COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

AGING AND OLDER ADULT SERVICES COMMITTEE HEARING

STATE CAPITOL
MINORITY CAUCUS ROOM
ROOM 418
HARRISBURG, PENNSYLVANIA

THURSDAY, SEPTEMBER 18, 2008
9:34 A.M.

PRESENTATION ON
PROPOSED ASSISTED LIVING REGULATIONS

BEFORE:
HONORABLE PHYLLIS MUNDY, MAJORITY CHAIRMAN
HONORABLE TIM HENNESSEY, MINORITY CHAIRMAN
HONORABLE JOHN C. BEAR
HONORABLE MICHELE BROOKS
HONORABLE JIM COX
HONORABLE LAWRENCE H. CURRY
HONORABLE FLORINDO J. FABRIZIO
HONORABLE MAUREE GINGRICH
HONORABLE BARBARA McILVAINE SMITH
HONORABLE DUANE MILNE
HONORABLE STEVE SAMUELSON
HONORABLE FRANK ANDREWS SHIMKUS
HONORABLE KEN SMITH
HONORABLE RANDY VULAKOVICH
HONORABLE KATHARINE M. WATSON
HONORABLE JEWELL WILLIAMS

* * * * *

DEBRA B. MILLER REPORTING
(717)439-3785
dbmreporting@msn.com

1 ALSO PRESENT:
CHARLES W. QUINNAN
2 MAJORITY EXECUTIVE DIRECTOR
ALICIA E. RIEGEL-KANTH
3 MAJORITY RESEARCH ANALYST
LOUISE F. STEPANIC
4 MAJORITY LEGISLATIVE ASSISTANT
SHARON E. SCHWARTZ
5 MINORITY EXECUTIVE DIRECTOR
CAROL A. TURNER
6 MINORITY LEGISLATIVE ADMINISTRATIVE ASSISTANT
7
8 DEBRA B. MILLER
REPORTER
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25

1 I N D E X

2 TESTIFIERS

3

NAME PAGE

4

CLIFFORD A. RIEDERS, ESQ.
5 PA ASSOCIATION FOR JUSTICE,
(FORMERLY THE TRIAL LAWYERS ASSOCIATION)........10
6
MICHELLE SEITZER
7 PUBLIC POLICY COORDINATOR,
PA PUBLIC POLICY COALITION
8 OF THE ALZHEIMER'S ASSOCIATION..................25

9 RAY LANDIS
ADVOCACY MANAGER,
10 AARP PENNSYLVANIA...............................31

11 CRYSTAL LOWE
EXECUTIVE DIRECTOR,
12 PA ASSOCIATION OF AREA AGENCIES
ON AGING, INC...................................36
13
ALISSA EDEN HALPERIN
14 SENIOR ATTORNEY AND DEPUTY DIRECTOR
OF POLICY ADVOCACY, PA HEALTH LAW PROJECT.......50
15
KAREN KULP
16 PRESIDENT AND CEO OF HOME CARE ASSOCIATES,
PA HOMECARE ASSOCIATION (PHA)...................59
17
JACQUELINE J. SHAFER, ESQ., MSW
18 MEMBER, ELDER LAW SECTION,
PA BAR ASSOCIATION..............................68
19
DIANE A. MENIO
20 EXECUTIVE DIRECTOR, THE CENTER FOR
ADVOCACY FOR THE RIGHTS AND INTERESTS
21 OF THE ELDERLY (CARIE)..........................73

22 LINDA ANTHONY
POLICY DIRECTOR, DISABILITY RIGHTS NETWORK
23 OF PENNSYLVANIA, INC............................89

24

25

1 TESTIFIERS (continued)

2

3 NAME PAGE

STUART H. SHAPIRO, M.D.
4 PRESIDENT AND CEO,
PENNSYLVANIA HEALTH CARE
5 ASSOCIATION (PHCA)/CENTER FOR
ASSISTED LIVING MANAGEMENT (CALM)...............135

6

TIMOTHY W. COUGHLIN
7 PRESIDENT AND CEO,
LIFESERVICES MANAGEMENT CORPORATION
8 FOR THE PENNSYLVANIA ASSISTED LIVING
ASSOCIATION (PALA)..............................141

9

WM. RUSSELL McDAID, M.H.A.
10 VICE PRESIDENT OF PUBLIC POLICY,
PA ASSOCIATION FOR NON-PROFIT HOMES
11 FOR THE AGING (PANPHA)..........................148

12 JOHN SCHWAB
DIRECTOR, THE HICKMAN,
13 A PERSONAL CARE HOME IN
WEST CHESTER, PA................................188

14

DANIEL G. GRANT
15 VICE PRESIDENT OF OPERATIONS,
UNIVERSITY OF PITTSBURGH MEDICAL CENTER
16 SENIOR COMMUNITIES..............................201

17 ESTELLE B. RICHMAN
SECRETARY, PA DEPARTMENT OF PUBLIC WELFARE.....210

18

MIKE HALL
19 DEPUTY SECRETARY FOR THE
OFFICE OF LONG TERM LIVING,
20 PA DEPARTMENT OF PUBLIC WELFARE................220

21

22

23

24

25

1 P R O C E E D I N G S
2 * * *
3 CHAIRMAN MUNDY: Good morning, everyone.
4 I would like to welcome you all to today's
5 public meeting on the Department of Welfare's
6 proposed assisted living licensure regulations,
7 which provide minimum licensing standards for
8 assisted living residences in the Commonwealth.
9 When Act 56, the assisted living licensure
10 law, was passed last year, I made a commitment to
11 hold a public hearing once the regulations were
12 published.
13 Today's hearing is to fulfill that
14 commitment and to solicit input on these proposed
15 regulations. Now is the time to speak up. Now is
16 the time to tweak the regulations, make them more
17 like what we want them to be.
18 Act 56 provides Pennsylvania with a great
19 opportunity to expand the spectrum of long-term-care
20 options available to seniors, especially those on
21 fixed incomes.
22 By licensing assisted living as a separate
23 entity, we recognize that older adults deserve the
24 opportunity to direct their own care, to live
25 independently, and to age in place as their care

1 needs change.

2 This is not only what the vast majority of

3 people want, but it is a cost-effective alternative

4 to institutional nursing-home care, the importance of

5 which will only increase with our aging baby boomer

6 population.

7 As with any issue, we need to strike an

8 equitable balance with these regulations. We must

9 ensure that consumer protections are in place, and at

10 the same time, that the regulations are not so

11 onerous as to discourage investment in facilities

12 that will provide this care.

13 I thank everyone who is involved in the

14 department's stakeholder meetings and for taking the

15 time to be here today. We have an impressive list

16 of testifiers. I look forward to a productive

17 dialogue.

18 Before I ask Chairman Hennessey for his

19 comments, I wanted to notify the members that all of

20 the comments that were submitted on the regulations

21 are available on the Independent Regulatory Review

22 Commission's Web site at www.irrc.state.pa.us.

23 Members may want to visit IRRC's Web site to

24 find out if any of their local providers have weighed

25 in on this issue.

1 Chairman Hennessey, is there anything you
2 would like to say?
3 REPRESENTATIVE HENNESSEY: Thank you,
4 Phyllis.
5 Thank you. Good morning. Good morning to
6 you all.
7 This is an exciting day. We get a chance
8 here to take a look at the proposed assisted living
9 regulations and to receive up-to-date reviews from
10 people who are the most affected by these regulations
11 or the proposed regulations.
12 I think that we have had about 150 different
13 formal comments filed to the regulations. Many have
14 cited substantial complaints or substantial problems
15 that they see in the regulations.
16 Frankly, from other people that we have met
17 with, they seem to look at the same regulations and
18 see absolutely no problem. So I think that today we
19 will probably hear a couple of rather conflicting
20 views of the regulations, and we will take a look at
21 that. And I think that we have perhaps another
22 30 days or thereabouts to make some legislative
23 comments to IRRC before these go into effect.
24 Let me just say that we are glad to hear
25 from you. I thank you for your attention to the

1 regulations and to looking into them and making these
2 comments and for your testimony today.
3 We will do the best job we can after
4 considering all of these comments and making our
5 recommendations to IRRC as far as these regulations
6 go forward.
7 Thank you.
8 CHAIRMAN MUNDY: Would the committee members
9 introduce themselves, please, starting at my far
10 right.
11 REPRESENTATIVE SHIMKUS: Good morning. I am
12 Frank Andrews Shimkus. I am from the 113th
13 Legislative District in Lackawanna County.
14 REPRESENTATIVE McILVAINE SMITH: I'm
15 Barbara McIlvaine Smith from District 156 in
16 Chester County.
17 REPRESENTATIVE BROOKS: Michele Brooks,
18 representing portions of Lawrence, Mercer, and
19 Crawford Counties in the 17th District.
20 REPRESENTATIVE SMITH: Ken Smith, 112th
21 District, Lackawanna County.
22 REPRESENTATIVE CURRY: Lawrence Curry. I
23 represent eastern Montgomery County, 154th District.
24 REPRESENTATIVE FABRIZIO: Flo Fabrizio,
25 2nd District, Erie County.

1 MR. QUINNAN: Chuck Quinnan, Majority
2 Executive Director for the committee.
3 CHAIRMAN MUNDY: Phyllis Mundy. I represent
4 the 120th Legislative District in northeastern
5 Pennsylvania.
6 REPRESENTATIVE HENNESSEY: Tim Hennessey
7 from northern and western Chester County down in the
8 southeastern part of Pennsylvania.
9 MS. SCHWARTZ: Sharon Schwartz, Republican
10 Executive Director for the committee.
11 REPRESENTATIVE WATSON: Good morning. I am
12 Kathy Watson. I represent a portion of Bucks County,
13 the 144th District.
14 REPRESENTATIVE COX: Good morning. I am
15 Jim Cox. I represent the 129th District in western
16 Berks County.
17 CHAIRMAN MUNDY: Our first testifier this
18 morning is the PA Association for Justice, formally
19 known as the Trial Lawyers Association, and we have
20 with us this morning Mr. Cliff Rieders, Attorney
21 Cliff Rieders, who will present testimony on their
22 behalf.
23 Mr. Rieders, you may begin whenever you are
24 ready. I understand we have to move for a
25 PowerPoint.

1 MR. RIEDERS: Just a few of you.
2 Thank you for the opportunity of making a
3 few remarks.
4 The act and the legislation is a credit to
5 the Legislature and does represent a major step
6 forward in connection with senior Pennsylvanians and
7 assisted living regulations which are an outgrowth of
8 the statute and which are sorely needed in the
9 Commonwealth.
10 Thanks to the intervention of Representative
11 Mundy, I have had the ability to meet with some of
12 the folks who are involved in writing these
13 regulations and discussed with them some changes, as
14 other stakeholders have, and I think that there is a
15 willingness and some energy to look at these
16 regulations and tweak them, or even rewrite them
17 where that would be necessary.
18 So I want to touch on a few points of
19 interest to me. The written remarks that I have
20 submitted to you have more detail. And in particular
21 I am interested in the concept of informed consent,
22 because that is something new in both the legislation
23 and the regulations that I certainly have not seen
24 previously in legislation of this type really outside
25 of the liability context.

