniors that were on waiting list for services and many thousand more seniors that were able to receive additional services. More seniors were able to choose to stay in their home as a result of the funding. Seniors and AAAs are hopeful that this additional funding from the Pennsylvania lottery will continue to be distributed to the local AAAs. These lottery funds are used for services such as personal care, home support, family caregiver support, home modifications, medical alert systems, protective services and more. These funds help those who are frail and disabled but have not reached that nursing home level of care. These funds can prevent or delay many from needing a nursing home level of care. The lottery funded services of the AAA are an important part of the long-term care system and need adequate funding.

The Commonwealth of Pennsylvania has dedicated the lottery proceeds to benefit senior citizens. Every effort should be made to continue that promise. Nothing should be enacted by state government that would reduce lottery proceeds. Pennsylvania provides many services to seniors through lottery funds that are not available in other states. Let's remain a frontrunner by preserving the lottery for senior citizens and allocating adequate funding to AAAs to meet the needs of seniors in every locality of the state.

The partnership between the Area Agencies on Aging (AAA), the Department of Aging (PDA) and the Department of Public Welfare (DPW) has been very positive and to the benefit of seniors and disabled individuals. AAAs have been providing services to seniors since 1975. AAAs provided long-term care services to disabled individuals under the age of 60 prior to the development of the Medicaid waivers. AAAs worked with the Departments of Aging and Public Welfare to develop the level of care assessment process and the Aging Medicaid Waiver Program. The AAA assessment role has been an appropriate and efficient way for government to determine if Medicaid funding should be used to pay for in-home or facility care. The assessment process also screens for mental health, intellectual disability or other related conditions that may affect a person's need for special treatment if they are entering a nursing facility. AAAs desire to continue this role and believe that the consistent results of the assessments have demonstrated that this is a good process that serves the individuals that are assessed and aides government in managing spending.

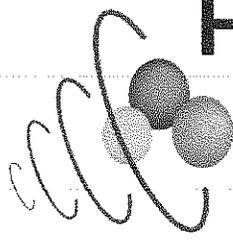
The Aging Medicaid Waiver program is another very valuable long-term care program performed in the partnership of AAAs, PDA and DPW. The Aging Waiver program enables older individuals to receive services in their home instead of moving to a nursing facility. The desire of most seniors is to remain in their home as long as they

are able. The Aging Waiver program has gone through dramatic changes in the past two years. The new service coordination system has been a challenge to the AAAs. I believe there is great value in AAAs providing service coordination in the Aging Waiver program because of our expertise, easy access for seniors and a coordinated system of service for seniors. One of the negative changes that has taken place in the current service coordination system is less contact between the service coordinator and the older adult. As I said earlier, less contact can lead to the health and safety issues of the older adult not being handled in a timely manner.

Over the past 10 years, DPW has considered changes such as managed care and ways of handling people who are dually eligible for Medicare and Medicaid. AAAs have tried to be part of these discussions and have not always been welcomed. AAAs want to be part of any long-term care decisions and want to continue to provide assessment and service coordination in whatever system DPW decides to pursue.

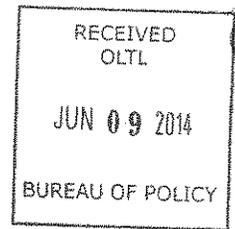
Since 1989, AAAs have been investigating reports of abuse, neglect, exploitation and abandonment of people age 60 and over. AAAs have been able to provide solutions to the problems uncovered in the investigations with services, legal remedies and sometimes criminal prosecutions. This service is one of our greatest responsibilities in helping to protect vulnerable seniors. Older Adult Protective Services must remain a high priority of the long-term care system. AAAs welcomed the passing of the Adult Protective Services Law to provide service to the disabled age 18 to 59. We look forward to the full implementation of the service by DPW.

AAAs recognize all of our valuable public and private partners in the provision of long-term care services. At the risk of offending the partners I neglect to mention and inserting some local names, we support our nursing facilities, personal care homes, Albright LIFE, Susquehanna Health Systems and all our other local hospitals, health systems and doctors, our in-home care agencies, Roads to Freedom, elder law attorneys, etc. that make up our long-term care system.