1 Under the statute, under Section 1001,
2 "informed consent" is introduced with respect to the
3 care of residents of assisted living centers.
4 "Informed consent" and "informed consent
5 agreement" is, therefore, a new type of document or
6 the introduction of a new type of legal concept, and
7 under the statute it means "a formal, mutually" --
8 very important terminology -- "agreed upon, written
9 understanding which: (1) results after thorough" --
10 another important word -- "discussion among the
11 assisted living residence" -- a little typo there; it
12 should be a "t" -- "staff, the resident, and any
13 individuals the resident wants to be involved; and
14 (2) identifies how to balance the assisted living
15 residence's responsibilities to the individuals they
16 serve with a resident's choices and capabilities with
17 the possibility that those choices will place the
18 resident or other residents at risk of harm."
19 Now, what that ambiguous language means is
20 that where a resident wants to take over their own
21 care in some way, that should be permitted, but it
22 shouldn't be casually permitted and it shouldn't be
23 forcibly encouraged. It shouldn't be a situation
24 where somebody who was at risk or may be marginal is
25 faced with an administration in an assisted living

1 center who wants to get out of some responsibility,
2 and therefore, puts pressure on an individual to
3 agree to something that they really shouldn't be
4 agreeing to, and that is my concern with the
5 ambiguity of this language.
6 The regulations in Section 1021 of the
7 statute provide, Section 1021 of the statute provides
8 for regulations to carry out the statute, and the
9 section creates standards for informed consent
10 agreements that promote aging in place, which include
11 a written acknowledgment of the risks that the
12 resident assumes while directing their own care.
13 So if somebody is going to, for example,
14 wanted to do some alternative medical care, some
15 holistic medical care, these written agreements have
16 to demonstrate an acknowledgement of the risks "which
17 release the facility from liability" -- and this is
18 the tricky language -- "which release the facility
19 from liability" for adverse outcomes resulting from
20 actions consistent with the terms of the informed
21 consent.
22 So if a person says, I don't want to take my
23 medicine for diabetes but I want holistic care
24 instead; I want massage therapy, this agreement is
25 supposed to inform them of the adverse outcomes that

1 may result, and a facility is not supposed to be
2 responsible for the fact that that person may die as
3 a result of not taking their medication.
4 Such informed consent agreements shall only
5 be entered into upon the mutual agreement of the
6 resident and the assisted living residence.
7 Now, what informed consent agreements are
8 not, at least according to the policymakers with whom
9 I have spoken. They are not intended to relieve the
10 entity from duty of due care. As we will discuss in
11 a moment, there is a difference between somebody
12 saying, I am willing to assume a certain risk from
13 care that I want to take over, there's a difference
14 between that and an institution having an obligation
15 of providing due care.
16 One is where a person knowingly voluntarily
17 releases somebody from providing them with a certain
18 degree of attention that they are entitled to, and
19 the other one is an obligation on the part of the
20 facility to provide a safe environment where the
21 person has not executed such a release, and that is
22 really the difference.
23 In the law, informed consent, when violated
24 typically, and before the statute, is a species of
25 battery. Informed consent always meant that if you

1 went into a physician and you said, I give you
2 permission to do a colonoscopy and they do a
3 different procedure, that is a battery. It is an
4 unlawful touching.
5 Informed consent agreements, as used in
6 Act 56, are different than the law of negligence and
7 the two should not be confused, and we have discussed
8 that with those who are writing these regulations.
9 I thought it would be worthwhile to take a
10 brief look at the concept of informed consent as it
11 exists in the Mcare Act.
12 Having started my career working for a
13 Senator on the other side of the building, one of the
14 things that was always drummed in to me was to try,
15 where possible, to have some consistency in
16 government.
17 So we will take a look at the only other
18 place where we have informed consent, and that is in
19 the Mcare Act, and that deals with the duty of
20 physicians.
21 And by the way, informed consent in
22 negligence law, in ordinary medical situations, does
23 not apply to institutions but is considered to be
24 sort of an individual right between a health-care
25 provider and an individual, a doctor and a patient.

1 Except in emergencies, a physician holds a
2 duty to a patient to obtain informed consent prior to
3 conducting a certain category of care. So it is
4 actually a list. It says if you do these things --
5 surgeries, chemotherapy, et cetera -- you have to get
6 informed consent. Whereas under the assisted living
7 regulations, anytime a patient wanted to do something
8 different that is ordinarily done in a center, you
9 get into the informed consent category.
10 So the difference is that under current law,
11 in the Mcare Act, it would be easier, because you
12 have a specific list of those things to which
13 informed consent would apply, and the current law,
14 Section 504 of the Mcare Act, says that consent --
15 and it uses some different language -- consent is
16 informed in that context if a patient has been given
17 a description of a procedure and the risks and
18 alternatives that a reasonably prudent patient would
19 require in order to make an informed decision. And
20 in such a situation, a physician is entitled to
21 present evidence of the description of the procedure
22 and those risks and alternatives acting in accordance
23 with accepted, reasonable medical practice.
24 So currently in the law, we deal with
25 informed consent that must be given for a certain

1 category of events. What we are dealing with are
2 risks and procedures, and I believe that probably --
3 I am sorry; risks and alternatives -- and I believe
4 that that "risks and alternatives" language needs to
5 be carried forth into these regulations as well.
6 I will just briefly cover the law of consent
7 as it exists today. I wrote a book on the subject,
8 so I'll only give you two or three points.
9 The doctrine of informed consent, whether it
10 involved consensual or nonconsensual surgery, again,
11 sounds in battery. It is because somebody is
12 unlawfully touched, whereas again, just coming back
13 to the assisted living, it is where an individual
14 chooses, an individual chooses to take charge of
15 their own care and, therefore, is releasing the
16 institution from care that otherwise would not be
17 given. So that is the somewhat subtle difference.
18 It is well established in Pennsylvania that
19 in informed consent cases, expert testimony is not
20 necessary to establish the community standard of
21 care. The question of whether a physician exposes
22 risks which a reasonable person would deem material
23 is for whoever the factfinder might be.
24 That sort of process as to what a material
25 risk is and what the community standard is is not

1 something that is built in currently to these
2 assisted living regulations. To me, it is kind of a
3 gray area, and gray areas always cause litigation,
4 and that always causes expense, and that always
5 causes aggravation for people. I do not like gray
6 areas.
7 Let us talk about the regulatory, go to the
8 regulations and deal with them with that little
9 background, and the first one I chose to look at was
10 2800.16, "Reportable Incidents and Conditions."
11 This is also a very hot topic right now. I
12 am a member of Pennsylvania's Patient Safety
13 Authority created under the Mcare Act, and the
14 Patient Safety Authority has been struggling since
15 its inception in March of 2002 simply to get a
16 definition of what a "reportable event" is.
17 The statute says that serious events must be
18 reported, and yet there is still, from the Patient
19 Safety Authority and the Department of Health, in
20 6 years, there is not an agreed-upon definition of a
21 "serious event" that has been circulated to
22 health-care providers in this Commonwealth, which, to
23 me, is just unforgiveable, and I do not want to see
24 the same thing happen here.
25 Now, regulations here are much better,

1 because they do have a specific laundry list. I
2 chose only to look at number (3), which says that a
3 reportable incident or condition includes the
4 following: "An injury, illness or trauma requiring
5 treatment at a hospital or medical facility. This
6 does not include minor injuries such as sprains or
7 minor cuts."
8 What a minor injury is, I can guarantee you,
9 is going to be a matter of some contest. As we have
10 found with the Patient Safety Authority, what we
11 thought was easy was not easy. We all thought it
12 would be easy to distinguish between incidents --
13 minor events -- and serious events.
14 Well, it turns out that that is much easier
15 said than done, and so I have suggested to the
16 regulators that they have a definition that would
17 incorporate the definition of "serious events" which
18 currently exists in the Mcare Act and would include
19 unanticipated events, and I may have suggested that
20 language to them.
21 As I said, the Mcare definition of "serious
22 events" is excluded by the regulations, the
23 assisted living regulations, and I thought it should
24 be included.
25 We talked about (a)(3) could add to its very

1 good laundry list -- and it is a good laundry list,
2 by the way, as is -- but I thought it should add an
3 occurrence or a happening that is "unanticipated" by
4 a reasonable patient and requires medical care.
5 And as you can see, that helps to tie in
6 with conventional definitions, because the focus then
7 is, what should a reasonable person expect in the way
8 of care, which if it does not occur then becomes
9 reportable?
10 The definition in the regulations is "an
11 injury, illness or trauma requiring treatment," which
12 is a very broad category, and I thought it would be
13 useful if consistent definitions were used. And
14 therefore, "unanticipated," which is in Mcare, is
15 inclusive, and I thought and I suggested to the
16 regulators it should be incorporated.
17 Section 2800.17 was a controversial
18 recommendation of mine that I suspect will not be
19 followed, and that is I believe that records should
20 be made available free of charge for a resident or a
21 resident's representative where there has been a
22 serious event.
23 The regulation, 2800.17, does have a
24 patient-bill-of-rights kind of language about the
25 release of records, but they get charged for it, and

1 the charges are very high.
2 And just to give you some kind of the way
3 this works in Pennsylvania, when people request their
4 records, it is a way that facilities make money.
5 They hire outside services. Those outside services
6 make the copies and essentially give a kickback --
7 nothing illegal about that; I do not mean that in the
8 illegal sense -- a rebate, if you will, to the folks
9 that hired them -- the hospital, the assisted living
10 center, et cetera -- and they essentially make money
11 on it. And I am concerned about that, especially
12 when you are dealing with people with very, very
13 sometimes marginal incomes or Social Security or
14 whatever.
15 If there is a serious event, it seems to me
16 they ought to be able to get their records free of
17 charge, and I hope that you will agree with me on
18 that.
19 Section 2800.19 gets into the waivers. Now
20 we are back to the informed consent. A residence --
21 and I apologize for the typo -- a resident may submit
22 a written request for a waiver of a specific
23 requirement contained in this chapter, and this is
24 what I consider the most dangerous part in the
25 regulations, and I would like you to think about this

1 and see if you share my concern.
2 The waiver request must be on a form
3 prescribed by the department, which they will work
4 on. The Secretary may grant a waiver of a specific
5 requirement if the following conditions are met, and
6 then there is a list of those conditions.
7 The regulations never state outright, to me
8 are not clear, that the waiver could not be executed
9 by somebody who was incompetent or otherwise not in a
10 condition to understand the terms and conditions, and
11 I do believe we will see some change, I hope, in the
12 final regs in this connection. I did receive some
13 positive feedback on that concept.
14 Section 2800.26, "Quality Management,"
15 requires the residence to establish a quality
16 management plan. That is extremely important. And
17 in the interests of time, I will not go through that
18 in detail, but it does give what must be in the
19 management plan -- a reportable incident, complaint
20 procedures -- and I think that is a real advance in
21 the rights of residents.
22 I believe the quality management plan --
23 going down to number (c) -- must include the
24 development and implementation of measures to address
25 areas needing improvement that are identified during

1 the review process, which is mandatory.
2 Section 2800.26, I have suggested that the
3 regulation should refer to regulations which indicate
4 the right to review the quality management plan, that
5 the regulations need to say who is going to review
6 it, who will approve it, how the resident is informed
7 of the procedure, how the complaint will be
8 addressed, and there needs to be -- and I beg of you
9 for this -- there needs to be a non-retaliation
10 provision, and I suggested this to the regulators.
11 It must say that if a resident files a complaint and
12 follows the procedure the way they are supposed to
13 and is not harassing anybody and is not acting
14 frivolously, that there be a non-retaliation
15 provision. I think that is crucial or they will not
16 work.
17 Section 2800.30, we are dealing with the
18 informed consent process, and this is the section
19 that says when a licensee -- when a licensee; that is
20 the place where the person lives now -- determines
21 that a resident's decision, in their opinion or their
22 behavior, creates a dangerous situation, places a
23 resident or staff at imminent risk of substantial
24 harm by virtue of the resident's decision to exercise
25 independence in receiving care, the licensee may

1 initiate an informed consent process to identify the
2 risks and reach a mutually agreed-upon plan of
3 action.
4 Here is the problem: If you have somebody
5 who is mentally impaired that is creating a dangerous
6 situation, and the licensee decides they are going to
7 do something about this in the way of creating an
8 agreement to remind the person of the dangers they
9 are creating, it is unlikely that you are going to be
10 able to reach a mutual agreement with such an
11 individual, and I think the regulations need to
12 address that situation.
13 When you have somebody, for example, who has
14 got dementia, and the facility is now concerned about
15 the danger that person may cause to say, well, you
16 are going to reach a mutually agreed-upon plan of
17 action, to me is not really realistic, and I think
18 the regulations need to address that eventuality in
19 greater detail, and we discussed some possible
20 approaches.
21 Section 2800.30 deals with a resident who is
22 cognitively impaired and indicates that the
23 resident's legal representative should be included.
24 Again, you want to make sure that is a real live
25 person. That typically ought to be a relative,

1 somebody with proper legal authority to act on behalf
2 of that individual.
3 Once again, oddly enough, the process is not
4 limited to a person who is competent, and I think
5 this process, this so-called mutual agreement process
6 where the assisted living center is concerned or
7 nervous, ought to clearly state that this is a
8 situation where it only applies to individuals who
9 are competent.
10 If somebody is not competent -- not
11 competent -- they should not be permitted to make a
12 choice that endangers others. And whether their
13 legal representative ought to be able to do this, it
14 seems to me, is another question that needs to be
15 specifically addressed.
16 So that is essentially, I shared with you my
17 concerns with respect to this aspect of the
18 legislation, which I do think is an advance, but it
19 is in need of additional specificity so that it does
20 not become an out-of-control quasi-legal problem.
21 If there are any questions I can answer, I
22 would be happy to try to do that.
23 CHAIRMAN MUNDY: Before we answer questions,
24 I want to welcome the Secretary of Public Welfare,
25 Estelle Richman. Thank you very much for coming.

1 You are aware that you are at the end of the
2 list today---
3 SECRETARY RICHMAN: I have lots of work to
4 keep me busy while I listen.
5 CHAIRMAN MUNDY: Well, I do appreciate your
6 interest and your being here. So all of you know
7 that you have the personal ear of the Secretary of
8 Welfare. Thank you.
9 Questions from the committee?
10 MR. RIEDERS: Thank you very much then.
11 Thank you for your work.
12 CHAIRMAN MUNDY: Thank you, Mr. Rieders.
13 REPRESENTATIVE HENNESSEY: Thank you.
14 CHAIRMAN MUNDY: Next, we have a panel of
15 presenters: the Pennsylvania Public Policy
16 Coalition, Alzheimer's Association, Michelle Seitzer;
17 Pennsylvania AARP, Ray Landis; and the Pennsylvania
18 Association of Area Agencies on Aging, Crystal Lowe.
19 Thank you all for being here, and we will
20 begin in just a moment.
21 All right. Whoever who like to begin first,
22 go first.
23 MS. SEITZER: Good morning, ladies and
24 gentlemen and honorable members of the House
25 Aging and Older Adult Services Committee.

1 Thank you, Chairwoman Mundy and Chairman
2 Hennessey, for convening this hearing and for
3 inviting our organization to join today's panel.
4 My name is Michelle Seitzer, and I serve as
5 the Public Policy Coordinator for the Pennsylvania
6 Public Policy Coalition, which represents the two
7 State chapters of the Alzheimer's Association.
8 Prior to serving in this capacity, I spent
9 9 years both as a volunteer and an employee of
10 several assisted living facilities in Pennsylvania
11 and Maryland, so I am honored to be here and speak on
12 this issue today.
13 The Alzheimer's Association provides care,
14 support, awareness, education, and advocacy for those
15 afflicted by Alzheimer's disease and related
16 dementias, which likely encompasses nearly 400,000
17 Pennsylvanians and hundreds of thousands of those who
18 are caring for them.
19 Alzheimer's and related disorders are a
20 complex and challenging spectrum of diseases, thereby
21 requiring unique and detailed provisions, both to
22 protect consumers in residential facilities and to
23 ensure that quality care is provided therein.
24 Given this critical need, we would also like
25 to thank Representative Katharine Watson for

1 championing the inclusion of her dementia-specific
2 amendments into Senate Bill 704. Her amendments made
3 the passage of this legislation especially meaningful
4 and established a strong foundation for working
5 through the regulatory process.
6 Several national studies estimate that
7 60 percent or more of assisted living consumers have
8 some type of dementia or cognitive impairment, of
9 which Alzheimer's is the most common type.
10 This data has strengthened our belief that
11 dementia-capable services should be available in all
12 units and levels of care in an assisted living
13 residence.
14 As the disease progresses, so does the need
15 for more specialized care. Therefore, if a facility
16 markets itself as a provider of Alzheimer's care
17 services, whether within the context of the
18 Special Care Unit or throughout the facility, we
19 believe that clear standards for providing such care
20 are crucial.
21 Our first priority issue is training.
22 Dementia often presents difficult and challenging
23 behaviors, and such conditions absolutely demand
24 specialized comprehensive and continuing
25 education.

1 An investment in training will provide the
2 skills, empowerment, and support needed to maintain a
3 higher retention rate of direct-care workers while
4 ensuring the protection of and highest quality of
5 care to vulnerable residents.
6 We affirm that basic dementia training and
7 awareness among all facility staff must be required.
8 The direct-care worker may not always be the first or
9 only staff member to interact with a resident inside
10 or outside of the Special Care Unit. Those who serve
11 daily meals may witness changes in a resident's
12 condition if trained to look for the warning signs.
13 Therefore, the following list highlights
14 what we consider to be a necessary minimum standard
15 for preparing a quality workforce: at least 8 hours
16 of training within 30 days of hire for all nurses,
17 CNAs, and direct-care staff assigned to this
18 Special Care Unit, and a minimum of 8 additional
19 hours of annual continuing education; at least
20 4 hours of training within 30 days of hire for all
21 other staff, including administrators, and 2 hours of
22 annual continuing education.
23 We also would like to see that new-hire
24 training topics include an overview of Alzheimer's
25 and related dementias, managing challenging

1 behaviors, effective communication, assistance with
2 activities of daily living, and creating a safe
3 environment.
4 We are gratified that the current proposed
5 regulations include these recommendations which
6 enhance the levels outlined in the current
7 personal-care-home regulations.
8 It is important to note that the proposed
9 Pennsylvania requirements are still less robust that
10 such diverse States as Illinois, Arkansas, and
11 North Carolina, where up to 40 hours of annual
12 dementia-specific training is required.
13 Our second priority issue is staffing.
14 Staffing patterns must appropriately meet the varying
15 levels of care needed by the consumers as they move
16 through the stages of dementia.
17 Continual and well-documented revision of
18 the care-plan assessment is a key measure that
19 supports aging in place and affirms that the
20 individual is receiving the care he or she
21 needs.
22 Research and practice models also indicate
23 that activities of daily living often take longer for
24 a person with dementia, and individuals will need
25 various levels of cueing and support to complete

1 their daily tasks in a way that maintains their
2 independence and dignity.
3 The final priority issue is disclosure. The
4 proposed regulations do provide for more detailed
5 disclosure for special-care designation, for which we
6 are grateful. Some clarification is still needed in
7 regard to what services are offered to consumers in
8 the general population. However, we affirm that it
9 is absolutely critical that prospective consumers of
10 assisted living facilities, particularly those
11 pursuing residence in a Special Care Unit, have a
12 clear understanding of what services will be provided
13 there.
14 In conclusion, thank you again for this
15 opportunity to speak on behalf of the nearly 400,000
16 afflicted Pennsylvanians, many of whom are currently
17 living in these facilities.
18 We hope that the Commonwealth will move
19 forward with these regulations and ensure that they
20 are properly and adequately enforced.
21 In a rapidly aging State such as ours, this
22 is indeed a step forward that is long overdue. We
23 offer our support to agency officials and members of
24 the Legislature, and we are always available to
25 advise on issues pertaining to your constituents

1 affected by Alzheimer's and related dementias.
2 CHAIRMAN MUNDY: Thank you.
3 Can everyone in the room hear the
4 testifiers? Are you able to hear?
5 REPRESENTATIVE McILVAINE SMITH: No; they
6 really need to speak into the microphone.
7 CHAIRMAN MUNDY: Yes. I know it is hard
8 when you are reading from your text, but in order for
9 the members to all hear you adequately, you are
10 really going to have to speak right into the
11 microphone.
12 Who is next?
13 MR. LANDIS: I will go.
14 Good morning. My name is Ray Landis, and I
15 serve as the Advocacy Manager for AARP Pennsylvania.
16 On behalf of our 1.9 million members across
17 the Commonwealth, I appreciate the opportunity to
18 be here today to speak about the proposed
19 assisted living regulations recently published by the
20 Department of Public Welfare.
21 AARP has submitted comments on the proposed
22 regulations to the Office of Long Term Living. I did
23 bring along copies of those, which I hope were
24 distributed to the members of the committee, and
25 they, as Chairman Mundy mentioned, are available on

1 the Independent Regulatory Review Commission's
2 Web site.
3 These comments were a collaborative effort
4 between the AARP Pennsylvania office and AARP's
5 experts on State long-term-care issues who are
6 involved in efforts to improve long-term-care systems
7 across the nation.
8 I should note that AARP is one of the
9 founding members of the Center for Excellence in
10 Assisted Living, a collaborative made up of
11 11 national organizations dedicated to promoting
12 high-quality assisted living through bringing
13 together research, practices, and policy that foster
14 quality and affordability in assisted living.
15 This comment from our representative on
16 the Center for Excellence in Assisted Living,
17 Donald Redfoot, sums up AARP Pennsylvania's overall
18 feeling toward Pennsylvania's proposed
19 assisted living regulations.
20 He said: "(These regulations) are excellent
21 in almost every section. These regs obviously
22 represent an enormous amount of work. The
23 taskforce that helped negotiate them are to be
24 congratulated."
25 By no means does this statement indicate