Hearing Loss Association of America

Lycoming Chapter



May 31, 2014

Governor Tom Corbett
ATTN: OLTL Policy
Long Term Care Commissioners
PO Box 8025
Harrisburg, PA 17105

RE: Testimonial-HLA/LC, Tyberg

Ra-LTCCommission@pa.gov

Dear Governor Corbett & Commissioners:

I represent the thousands of elderly Pennsylvanians on behalf of the Hearing Loss Association of America as a deaf advocate, an educator, a peer mentor, and human services professional.

I am at the podium with the microphone. Think about this scenario. I am standing at the podium with the microphone without using my voice, but moving my lips saying the following..."Thank you Governor Corbett for funding the Long Term Care policy for Pennsylvanians, and I thank the commissioners for being present today to hear the voices of elderly individuals with diverse ability issues." The people in the audience and the commissioners are listening and moving forward trying to hear what I am saying but are stumped because they are not hearing anything. People are thinking there is something wrong with the

microphone system. However, I begin to use my voice repeating what I just said in quotes. People realized there was nothing wrong with the microphone system at all, but the fear and facial gestures of concern has gone away. Everyone has now witnessed firsthand the world of silence, and the unknown whether you are young, middle-aged, or an elderly later-in-life individual with a hearing loss. Think about how it felt when there was no communication.

Let me ask these "How would you feel" questions:

- If as a grandparent attending your grandchild's school play, orchestra or chorus concert, or graduation and you are unable to hear anything being said.
- If you attend a Board of Education meeting unable to follow the dialogue or participate because of the seating arrangements and no accommodations.
- If you participate in a training session or educational presentation in your community and unable to comprehend anyone as they speak.
- If you attend a social event unable to hear or follow the conversations and dialogue, because you are unable to hear them.
- If you are driving at night in a vehicle, and it is pitch black outside and you cannot see nor hear the person trying to have a conversation with you in the vehicle.
- If you attend a township meeting as a taxpayer to know what is going on and provide community input and you cannot participate.
- If you are unable to participate on a Board of Directors meeting because you are unable to hear because they officers decide at the last minute to use the speaker phone which you cannot understand, although your expertise would be a valuable resource.
- If you decide not to apply for a job you are highly qualified for but you are unable to purchase a hearing aid or cochlear implant to hear over the telephone, but the company refuses to modify the job description for you to work there.
- You stop attending church services which has been a major part of your life because you no longer can hear the pastor or lay people speaking during services.
- If you are unable to go to movie theaters and enjoy the feature films or community plays being performed because you cannot afford to purchase hearing aids.
- If family members and children live out of state and communication with the stops completely because you cannot purchase hearing aids to be able to hear them on the telephone or have no access to a computer.
- If you are unable to go through a drive-thru window at any fast food restaurant like everyone else because you are unable to hear the person on the speaker.
- If you are unable to communicate effectively with family members at home without continuous aggravation and frustration due to misunderstanding or repeating themselves.
- If you are at a doctor's office and unable to understand what the nurses and doctors is explaining to you about your medical condition.

- If in an emergency or disaster situation in a shopping area where flooding has almost reached the top of the levy and an unmarked police car with a police officer inside the car announces on his speaker to evacuate the area immediately. You do not hear this or see anything out of the norm except you observe people are rushing out of stores and not sure what's happening. This causing fear and panic on your part because you did not hear this audio announcement.
- If a person cannot hear someone knocking on their front door because they cannot hear.

These are only a handful of examples people with hearing loss face almost daily. This also illustrates how our technology audio savvy society overlooks the needs of individuals with hearing loss. Grant you technology has done wonders for hearing loss with advanced assistive technology devices, e-mail access, cell phone access through text messaging, and relay services. Hearing aids, and all specialized assistive technology devices are paid by the consumer. Insurances are not there to help us. The exception to the rule is the use of PATF, veterans getting assistance through the VA, and if a person is working getting assistances from the vocational rehabilitation program.