1 that AARP feels that these proposed regulations are
2 perfect. You will note in our comments that we do
3 suggest a number of changes that we hope the
4 Department of Public Welfare and the Office of Long
5 Term Living will consider as they put together final
6 form regulations.
7 We have particular concerns about the
8 ability of assisted living residents to choose their
9 own health-care providers and pharmacy services.
10 Also, we do feel that these regulations are
11 an opportunity to address another issue that is
12 important -- end-of-life issues. And we noted in our
13 comments that we do feel that we could provide
14 information about advance directives to
15 assisted living residents and also ensure that
16 hospice services are provided for assisted living
17 residents.
18 As we know, end-of-life issues and the costs
19 of end-of-life care are growing rapidly and make up a
20 large portion of our health-care costs, and we feel
21 that these regulations in assisted living present an
22 opportunity to address this growing and important
23 issue.
24 We do believe, however, that the proposed
25 regulations are an important step forward in

1 Pennsylvania's efforts to balance its
2 long-term-living system and allow consumers to have
3 more of an ability to age in place.
4 Assisted living fits nicely into a system
5 of long-term care in Pennsylvania that includes
6 home care, personal-care homes, assisted living
7 residences, and nursing-home care.
8 AARP feels there is a role for all these
9 forms of long-term care, including personal-care
10 homes.
11 It is important to note that we do not
12 believe that the establishment of assisted living and
13 publication of assisted living regulations should be
14 viewed as carte blanche for all personal-care homes
15 who become assisted living residences.
16 Some consumers will choose a personal-care
17 home because it is less expensive and they do not
18 desire or need the services provided in
19 assisted living.
20 We believe the new law and the proposed
21 regulations make assisted living a true alternative
22 for the provision of long-term-care services instead
23 of a marketing phrase.
24 As Chairman Mundy noted in her opening
25 remarks, "balance" is a key word in the discussion of

1 assisted living in these proposed regulations. In
2 addition to advancing the effort to balance our
3 long-term-care system, the proposed regulations are
4 an attempt to balance the needs and rights of
5 residents with the ability of providers to offer
6 assisted living services.
7 My guess is that we will hear quite a bit of
8 testimony today stating the balance is tilted one way
9 or the other. AARP's feeling is that these proposed
10 regulations represent a good effort toward achieving
11 that balance.
12 Certainly we believe that some aspects of
13 the proposed regulations could be improved without
14 upsetting that balance, but our overriding goal after
15 a decade, over a decade of debating this issue is to
16 finally see assisted living defined and regulated by
17 Pennsylvania. AARP believes these proposed
18 regulations offer an excellent way forward.
19 Pennsylvania has taken a huge step forward
20 in expanding affordable assisted living options
21 through the enactment of our new assisted living law
22 and the careful drafting of these proposed
23 regulations.
24 We look forward to the continuation of the
25 regulatory process and the eventual final approval of

1 regulations so the era of the provision of
2 assisted living services in Pennsylvania can begin.
3 Thank you.
4 CHAIRMAN MUNDY: Thank you.
5 You may proceed, Ms. Lowe.
6 MS. LOWE: Good morning.
7 CHAIRMAN MUNDY: Good morning.
8 MS. LOWE: I want to thank you all for
9 having the hearing today and allowing us to express
10 our comments with regard to the proposed
11 assisted living regulations.
12 I am Crystal Lowe. I am the Executive
13 Director of the Pennsylvania Association of
14 Area Agencies on Aging, and we have some very
15 fundamental investment in what happens with
16 assisted living, because we serve as a community
17 focal point for seniors, their families, as well as
18 the community.
19 Area Agencies on Aging play several key
20 roles for people who might be looking for
21 assisted living services. We provide information and
22 referral, complete level of care assessments, as well
23 as perform ombudsman and protective services
24 functions. We serve in these same capacities in
25 nursing homes and personal-care homes at this time.

1 Just to give you an idea, we completed
2 100,000 assessments and recertifications in the past
3 year. We also had our ombudsman conduct more than
4 10,000 complaint investigations that were initiated
5 by residents. So we do have some experience and some
6 investment in what happens.
7 I also participated in the Assisted Living
8 Work Group, and it was an extremely helpful process
9 in identifying various perspectives of stakeholders
10 to try and come to that balance.
11 Throughout the months that we worked
12 together, we looked at other States. We compared the
13 regulations with our current personal-care-home
14 regulations and tried to come up with what was the
15 best solution.
16 The process was very engaging and
17 informative, and in many instances, moved the
18 stakeholders' positions closer together, and in a few
19 instances, we actually achieved consensus, but
20 consensus was not the goal of the process.
21 As Ray mentioned, the regulations for
22 assisted living have been in the works for more than
23 a decade, and we really do hope this critical feature
24 of the long-term-living system will finally become a
25 reality for older people and disabled adults so that

1 in fact they can age in place and they can make real,
2 true choices about where they receive their care.
3 We also want to assure that assisted living
4 becomes a real option for low- and moderate-income
5 adults.
6 We formally submitted our comments through
7 IRRC, and we also are a member of the Pennsylvania
8 Consumer Alliance, who a number of other
9 representatives of will speak to you today.
10 But we are here today to offer, and this is
11 on just several topics, and the first has to do with
12 better assuring that consumers are receiving the
13 services they need promptly, and also to talk about
14 the functions being proposed for the ombudsman, that
15 they are appropriate.
16 Many of the residents who will enter
17 assisted living will have physical and cognitive
18 impairments, some of which may be very significant.
19 Therefore, it seem incongruous that the time to
20 complete the evaluation, the assessment, and the
21 support plan is so protracted.
22 To illustrate, everybody who comes in needs
23 to have a screening prior to coming into the
24 facility. The medical evaluation should be conducted
25 either 60 days before or 15 days after. The

1 assisted living resident assessment is to be
2 completed 15 days after admission, and the support
3 plan needs to be done within 30 days.
4 So essentially, that is quite a length of
5 time that someone would in fact not necessarily know
6 what their supports are that they are going to be
7 getting nor what the true cost of the service will
8 be.
9 We recommend that most of these time frames
10 be shortened. A medical evaluation should be
11 completed prior to admission. After all, this is a
12 group residence, and not only are the residents at
13 risk, so are the staff.
14 An assessment should be completed within
15 3 days of admission and a support plan within 7.
16 Consumers need to have adequate supports in place
17 quickly, as well as understand the costs associated
18 with the care.
19 Additionally, staff that are conducting the
20 assessments and developing the support plans need to
21 have sufficient training and experience to assess
22 consumers' needs.
23 While truly many of the consumers who are
24 going to be entering the assisted living will be
25 fairly independent, that is not necessarily true for

1 all, and we need to assure that the people who are
2 making these assessments are competent and able to
3 understand not only existing needs but unanticipated
4 needs and be able to prepare for them.
5 We see the assessment component as critical.
6 To our second point, the Ombudsman Program
7 in Pennsylvania is an extremely valuable resource.
8 However, we are worried that the regulations seem to
9 expand the scope of the Ombudsman Program beyond what
10 the system can handle and what Federal requirements
11 allow.
12 On the capacity side, there are currently
13 insufficient resources to provide the assistance that
14 is currently being required, and these new
15 requirements we see as additional unfunded mandates.
16 The State and Federal allocation for the
17 Ombudsman Program is only a little over $900,000, and
18 that averages to about $15,000 for each AAA. That is
19 less than a half-time staff person. When you
20 consider there are 90,000 nursing-home beds and
21 another 50,000 personal-care-home beds, you can see
22 that that is a lot for the ombudsman to oversee.
23 The most critical issue, however, is concern
24 that the regulations suggest that the role of the
25 ombudsman move beyond being resident-centered,

1 beginning and ending with the resident.
2 According to Federal law and guidance from
3 the National Long Term Care Ombudsman Resource
4 Center, the ombudsman shall be directed at all times
5 by the resident, by what the resident wants, and they
6 are to seek to empower the resident.
7 It entails working with the resident to
8 identify the real issue, determine what the resident
9 wants to be done about the problem, make sure the
10 resident has all the information that they need and
11 explore possible solutions with the resident, and
12 empower the resident or negotiate on behalf of the
13 resident with a facility.
14 These regulations imply additional
15 investigation and oversight responsibilities. For
16 example, in transfer and discharge, if the residence
17 determines that the resident's functional level has
18 advanced or declined so that the resident's needs
19 cannot be met by the residence, the residence has to
20 notify the resident and a designated person.
21 We recommend that the language state that
22 the residence has to notify the resident and their
23 designated person and provide contact information to
24 the ombudsman.
25 There is a subtle difference there. The

1 implication when you notify is that action will be
2 taken. An ombudsman who receives information, are
3 they just going to sit there? I mean, I believe that
4 when they are notified, they have the obligation to
5 do something.
6 Also, when we look at the one, 2800.30,
7 there is a statement that says "For cognitively
8 impaired residents, the ombudsman shall be
9 automatically notified by the licensee." We believe
10 this provision is particularly problematic on the
11 capacity side, as well as it seems to overstep the
12 bounds of what the ombudsman should be doing.
13 Notification, as I said, implies that action
14 will be taken, and for cognitively impaired adults,
15 what is the role of the ombudsman? They are not
16 going to necessarily be able to determine what the
17 resident wants. Further, the ombudsman should not be
18 the central point of contact for a transfer and
19 discharge.
20 We believe there must be some neutral party
21 involved. Truly, there needs to be some oversight,
22 but the ombudsman is not neutral. The ombudsman
23 always sides with the resident, whether that may be
24 the right decision or the wrong decision. They will
25 negotiate with facilities, but not on behalf of

1 facility interests.
2 We further recommend the establishment of a
3 formal appeal process, such as the Office of Hearings
4 and Appeals, when a resident is faced or when they
5 want to appeal a transfer and discharge notice. This
6 will assure in fact that the resident is guaranteed
7 due process.
8 Lastly, we believe that a regulated
9 assisted living industry is essential. We think the
10 regulations proposed are a good step forward. We
11 believe that we need to balance our long-term-care
12 system. I think you are going to hear that a million
13 times today.
14 We want to assure that what is put in place
15 is of high quality and carefully balances the
16 interests of consumers, the interests of providers,
17 as well as funders, because we do believe that that
18 is a critical issue as well.
19 However, I want to stress again that the
20 passage of assisted living still leaves low- and
21 moderate-income adults largely shut out. There is no
22 public mechanism at this moment in time for funding
23 assisted living for low-income consumers other than
24 the waiver.
25 So it is sad to say that under the current

1 financial system, if the regulations are put in place
2 beginning July of '09, a 95-year-old woman -- and I
3 have had personal experience with this -- who has
4 lived in an assisted living facility for 5 years and
5 gone through $200,000 in assets, and if she only has
6 an income of a thousand dollars a month, her only
7 choice is to leave that facility and go to a
8 personal-care home. Those are really her only
9 choices if she does not meet that nursing level of
10 care. That is really a sad commentary on our
11 system.
12 So I know that that is not the primary
13 purpose of today, but I did want to leave you with
14 that thought.
15 And again, thank you very much for providing
16 me the opportunity to give you some comments today.
17 CHAIRMAN MUNDY: Thank you all.
18 Questions from the members?
19 Representative Brooks.
20 REPRESENTATIVE BROOKS: Thank you, Crystal,
21 very much for being here.
22 And I applaud the Area Agencies on Aging.
23 You do a tremendous job with very little funding, and
24 honestly, I think we need to direct more funding to
25 your agencies.

1 MS. LOWE: Thank you.
2 REPRESENTATIVE BROOKS: And the Ombudsman
3 Program is a terrific program. They do a great job.
4 And that is my question, that if there were more
5 funds directed to the agencies, do you feel that the
6 ombudsman could do more of these items, or do you
7 think they still should be separated?
8 MS. LOWE: Again, I think the whole focus of
9 the Ombudsman Program is to be resident-centered and
10 not to serve as a negotiator, if you will, for the
11 facility. They really need to continue to focus on
12 what are the issues the resident wants and advocate
13 on their behalf.
14 And I know that sometimes that presents some
15 pause for the ombudsman, because, you know, as
16 professionals, sometimes they see the decisions
17 people make may not be the best decisions, but that
18 is their job. They are to advocate on behalf of the
19 resident's wishes and their rights.
20 REPRESENTATIVE BROOKS: Again, I would like
21 to thank you, and again, just to emphasis that you do
22 so much with so little, and if we could only have
23 some other agencies run the way the AAAs do, we would
24 be in great shape across this State.
25 So thank you for everything that you do.

1 MS. LOWE: Thank you.
2 CHAIRMAN MUNDY: Representative Gingrich.
3 REPRESENTATIVE GINGRICH: Thank you,
4 Madam Chairman, and thank you for arranging this
5 hearing.
6 This is such a timely and exciting time for
7 long-term care. I thank all three of you for your
8 presentations. They were all very helpful, very
9 enlightening.
10 Having been in the State Legislature for
11 6 years now, and one of the main reasons having come
12 here was my 15 years before that working in long-term
13 care and realizing the needs we have, and
14 interestingly enough, while I have been here
15 6 years, almost 10 years prior to that, I have been
16 talking about assisted living licensing, because it
17 has been a dream, but it is one we all know is
18 necessary. And we are there and we are so close to
19 getting the regulations in and functional so that
20 implementation is easy, so this is so important
21 today. This is critical stuff.
22 Just to piggyback -- two things -- but just
23 to piggyback on what Michele Brooks said, and I agree
24 with everything you say about our local AAAs. They
25 do a fabulous job, and I do not even know how they

1 keep up with it.
2 But this ombudsman piece here really has my
3 attention, because I found that to be -- I had some
4 interesting situations in my district in Lebanon
5 County, as we all know.
6 The ombudsman is a key role, and he needs to
7 be the advocate, I think, for the resident. If you
8 were to read the regulations the way they are now,
9 and I think a lot of it is just clarification, but if
10 you were to read it now, who would be, who would be
11 that resident's advocate? As now we move this
12 ombudsman over into really a different role, it looks
13 like they are more of a negotiator/facilitator
14 between and to all parties. What would your thought
15 be on that?
16 MS. LOWE: Well, I think that that concept
17 is problematic. I mean, I do not want to see the
18 ombudsman role move into that negotiator role. They
19 need to continue to remain as the resident advocate.
20 I mean, I think that is essential. In the absence of
21 that, there is no one.
22 REPRESENTATIVE GINGRICH: Yes; I agree, and
23 that is a concern. I think we are all hearing that.
24 And the other thing, another excellent point
25 about the assessment process, the timing thereof, it

1 being done in time to properly place, but to put
2 systems in place quickly. Again, going back to all
3 my years working in long-term care, a lot of those
4 people need care a minute in the door.
5 MS. LOWE: Right.
6 REPRESENTATIVE GINGRICH: So we certainly
7 want to make sure that we ascertain what their need
8 is and put that all in place.
9 So I am just reinforcing what you say on
10 that, and thank you all for very good points.
11 MS. LOWE: Thank you.
12 CHAIRMAN MUNDY: Thank you.
13 Representative Hennessey.
14 REPRESENTATIVE HENNESSEY: Thank you,
15 Madam Chairman.
16 Crystal, you had mentioned, and just to
17 follow up on the ombudsman point that Representative
18 Gingrich was asking about, is there a specific point
19 or place in the regulations, proposed regs, that
20 define and expand the scope of the ombudsman?
21 I do not see it. I think perhaps it is
22 woven throughout the regulations with the assumption
23 that the ombudsman would jump in and take on
24 additional roles. But is there a specific part of
25 the regs that we can address that deal with that, or

1 is this something that we have to review in
2 law?
3 MS. LOWE: There are several areas that
4 specifically it is mentioned in there.
5 Unfortunately, my written comments to IRRC have the
6 details in.
7 I know the one specific area is 2800.30, and
8 it really does not -- it implies it. It talks about
9 the notification, for example, on the cognitively
10 impaired older adult.
11 And, you know, I think I can state very
12 clearly that an ombudsman who receives notification
13 would certainly feel an obligation to do something.
14 I mean, it seems to imply that some action needs to
15 be taken, but again, in the instance of a cognitively
16 impaired adult, really, the designated person, I
17 mean, that is whom we should be working with in terms
18 of this particular issue.
19 If that person does not have a designated
20 person, someone needs to assure that they do have a
21 designated person, whether that becomes a guardian
22 through the court process or whatever.
23 But it seems like it is not necessarily
24 totally stating very clearly, but it does imply in a
25 number of situations where that scope is expanded.

1 REPRESENTATIVE HENNESSEY: But you see, it
2 is just a matter that arises by implication, not by
3 anything expressed in the regulations.
4 MS. LOWE: Yes.
5 REPRESENTATIVE HENNESSEY: Okay. Thank you
6 very much.
7 Thank you, Madam Chairman.
8 CHAIRMAN MUNDY: Thank you very much. I
9 appreciate your testimony.
10 Our next panel includes the Pennsylvania
11 Health Law Project, Alissa Halperin; the Pennsylvania
12 Homecare Association, Karen Kulp; the Elder Law
13 Section of the Pennsylvania Bar Association,
14 Jacqueline Shafer; the Center for Advocacy for the
15 Rights and Interests of the Elderly, CARIE, Diane
16 Menio; and the Disability Rights Network of
17 Pennsylvania, Linda Anthony.
18 You folks can settle yourselves.
19 Would you each identify yourselves before
20 you speak so that our stenographer can get your names
21 correctly for the record.
22 Who would like to go first?
23 MS. HALPERIN: I will go first.
24 Good morning. My name is Alissa Halperin.
25 I am a Senior Attorney and the Deputy Director of

1 Policy Advocacy at the Pennsylvania Health Law
2 Project. Thank you for the opportunity to speak to
3 you today about this important issue.
4 The Pennsylvania Health Law Project is a
5 statewide nonprofit public interest law firm. We
6 provide free legal services to lower income people,
7 people with disabilities, and the elderly who are
8 having trouble accessing health care and accessing
9 quality long-term care.
10 The Pennsylvania Health Law Project is
11 leading the efforts of the Pennsylvania
12 Assisted Living Consumer Alliance.
13 The Pennsylvania Assisted Living Consumer
14 Alliance was formed this year to make sure that the
15 new licensing rules protect residents who are elderly
16 or have disabilities. Consumers, family members, and
17 advocacy organizations comprise our alliance.
18 You have listed in the testimony all the
19 organizations. I am not going to bother you with
20 that in person since I know that time is limited.
21 The Pennsylvania Assisted Living Consumer
22 Alliance, or PALCA, strongly supports the need for
23 passage of good assisted living regulations. To
24 ensure that Pennsylvania's older adults and persons
25 with disabilities are provided with adequate care,

1 the Department of Public Welfare has gotten off to a
2 good start with the proposed regulations. As
3 written, however, the proposed regulations simply do
4 not do enough to protect the consumers that
5 assisted living facilities will serve.
6 Even though many personal-care homes call
7 themselves assisted living facilities,
8 assisted living is a new model of care for
9 Pennsylvania, in concept, in care level, and in
10 construction.
11 We need to push past the impression
12 suggested by some that assisted living already exists
13 in an appropriate and approved form in Pennsylvania,
14 and that facility as so titled will face hardships if
15 forced to comply with standards that are actually
16 designed to meet the higher level of care and to
17 deliver the model of care called for in the creation
18 of this new licensure status. We must set aside the
19 idea that grandfathering of personal-care homes or
20 their staff is in any way appropriate.
21 As written, the assisted living regulations
22 do not go far enough toward meeting the ultimate
23 objective of quality care provided by adequate
24 amounts of appropriately trained staff in a safe,
25 supportive, and stimulating apartment-like setting.

1 PALCA has submitted extensive written
2 comments to the proposed regulations detailing the
3 critical issues that need to be addressed before the
4 regulations are finalized, and we have also submitted
5 detailed comments highlighting the positive changes
6 made to what exists for personal-care homes.
7 Those are in your packet, so I am not going
8 to go through that too much, because I know we are
9 also pressed for time. But I do want to stress that
10 all the good things that the department did do to
11 improve upon what we have in personal-care homes in
12 the assisted living regulations must be retained in
13 the final version of the regulations.
14 But again, I would like to draw your
15 attention today only to a few of our concerns, not
16 because any are less important but because I happen
17 to know what some other people might be speaking
18 about and I only have a few minutes.
19 They are, how is the facility staffed, and
20 how are the facility staff trained? We are concerned
21 about the training of administrators and their
22 designees. With assisted living comes entirely new
23 concepts and entirely new rules for administrators to
24 implement, rules around such things as Medicaid
25 waivers, interacting with residents' health insurance

1 as potential payers for health-care services,
2 implementing informed consent agreements, following
3 excludable condition requirements, and enabling aging
4 in place, all this along with providing, managing,
5 and overseeing the kind of care that this
6 greater-care-needs population will require.
7 Despite all these additional components an
8 administrator will be required to master and
9 implement, the proposed regulations require no
10 additional training hours, nor additional training
11 content beyond what is required to administer a
12 personal-care home.
13 For this reason, we strongly recommend a
14 training curriculum that is enhanced to cover
15 necessary content as well as dementia care and is
16 provided in no less than 150 hours prior to being
17 employed as an administrator.
18 We strongly support the minimum
19 qualifications of administrators. We urge that they
20 be adopted, and we oppose any effort to permit
21 personal-care-home administrators to be
22 grandfathered.
23 To be an assisted living administrator, one
24 must meet the administrator qualification
25 requirements from the personal-care-home regulations

1 plus have work experience. In fact, the only change
2 from what we have for personal-care-home regulations
3 is the addition of having work experience.
4 Many would suggest that individuals who
5 are grandfathered of having to meet those
6 personal-care-home regulation requirements that went
7 into effect in 2005 should again be grandfathered out
8 of having to meet this qualification requirement
9 again for assisted living, simply because they
10 already call themselves assisted living facility
11 administrators.
12 This is simply unthinkable given the
13 significant difference in administration, in
14 population, and in responsibilities of the
15 assisted living administrator.
16 The qualifications for administrator in the
17 proposed regulations are a bare minimum qualification
18 that all assisted living administrators must be
19 required to meet, with no exception or
20 grandfathering.
21 We strongly support the administrator and
22 designee, administrator or designee staffing
23 requirements of the proposed regulations. It has
24 been a travesty in personal-care homes that the
25 administrator is barely present.