I emphasize medical health insurance and durable medical equipment under Social Security does not cover the cost of hearing aid(s) ranging from \$800 to \$4,000 each. There are 39 million Americans accounted for by CDC with hearing loss. I know this figure does not really touch on the reality of the true statistics, because so many go without hearing aids due to financial hardship. In our area alone, 17% of the elderly have a hearing loss. This has become quite an issue where I work as an AmeriCorp member at the Office of Aging where resources are not available for people with hearing loss. I see this all the time!!!! There is not a day I am out in the community where I don't meet an individual with a hearing loss or wears a hearing aid. I am meeting more elderly on fixed incomes and no family members at all with hearing loss.

There are two words I am "hearing" consistently in this meeting today..."communication and safety". Our inability to hear creates communication barriers. Once an individual realizes they have a hearing loss and doesn't know where to go or who to turn to for resources and financial assistance the enormous challenge is just beginning in their lives. What do I mean? It is not just about the hearing loss itself, but the person begins to withdraw from social events or family interactions. What is worse is the frustration, aggravation, anger, anxiety, and onset of depression. This obvious leads to more medical issues than the hearing loss alone and becomes a costly problem.

Hearing loss like dementia, Alzheimer's disease, heart disease, and other major illnesses our elderly Pennsylvania residents endure need adequate medical attention. However, I have witnessed firsthand sadly at meetings such as this

one how hearing loss tends to take a back seat when it is just as important as the diseases we mentioned. Are nursing home and other facilities adequate for elderly with hearing loss – no? Hearing loss research shows these individuals suffer from dementia. Americans have worked all their lives to survive and raise their family for future generations. These same Pennsylvanians have paid their taxes and helped the community they lived in. As an individual in the human services field with a hearing loss our state needs to assist those with hearing loss for elderly assistive living quarters and medical devices. The baby boomer generation is not willing to sit back in their rocking chair - - - we are doers beyond retirement age.

As a peer mentor for individuals with hearing loss, individuals share their frustrations and discontent with agencies and services. For example, many fliers and brochures from agencies have no other alternative contact to the agency except by phone number. How does the deaf elderly person participate or get help? People are asking for help and HLAA directs people to the right resources whether it is about coping and adjusting with hearing loss or how to purchase a hearing aid. The HLAA can guide individuals with resources, education, support, and information so people can sustain a better quality of life.

Our Hearing Loss Association of America-Pennsylvania Advisory Council is willing to provide staff/personnel training about hearing loss to agencies and interested businesses. We also work closely with the ODHH. This will break down the myths and communication barriers. It is my hope the Long Term Care Commission will “hear” our voices which has been neglected for so long.

I thank the commissioners for being here at Pennsylvania College of Technology and allowing me to provide this testimony about a critical problem.

Respectfully,



Kay Tyberg

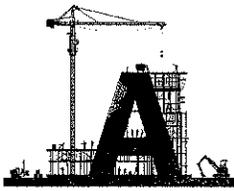
President of HLAA-LCC

Advisory Council Member of HLAA-PA

Certified Peer Mentor for Hearing Loss

Sign Language Instructor

Deaf Advocate



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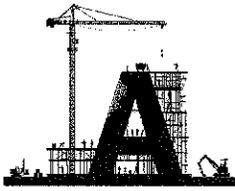
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SECRETARY DUKE & SECRETARY MACKERETH
GOOD MORNING COMMISSION MEMBERS -
MY NAME IS JA, I AM THE INTAKE & OUTREACH COOR.
THANK YOU FOR YOUR TIME AND THE OPPORTUNITY
TO DISCUSS THE ~~PROGRAM~~ LYCOMING LIFE PROGRAM
WITH YOU THIS MORNING.

According to the US Census Bureau ~~2010~~ 1 in 84
Pennsylvanians are 60^{YRS} or older. AND BY ^{the year} 2020 Pa's
60^{YR} and older population is expected to be 25% of
our total population - ^{that is} more than 3 million people.

This leads to the ultimate question of ^{How can we} preparing
for their long term care needs. Or as ^{a recent article in} ~~the~~ ~~Pittsburgh Post Gazette~~ called it - Preparing for
~~the~~ ~~silver tsunami~~ the Silver Tsunami. As ^{surveys} studies
show individuals want to stay in their own home
and receive care. ^{not entering a nlt.} Thus making the need for
Home Based Community Services on the rise ^{and in} demand.

THE LIFE PROGRAM, nationally known as PACE~
Provides All Inclusive Care for Elders. PACE provides
patient centric care to many of the frailest



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In our society, while enabling them to live in their homes and stay in their community.