1 There is no question that managing,
2 supervising, and overseeing all the moving parts of a
3 challenging 24-hour-a-day, 7-day-a-week business such
4 as an assisted living facility is a complex task.
5 How could it be acceptable that the one and only
6 person trained in how to manage, supervise, and
7 oversee a facility could be only present 20 of the
8 168 hours in a week?
9 Residents cannot confine their falls, their
10 strokes, their fevers, their need for access to their
11 funds, their desire to lodge a complaint about the
12 quality of care, their need for reassessment, or
13 other emergencies or reportable incidents to the
14 20 hours per week the administrator would be present
15 were the personal-care-home standard to carry over to
16 assisted living.
17 For this reason, PALCA strongly supports the
18 requirement that there be an administrator or an
19 administrator designee that has satisfactorily
20 completed the administrator training on duty at all
21 times.
22 We urge that there be minimum hours of
23 direct-care-worker training and that all direct-care
24 staff have first aid and CPR training.
25 The direct-care-staff training in the

1 proposed regulations is incomplete and insufficient.
2 Under the proposed regulations, direct-care staff
3 need not complete any minimum amount of hours of
4 training. Direct-care staff need not have any
5 training in first aid or CPR.
6 Clearly, given the care needs of the
7 anticipated assisted living resident population, more
8 training is needed.
9 I would like to draw your attention to the
10 context of this regulatory flaw. We have provided in
11 our testimony a chart that demonstrates the training
12 required for many jobs in this Commonwealth that do
13 not require any prior education level.
14 To be a nail technician, you must have
15 200 hours of training. To be a cosmetologist, you
16 must have 1,250 hours of training. To be a barber,
17 1,250 hours of training. To be a dog warden,
18 56 hours of training. And in fact a legislative
19 proposal that was floating around this building about
20 a year and a half, 2 years ago, would have required
21 300 hours of training to be a basic dog groomer. And
22 we have no minimum hours of training for a
23 direct-care staff person in an assisted living
24 facility. Surely caring for human lives calls for as
25 much if not more training.

1 PALCA is urging the State to adopt minimum
2 training hours no less than the 77-hour core
3 competency curriculum adopted and created by the
4 Workforce Task Force under the Department of
5 Labor and Industry that was comprised of stakeholders
6 from all sides of the aisle and to require that all
7 direct-care staff be trained in first aid and CPR.
8 Lastly, we urge higher staffing levels. As
9 written, the proposed regulations rely on the archaic
10 labeling of residents as "mobile" or "immobile" and
11 relies solely on those labels to determine whether
12 the resident needs 1 versus 2 hours of direct care.
13 This formula in turn defines how many staff
14 an ALR, an assisted living facility, must employ to
15 care for residents. This provision is another one
16 that remains completely unchanged from what we have
17 in the personal-care-home system -- once again,
18 despite the increased acuity for which
19 assisted living facilities are being licensed to
20 serve.
21 Instead of leaving the personal-care-home
22 calculus as is, the regulations should establish a
23 floor of at least 2 hours of care per resident
24 per day with the actual care hours above that, being
25 determined based on the assessed needs of each

1 resident.

2 The care needs should be identified by a
3 standardized mandated assessment tool, uniform across
4 all facilities, that calculates staff time required
5 to meet each identified care need so that licensure
6 staff can come into a facility and determine whether
7 adequate and appropriate amounts of staff are
8 present.

9 I thank you for the opportunity to share our
10 ideas with you today. Everyone in this room cares
11 very much about Pennsylvania's loved ones, and
12 everyone supports standards to ensure that they are
13 safely cared for in apartment-like settings that
14 promote privacy, autonomy, and most importantly,
15 dignity.

16 Thank you.

17 CHAIRMAN MUNDY: Next?

18 MS. KULP: I will go next.

19 Good morning. My name is Karen Kulp, and
20 I am the President and Chief Executive Officer of
21 Home Care Associates.

22 Home Care Associates is a worker-owned
23 home-care company based in Philadelphia. We have
24 about 200 employees, and over the course of our
25 history, we have probably trained 1,500 home-care

1 workers who work all over the Philadelphia area.
2 I was also on the work group that worked
3 with---
4 REPRESENTATIVE McILVAINE SMITH: Excuse me.
5 Could you please speak up?
6 MS. KULP: Sure.
7 REPRESENTATIVE McILVAINE SMITH: If you
8 could talk into the mike. Thank you.
9 CHAIRMAN MUNDY: Maybe you could switch
10 mikes, because my thought is that that mike is not as
11 good as the other one. Let's see if this one is
12 better.
13 MS. KULP: Is this better?
14 CHAIRMAN MUNDY: Yes.
15 MS. KULP: Okay.
16 So I was participating in a work group to
17 come up with assisted living regulations, and I can
18 tell you that it was a very time-consuming and, I
19 think, a really good process.
20 A lot of the folks that I saw many weeks in
21 a row are here, so it is good to see everybody again.
22 And I really do believe that people who did sit at
23 the table really tried to represent the best ideas
24 for regulating assisted living. So I just wanted to
25 say that off the top.

1 I commend the committee for holding this
2 herring to stimulate further discussion around the
3 issues concerning the proposed assisted living
4 regulations, which will create another option for
5 long-term care that is beneficial to consumers,
6 families, and providers.
7 I really think as we look at the long-term
8 care and ALRs, especially we have to really keep in
9 mind that we are really doing this for consumers and
10 for the residents of Pennsylvania, and to my mind,
11 that is the most important audience that these
12 regulations should be written for.
13 To meet the challenge of Pennsylvania's
14 growing elderly population, we must work to redesign
15 the current long-term-care system by expanding more
16 consumer-friendly options and controlling the costs
17 of such options.
18 Older Pennsylvanians must have an array of
19 care options, which now include in-home medical care,
20 personal care, personal-care homes, adult day
21 services, and skilled nursing-care facilities.
22 The Commonwealth's goal of achieving a
23 balance of 50/50, with 50 percent of our elderly
24 population being cared for in facilities and
25 50 percent being cared for in the communities,

1 I think is a laudable goal, but it is going to take a
2 lot of effort and energy, I think, for all of us to
3 achieve that.
4 Again, I really commend that the Department
5 of Public Welfare did establish this work group. I
6 think that we worked really hard to come up with
7 solutions. We didn't always reach consensus, but we
8 did have an opportunity to put out our ideas and
9 concerns, and I think that government should always
10 do that.
11 But what I am going to talk about are three
12 areas that are of particular concern to home-care
13 providers. I am also a member of the Pennsylvania
14 Homecare Association.
15 The first one is consumer choice. If
16 Pennsylvania is to meet its goal to create a balanced
17 long-term-care system by adding assisted living as
18 another option for long-term care, these regulations
19 must offer consumer choice, which is and has been a
20 guiding principle for all community- and home-based
21 services.
22 In fact, we are surprised that consumer
23 choice is not assured under the proposed regulations.
24 Members of our association believe that services
25 provided in an assisted living facility, like the

1 services we as a home-care agency provide in a
2 private home, should evolve around the needs and
3 wishes of the consumer.
4 The proposed regulations take away
5 consumers' choice of supplemental health-care
6 providers. Consumers should not be required to
7 surrender their choice of physicians, home health
8 care, hospice, personal care, and other specialists
9 by virtue of moving into an ALR.
10 While we welcome the ALR's assistance in
11 aiding residents and securing medical care and
12 supplemental health-care services, ALRs should not
13 mandate that consumers use only those health-care
14 providers that are approved or designated by the
15 residence.
16 Again, if ALRs are to be another option for
17 long-term care, which will enable individuals to
18 age in place, we must guarantee that consumers have
19 the same freedom to manage their own supplemental
20 health-care services as individuals do living in
21 their own homes.
22 Currently, many home-care agencies,
23 including Home Care Associates, provide aide services
24 to individuals living in assisted living residences.
25 These arrangements not only benefit the residents

1 throughout the consistency of care -- somebody that
2 they might have had in their homes -- it also works
3 to the advantage of the residents themselves, because
4 that person is often very familiar with the consumer
5 and can provide services that the residence cannot
6 provide and also can be a liaison between the
7 consumer and the other care staff.
8 At Home Care Associates, we have followed
9 many consumers from being in their own home into
10 assisted living and developed that relationship over
11 many years. So it is something that I think is
12 pretty sacred that we don't want to interrupt by
13 going to an ALR.
14 Having a consistent caregiver, not just an
15 aide, but whether it is medical care or a physical
16 therapist or whatever, I think is really key to
17 health-care quality and how people feel about their
18 heath care, and I cannot emphasis that enough.
19 So I think it is a really critical issue
20 that people can choose and stay with the providers
21 that they started with.
22 Under the proposed regulations, the
23 definition of "supplemental health care services"
24 under Section 2800.4 states that these types of
25 services are "any type of health care

1 service...except for any service that is required by
2 law to be provided by a health care facility under
3 the Health Care Facilities Act."
4 Because home health, hospice, and home care
5 are under the Health Care Facilities Act, this type
6 of care should not be listed under "supplemental
7 heath care services," which appear in 2800.22(c).
8 That distinction is of great importance for consumer
9 safety.
10 The Pennsylvania Department of Health
11 licenses all providers covered by the Health Care
12 Facilities Act, including these providers of home
13 care. As such, the department's primary job is to
14 establish and enforce quality care and safety
15 standards for these licensed health-care
16 providers.
17 Assisted living residences should not be
18 permitted to provide these licensed levels of
19 health-care services without utilizing a licensed
20 health-care provider, such as home health or a
21 home-care agency.
22 Second, the application and admission, and I
23 know that Crystal talked about this earlier.
24 Another area of concern is the application
25 and admission standards developed within the

1 regulations. As proposed, a consumer would have to
2 move in and sign a contract and begin payment before
3 the facility is required to identify the consumer's
4 needs, explain how it will meet those needs, and how
5 much these services would cost.
6 Although the proposed regulations provide
7 for a short-term prescreening checklist to determine
8 whether the consumer could be safely admitted to an
9 ALR or if their condition or needs prohibit their
10 admission, a residence is only required to perform a
11 comprehensive screening within 15 days after
12 admission to the facility.
13 In addition, the facility has until 30 days
14 after admission to develop the resident's actual care
15 plan. This is unacceptable.
16 As Pennsylvania attempts to build its
17 continuum of long-term care, which will provide
18 consumers with various options, it is just as
19 important to establish consistent standards across
20 the continuum for such things as assessments, care
21 planning, and staff training.
22 Nursing homes, home health, and the
23 Area Agencies on Aging all have mandated assessments,
24 care planning, and worker training requirements
25 within time frames that should be used as a guide to

1 establish similar mandates for assisted living
2 facilities.
3 Home health agencies are required to do an
4 assessment prior to start of care, followed by a care
5 plan, and the requirement of 75 hours for a home
6 health aide, which I think is really a minimum
7 requirement.
8 While there are differences among care
9 settings, consistent standards should be our goal
10 as we seek to establish a true long-term-care
11 continuum.
12 In-home services administered by the AAAs
13 also require an assessment and care plan prior to the
14 start of care and have a minimum 40-hour training
15 requirement for direct-care workers. We recommend
16 much shorter time frames for the assessment and care
17 plans that are within the same ranges as the other
18 options for long-term care.
19 If assisted living residences are given
20 15 days to do an assessment and a month to develop a
21 care plan, consumers are put in the untenable
22 position of having to move into a facility without
23 knowing for certain if it can meet their needs or if
24 they will be able to remain in the residence.
25 Assessments and care plans, like other care

1 settings, should be completed prior to receiving the
2 care and support.
3 Thank you.
4 CHAIRMAN MUNDY: Thank you.
5 Who is next?
6 MS. SHAFER: Good morning.
7 CHAIRMAN MUNDY: Good morning.
8 MS. SHAFER: Can everyone hear me?
9 CHAIRMAN MUNDY: So far so good.
10 MS. SHAFER: Okay.
11 Good morning, Chairwoman Mundy, Chairman
12 Hennessey, and Representatives and staff of the House
13 Aging and Older Adult Services Committee.
14 I am Jacqueline Shafer, and I am speaking on
15 behalf of 29,000 members of the Pennsylvania Bar
16 Association.
17 And like many kindred spirits that I have
18 just recently discovered in this room, I also worked
19 for 16 years in the long-term-care industry in a CCRC
20 before joining the profession of the law.
21 I am a member of the PBA and serve on the
22 counsel of the PBA's Elder Law Section. A portion of
23 our mission is to improve substantive laws affecting
24 the elderly clients we represent. We thank you for
25 inviting the PBA to testify on this important topic.

1 The Pennsylvania Bar Association has great
2 respect for the fact that the Legislature embraced
3 the need for a level of care known as assisted living
4 within our State.
5 We believe the Office of Long Term Living
6 and the Department of Public Welfare have made an
7 excellent beginning, identifying many elements that
8 will serve as the foundation for a carefully crafted
9 set of regulations to serve some of the very frail
10 and vulnerable of Pennsylvanians.
11 However, while we want to be supportive of
12 this process and of the need to develop regulations
13 for the assisted living industry, we have also
14 discovered several areas of deep concern.
15 Therefore, the PBA formally opposes several
16 elements of the proposed assisted living regulations
17 in their current format and content, because they do
18 not represent the best interests or the needs of the
19 elderly community in our Commonwealth.
20 The PBA includes more than 800 attorneys in
21 its Elder Law Section whose practices are primarily
22 dedicated to Pennsylvania's large senior citizen
23 community.
24 These services that these lawyers render to
25 their clients include advice and counsel regarding

1 retirement life, end-of-life decisionmaking, housing
2 placement issues, contract review, completing
3 applications for living arrangements, and for public
4 benefits, and they often continue to assist these
5 clients when adverse decisions require an appeal to
6 the appropriate authority.
7 Seniors have a variety of housing
8 alternatives in Pennsylvania. Unfortunately, not all
9 of these alternatives are feasible for all seniors,
10 for both economic and service delivery reasons.
11 Our consumers may be private pay or on
12 public benefit, but all are potential patrons of
13 assisted living facilities. As such, they must be
14 able to distinguish between what is offered at
15 various levels of care in order to make an informed
16 decision prior to the signing of any contract for
17 care.
18 One of the very ubiquitous and we think
19 fundamental questions that arise from our contact
20 with clients is, what is the difference between
21 personal care and assisted living? It is a very
22 common question.
23 We were earnestly hoping that the proposed
24 regulations offered us a clear method of distinction,
25 a way that would make the differences clear to us so

1 that we could better advise our clients.
2 Unfortunately, we are all as much in the dark after
3 these regulations were issued as before.
4 Another question often posed by our clients
5 is, how can I make a fair comparison between these
6 facilities so that I know my needs will be met and
7 that I can afford to go there? It seems to us that
8 this is a very basic question, and yet, again, we are
9 unable to give clear direction to these clients
10 because the regulations as written offer little in
11 the way of comparison of what we think these distinct
12 levels of care are.
13 We believe this is partly what the
14 discussion about preadmission screening contains. If
15 a resident had a preadmission screening performed and
16 it was required under the regulations, we would know,
17 they would know, and more importantly, the facility
18 would also know whether or not they could truly meet
19 those regs or those needs.
20 A third question which also arises with
21 frequency is, what if the facility says that they can
22 no longer meet my needs and that they want to
23 discharge me? Do I have any recourse to object? Any
24 way to appeal their decision? Well, at the moment,
25 we do not think so, but "caveat emptor" should be

1 emblazoned across the front of their resident
2 agreement.
3 And I would like to just add here, while I
4 was listening to the former panel, I noted in the
5 ombudsman discussion there is a parallel in the
6 law.
7 I am an elder law attorney, and as such, I
8 generally would be on the plaintiff's bar. However,
9 I am also trained as a mediator, and when I'm in
10 mediation, I'm forbidden to also represent a client,
11 and I think that analysis bodes well for the
12 discussion of what the ombudsman's role is as
13 essentially a mediator and an advocate. The two
14 elements just are incompatible with one another.
15 While the assisted living statute and the
16 proposed regulations are an important conceptual step
17 in Pennsylvania's commitment to help seniors to
18 age in place, the current regulations fall short of
19 providing the framework necessary to achieve this
20 objective.
21 As attorneys, we have focused our comments
22 upon those sections of the proposed regs which
23 interfere with our ability to adequately and
24 effectively represent this vulnerable population of
25 consumers.

1 We are also concerned that the proposed
2 regulations do not provide an overarching and
3 fundamental set of rights that afford even
4 unrepresented seniors a modicum of security that
5 their long-term living purchase will be a sound one,
6 and in the event it is not, that they have a clearly
7 defined path for redress.
8 In light of the foregoing, we have provided
9 the comments that we submitted to the Department of
10 Public Welfare and the Independent Regulatory Review
11 Commission on the proposed assisted living regs
12 published August 9 with reference No. 14-514.
13 On behalf of the members of the Pennsylvania
14 Bar Association, thank you again for inviting us to
15 testify, and we are available to answer questions or
16 provide any additional information.
17 Thank you.
18 CHAIRMAN MUNDY: Thank you.
19 MS. MENIO: Good morning.
20 My name is Diane Menio, and I am the
21 Executive Director of CARIE, which stands for the
22 Center for Advocacy for the Rights and Interests of
23 the Elderly.
24 Thank you for sponsoring the hearing today
25 about the proposed assisted living regulations and

1 the opportunity I have to comment here today.
2 As a member of the Assisted Living Workgroup
3 of the Department of Public Welfare, I appreciate
4 being part of the process that DPW and the Office of
5 Long Term Living undertook and understand the
6 challenges of trying to address the concerns of a
7 variety of stakeholders, many with opposing views
8 in drafting regulations, also drafting the
9 legislation.
10 As the formal regulatory review process
11 begins, the tug of war over conflicting ideas will
12 no doubt continue, and you will hear about those
13 today.
14 As a member of the Pennsylvania
15 Assisted Living Consumer Alliance, we were very
16 much a part, an active part, of developing
17 recommendations, and we do support the comments and
18 recommendations submitted by PALCA today.
19 I am going to kind of jump through this
20 because I was asked to not take up too much time, so
21 I am going to go to some key points that I want to
22 talk about.
23 First of all, one of the things that we
24 really haven't talked enough about is marketing
25 standards, and this is something that we experience

1 directly through the consumers who call us.

2 One of the things we do is coordinate the

3 statewide Medicare fraud prevention project, and

4 through that project, we have witnessed the impact of

5 marketing abuses on consumers as well as the cost to

6 the system.

7 I also want to talk a little bit about

8 something personal to me. My mother has dementia,

9 had a rapid decline this summer, and at the time when

10 she was in the middle of all of this and we realized

11 she could no longer be safe at home, I started

12 looking at various options, and I called a number of

13 personal-care homes thinking that assisted living

14 might be the good option, more home-like and so on.

15 And I called one of the places, and I will

16 just tell you about one of my calls; I had several

17 that were kind of interesting. But one of the calls

18 I had, I got this wonderful marketing spiel when I

19 called, and they told me how lovely it would be there

20 and they told me that, you know, she would certainly

21 have a single room. And they said, did you look at

22 our online tour on the Web site? And I said yes, I

23 did, and eventually I got to the point of asking them

24 -- well, first of all, they called themselves

25 assisted living, and I said, do you know about the

1 new law that passed, by the way? And she knew
2 nothing about it. And I said, well, do you think you
3 will want to apply? And of course she didn't know
4 anything about that. But when I said to her, so you
5 know that one of the provisions in the law is that
6 you won't be able to call yourselves assisted living
7 anymore, and one of the things she said to me was,
8 well, then I guess we'll call ourselves senior living
9 or something else.
10 And I have to say that currently the
11 confusion that consumers have over this terminology
12 of assisted living, senior living, personal-care
13 homes, they really do not, even nursing homes, many
14 people go into assisted living or personal-care homes
15 and they think they are in a nursing home. Consumers
16 really are very confused, so we really need to think
17 about the terminology.
18 But after I got into this and I started
19 asking more questions, I said, now what happens? My
20 mother is kind of young; she's 74 years old. And I
21 said, what happens if my mother runs out of money;
22 what will happen? And I got this assurance that "We
23 put no one out; we take care of everyone." And I
24 said, well, what does that mean, because she won't
25 have the money to pay. "Well, what we would do is we

1 would move her to a low-income room." Now, I said,
2 what does that look like? And she said, well,
3 there's four people in a room. Now, this is from the
4 single room that she would nicely have to a room with
5 four people in it. And I said to her, I said, well,
6 gee, that is interesting; I didn't see that on the
7 online tour.
8 And I wanted to talk about that, because
9 that speaks to the marketing issue. What I was being
10 told, and if I had not been an informed consumer, and
11 believe me, I also have to tell you that the
12 experience that I am going through with my mother has
13 taught me that I really know nothing, and as informed
14 as I like to be and as much as we help our clients
15 who call us every day, this is new territory for me.
16 And, you know, I can also tell you that
17 right now, my mother is in a nursing home, and it was
18 a very difficult decision for me to make, to make
19 that placement in the nursing home. But I can tell
20 you that she is in what some people might call the
21 gold standard of nursing homes, a wonderful place,
22 and the place she is in is a locked unit. There are
23 about 20 residents.
24 I spend a lot of time there, as do other
25 family members, and when I'm there in the evening,