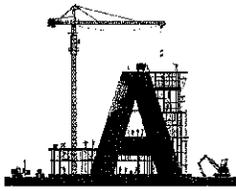
The requirements for enrolling into the LIFE program are :

- must be 55 +
- live in a designated county, cur is Lycoming + part of Clinton
- Be determined as NFCE by physician
- Assessed by CAA and NFCE determination
- And must be capable of living in their home safely

The Lycoming LIFE program provides many services to the participants all based on medical needs. ~~When an individual joins~~ The program is able to provide the entire continuum of care and services to seniors with chronic care needs while maintaining their independence in their home for as long as possible ~ Various care and services include:

Nursing
Physical, Occupational + Rec. Therapy
meals
Nutritional Counseling
Social Work
Personal Care

Medical care provided by a LIFE physician familiar w/ the history, needs and preferences of each participant.
Home Health care and personal care



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~~TRANSPORTATION TO AND FROM THE CENTER~~

- All necessary prescription drugs
- social services
- medical Specialist such as podiatry + speech therapy
- Respite Care
- Hospital and NH care when necessary

~~The Lycoming LIFE program~~

AS THE INTAKE / OUTREACH COOR. I WORK CLOSELY

WITH THE Lycoming Housing Authority, SENIOR HOUSING COMPLEXES, SUSQUEHANNA HEALTH, HEPBURN CLINIC AND ELDER CARE LAWYERS

THE OFFICE OF AGING TO PROMOTE THE LIFE PROGRAM

OUR GOAL IS TO BE A COMM. RES.

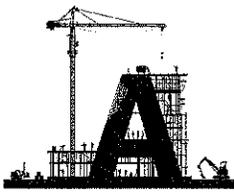
~~PART OF THE AND WE HAVE BEEN VERY SUCCESSFUL~~

~~IN GAINING REFERRALS AND NEW INQUIRIES FOR PERP~~

At the LIFE center in Lycoming we provide care for 75 individuals. This care we provide also effects their family members. We have many participants

who live w/ ^{their son + daughter or sister + brother} ~~family~~ members who work full time and ^{or have children} maintain their lifestyle

they would not be able to ~~do so if~~ their loved one wasn't a participant in LIFE!



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The LIFE program provides such a complex care plan ~~to~~ with each participant that hospitalization, ER visits and nursing home admissions are reduced.

In Lycoming LIFE program we have several

Participants who ^{Prior to joining the program} were noncompliant, ^{with medicine} hospitalized for ^{Uncontrolled Diabetes w/ super levels ranging in 500-1000 range!} ~~hospitalized for~~ ^{due to not detecting earlier} UTI's on a consistent basis and or were in a nursing Home. Since the LIFE program is ~~so~~ ^{enrolling in} ~~even a~~ complex

care plan ~~I am able to~~ ^{of the importance of compliance - importance of proper medicine mgt.} state these participants have been educated and ^{we have} managed to reduce ^{visits or ER visits} the reoccurring hospital stays and were able to be d/c from NHT and return home! Thus allowing Participants Quality of LIFE - the ability to live at home w/ family and enjoy doing things they have interest instead of spending their time in the Hospital or NH.

Challenges the LIFE program faces is 1) We do not Presume MA eligibility as NH do, therefore, DPW in Luzerne County has ^{albaranoconstruction.com} 30 days to review - this is complex to an individual who is ^{PA-057821} STRUGGLING FOR CARE.

Good morning from York County PA. My name is Beverly Grove and I am currently licensed in the Commonwealth as a Registered Nurse and a Nursing Home Administrator. My background includes intensive care, emergency room, pre-hospital, and home health nursing. In 1999 I started in long term care as a Quality Assurance nurse, then Director of Nursing, Assistant Administrator and Administrator. Most recently I have been practicing as a Director of Nursing. I am Vice-President of the Advisory Board for the York County Aging Office. I also serve on the Advocacy Committee and am Chairperson for the Personal Care Home Committee.

Our committee formed as we were seeing the marked decrease in available Social Security supplement beds in personal care due to closure of these personal care homes by the PA Department of Welfare. From 2001-2014 there has been a 31% decrease in available personal care beds in Pennsylvania. With each closure residents were forced to leave their home and the caregivers they trusted and loved to take up new residence with strangers and often not even be allowed to stay in the county they resided. The reasons for closure were many and stemmed from lack of knowledge in caregiving, poor business management, old facilities requiring major repairs and numerous others. These owner operators were often providing care out of the goodness of their hearts and were trying to meet the needs of the population that they served but clearly did not have the tools and knowledge necessary to meet the requirements.

Most personal care homes in Pennsylvania are for profit, private pay and do not accept Social Security supplement. When a resident runs out of private funds they are then often evaluated for a long term level of care and become residents of long term care facilities. There is no mandate as in long term care that a personal care home must accept the Social Security supplement and continue to provide care.

Let me give you a visual of an individual that goes to live in a personal care home. They are physically challenged or have a mental illness or

SUPPLEMENT

intellectual disability. Often they were recently in the hospital or receiving care from a private practitioner. They may have physical needs but most often just need someone to "help" them through the day; provide meals, oversee medications, assist with hygiene and provide a safe environment. They are not asking to live in a facility with crystal glasses, sterling silver and china on the table. They would be content with Melmac dishes, Tupperware tumblers and mismatched flatware. They are simply looking for somewhere safe, with people who care about them, and having their basic needs met.

Herein lies the biggest problem. The current personal care homes that accept Social Security supplement are only getting \$35 a day to provide these services. It simply cannot be done. I am well aware that we have no money in Pennsylvania, but listen to me; we do not need to take more money from the Commonwealth. We need to put the right money in the right place. Get the low Case Mix residents out of long term care and back into personal care where they belong. It will meet the DPW objective of decreasing the overall number of long term beds in Pennsylvania.

Pay the right fees to the right provider. Are you aware that adult day care gets around \$75 a day for 8 hours of care and we are paying only \$35 a day for 24 hours of care? Long term care is struggling to provide care to the sicker, more disabled resident but having their reimbursement decreased by the low acuity residents that should be in personal care.

Personal Care Homes have received no increase since 2007. Private pay personal care homes charge \$60-\$150 a day for care. They spend down the individual's private funds and then when their funds are gone they are sent to live in long term care.

In April of 2007 an excellent document was published, The Assessment and Cost Review of Personal Care Homes in Pennsylvania. It was conducted and completed under the direction of the Legislative Budget and Finance Committee. In 2007 this comprehensive study compared

Pennsylvania with other states and found that the actual cost of service was significantly higher than the reimbursement rate. A significant increase was recommended at that time and to date no increase has ever been afforded to Social Security supplement. This same report showed that other states separate room and board from the "care" portion. A 1915 (C) Waiver supports this, and I recommend that you review this study for its valuable information.

Pennsylvania has an opportunity, as it reviews the new Medicaid Home and Community-Based Services Rules, to develop a plan for Pennsylvania to expand home and community based services that includes rather than disenfranchises the population served within the personal care home system.

For too long the needs of this population have been overlooked. It is sad to think that people are paying more to board a pet than Personal Care Homes are receiving to care for their residents.

Where do we stop the cycle and how? The time is now to take a serious look at how the Commonwealth is allocating its monies.

Consider these points:

1. Take advantage of Federal dollars available as cited in the Medicare Home and Community-Based Services Rules.
2. Review the Assessment and Cost Review of Personal Care Homes and heed the valuable information it includes.
3. Devise a plan to keep low acuity residents in personal care homes instead of transferring them to long term care. Adjust the Social Security supplement and require a percentage of beds in all Personal Care Homes to be supplemental beds. *OR Provide a Tiered Reimbursement*
4. Recognize the ability to save the Commonwealth money by allocating funds appropriately.
5. One last consideration that cannot be ignored, while we all know an increase in minimum wage is desirable, it would cause instant closure of all Personal Care Homes if enacted.

I appreciate you allowing this time for public comment. The Personal Care Home community is desiring to remain a viable commodity in the service to the chronically disabled population requiring our care and services. It is the consumer's health, safety and general welfare that motivate us to do the job we do. Thank you for your time and consideration.

Beverly A. Grove RN/NHA
Personal Care Home Committee
York County Aging Office