1 there are between six to seven staff, nurses, aides,
2 and activity staff. Very important staff, by the
3 way, the activity staff. And with that and the
4 20 residents, or up to 20 -- they have 18 to 20
5 usually -- those people are very well taken care
6 of.
7 My mother has been there 2 months. She has
8 fallen about six times. I have my cell phone right
9 here because I get a call every time we have a
10 problem. I never used to carry it. In fact, I have
11 gotten in a lot of trouble because I didn't answer
12 it. But now I have to be; I am on alert constantly,
13 because things do go wrong.
14 I am really concerned, and I have had people
15 say to me, why not an assisted living? Well, I'm
16 really concerned when I look at the staffing levels
17 in assisted living. And my mother could have been
18 admitted to an assisted living, because her primary
19 issue is dementia. So I am very concerned about
20 that.
21 I do want to just point you to the comments
22 of Carol Cirka and Carla Messikomer of Ursinus
23 College. They did a study called "*Ethical*
24 *Perspectives in Assisted Living: A Leadership Role*
25 *for Pennsylvania*," and they made a number of

1 recommendations. I cannot go through them all today,
2 but they do suggest establishing standards for
3 ethical marketing practices that focus on consumer
4 disclosure and advertising policies.
5 People need to know what aging in place
6 means, really means. People need to know what they
7 can see when they get there. People need to know
8 what kind of training staff gets. People need to
9 know how many staff are present to take care of those
10 needs. What is going to happen when mom falls? You
11 know, how long is it going to take for someone to get
12 there and help her?
13 Those are all very important things for
14 consumers to know, because believe me, most consumers
15 do not know those questions to ask, and it needs to
16 be right up front.
17 I also want to just talk a little bit about
18 the rights of residents. Again, this ties right in
19 with knowing what you are buying.
20 People need to know specifically what their
21 rights are. The proposed regulations really need to
22 be modified to identify the specific rights of
23 assisted living residents and that resident be
24 informed of all of their rights and how to use them
25 in an understandable manner and ensure they are free

1 to exercise these rights without repercussions, and I
2 believe the first testifier talked about that, the
3 need for a non-retaliation clause.
4 And we are, by the way, a long-term-care
5 ombudsman in Philadelphia, so we have direct
6 experience with the program. We have been doing this
7 program for more than 25 years now.
8 As an ombudsman, we routinely deal with
9 issues related to residents' rights for residents in
10 nursing facilities and personal-care homes, as well
11 as problems with inappropriate discharges. We field
12 inquiries from both hospitals and families about
13 problematic discharges from homes. Unfortunately, we
14 usually receive these calls after the discharge
15 occurred.
16 For hospitals, the problem is usually that
17 the facility sent a resident to the hospital but it
18 is refusing to let them return. They are not
19 acting under the same requirements the nursing homes
20 have.
21 When we hear from families, they were often
22 unaware of the discharge process or their rights and
23 are trying to resolve the problems associated with
24 inappropriate discharges, but by then, believe me, it
25 is too late.

1 It is also a common complaint to hear from
2 residents that facilities threaten to discharge them
3 if they don't comply with a particular request or
4 policy. The threat of discharge or being punished
5 for complaining is a fear that many residents and
6 families have that can impact their quality of care
7 and life.
8 In one personal-care home, each time our
9 ombudsman visited, he learned that afterwards,
10 residents were grilled as to what they had discussed.
11 On several occasions after returning to that
12 facility, residents withdrew their complaints.
13 We need to make sure that this does not
14 happen and that residents and families feel
15 comfortable voicing concerns and that they get some
16 response.
17 We strongly recommend the addition of adding
18 the following rights: the right to choose
19 health-care providers subject to limitations on the
20 choice of supplemental health-care providers, and
21 that is pursuant to section 2800.142; a resident has
22 the right to refuse treatments or services prescribed
23 or recommended; a resident has the right to manage
24 his or her own financial affairs; and a resident has
25 the right to reside and receive services with

1 reasonable accomodation of individual needs and
2 preferences except where the health and safety of
3 other residents would be endangered.
4 The requirements for a 30-day notice and an
5 appropriate discharge need to be expanded to include
6 specific appeal rights or an appeal process to ensure
7 that residents can challenge a facility's decision
8 regarding discharge. The resident should be
9 guaranteed the right to stay in the facility during
10 the appeal process, and if the facility facilitates
11 an inappropriate or unsafe discharge, penalties
12 should be imposed.
13 For example, a facility should not be
14 permitted to discharge a resident to the home of a
15 caregiver unwilling or unable to care for the
16 resident, a homeless shelter, or an unlicensed
17 boarding home.
18 And I mention a homeless shelter because we
19 had this. If fact, we handled a complaint last year
20 successfully of a nursing home that was ready to
21 discharge a resident to a homeless shelter, believe
22 it or not.
23 Facilities should also provide a list of
24 residents' discharge rights when issuing a discharge
25 notice, since this information is given upon

1 admission and is often forgotten when a discharge
2 notice is issued.
3 And I can tell you, having signed admission
4 papers, that it is voluminous and people do not have
5 the time to read all of that or necessarily keep it
6 in a place where they can refer to it from time to
7 time.
8 Residents' rights should be expanded to
9 address the need for Resident and Family Councils.
10 And I have to say that this is something that is so
11 important as we find, and right now it happens in
12 some personal-care homes but mostly in nursing homes.
13 And it is a good time for residents and staff and
14 families to have a dialogue around some of those
15 issues that maybe they do not feel as comfortable
16 complaining as an individual, but as a group they may
17 be able to do that.
18 The regulations do grant residents the right
19 to freely associate, organize, and communicate with
20 friends, family, physician, attorney, and other
21 persons. Residents should also be able to organize
22 and meet in a facility in a private space without the
23 presence of staff unless invited by the group.
24 And we do think the staff should designate a
25 person to assist the group and respond to any written

1 requests from the meetings, and the staff should
2 respond to any complaints or recommendations made by
3 the council.
4 The same rights should be granted to family
5 members wishing to organize and meet about the care
6 and services provided in a facility, as we know that
7 there are many mentally impaired clients who may not
8 be able to meet on their own.
9 Resident and Family Councils have proven to
10 be effective means to help residents and their
11 families discuss concerns and resolve problems. The
12 councils also allow for guest speakers to attend
13 meetings and provide education on topics identified
14 by the group.
15 The addition of Resident and Family Councils
16 fits with the department's description: "The
17 proposed rulemaking protects consumers' health and
18 safety, privacy and autonomy...."
19 I also wanted to address informed consent.
20 We have serious concerns about the informed consent
21 provisions of the law.
22 While we do believe that it is important for
23 consumers to be informed and educated, we do not see
24 any advantage to consumers in signing a contract that
25 might limit their individual rights. By signing,

1 consumers are relinquishing the rights they have
2 under law to refuse medical treatment and to make
3 decisions about their care.
4 The support planning process is actually a
5 wonderful vehicle for discussing concerns about
6 whether those decisions are placing the resident at
7 risk and to arrive at mutually agreeable methods of
8 addressing them.
9 If agreement is not possible and the
10 consumer continues to wish to exercise their rights,
11 the residents have other remedies available. They
12 can document their efforts to educate the consumer
13 about potential harm or risk, and in some
14 circumstances, they might even discharge that
15 resident for illegal reasons.
16 We know that facilities are quite concerned
17 about liability. However, we are concerned that the
18 informed consent process could be abused in order to
19 limit the liability of the facility.
20 We also believe that there are too many
21 unanswered questions about how this process will
22 work. For example, a residence can initiate an
23 informed consent process when a consumer's behavior
24 is placing other residents at risk, but that
25 agreement cannot result in an agreement that places

1 other residents at risk, so what is the point of
2 using a consent agreement in that situation?
3 There must be an independent advocate
4 available for consumers to ensure that when they are
5 signing an informed consent agreement, what it means
6 for them.
7 I do want to say that the use of the
8 ombudsman, I believe, is inappropriate. Jacqueline
9 mentioned that lawyers are also not mediators, but I
10 do believe that legal services providers can help
11 people understand contracts and can represent
12 consumers.
13 I also wanted to mention, Crystal had talked
14 about the underfunding of the Ombudsman Program.
15 Legal Services is another critical program that is
16 underfunded in the Area Agencies on Aging and a very
17 important role. This, I think, is a very important
18 role for Legal Services staff. The ombudsman, as you
19 know, is not trained to negotiate contracts.
20 And I also would say that the Federal rules
21 governing the Ombudsman Program really permit this
22 function. The Federal statute identifies the
23 ombudsman as the "resident advocate," which means
24 that the mediator role is simply inappropriate under
25 Federal law, and I would urge you to look at Federal

1 law before implementing this provision.
2 The resident often is an older adult with
3 multiple health problems. The provider benefits from
4 legal counsel and other support and experience.
5 Again, without someone who represents that resident
6 -- and this is why I mentioned an attorney --
7 understanding that contract is extremely critical.
8 There is one particular nursing facility in
9 our area, and this is the closest we can get to
10 having experience with negotiated risk or risk
11 contracts. They require certain residents or
12 residents who have had acting-out behaviors or
13 behaviors that were not acceptable to that facility
14 to sign what they call a "behavioral contract."
15 With the ombudsman speaks to residents about
16 those contracts, they respond by stating that they
17 believed they had to sign it or faced being
18 discharged, even though they did not understand or
19 agree with the contract.
20 The contract does not resolve the underlying
21 behavioral problems and in fact is more likely to
22 escalate problems when staff refers to the contract
23 at times when residents are acting out.
24 While the proposed regulations state that a
25 licensee may not require execution of an informed

1 consent agreement as a standard condition for
2 admission, an applicant should not be denied
3 admission for refusal to sign an informed consent
4 agreement under any circumstances, particularly
5 without the right to appeal.
6 Section 2800.43(c) states that waiver of any
7 residents' rights shall be void. This is what we see
8 happening in the behavioral contracts, and we fight
9 them for residents, and we usually win.
10 This seems to be in conflict with the
11 signing of an informed consent agreement that
12 specifically waives residents' rights. With so much
13 potential for confusion and abuse, it is apparent
14 that an independent advocate be available to help
15 consumers and families navigate this challenging new
16 provision.
17 I do guarantee you that the ombudsman will
18 be very busy with these also as the residents'
19 advocate.
20 The last point I wanted to make is -- well,
21 actually, I am skipping over that last point.
22 The vulnerable assisted living residents
23 deserve the best possible standards of care and
24 effective enforcement of those standards, and
25 "enforcement" should be in all capital letters

1 because enforcement is so critical here.
2 And, you know, the regulations are only as
3 good as enforcement, and we have experienced that
4 every day. So we really hope that we are able to
5 have strong enforcement of these regulations.
6 We hope we can count on your support to help
7 ensure that the final regulations will ensure the
8 health, safety, and well-being of older
9 Pennsylvanians who will reside in assisted living
10 residences in Pennsylvania and that the final form
11 regulations will include our recommendations as well
12 as those of PALCA.
13 Thank you again for providing the
14 opportunity to testify today.
15 CHAIRMAN MUNDY: Thank you.
16 Next?
17 MS. ANTHONY: I want to thank you very much
18 for the opportunity to provide comments today. And I
19 apologize for my back to some of you.
20 As a person with a disability, I did
21 participate in the work group and I participated in
22 the coalition's paper that you have before you.
23 But as a person with a disability, I wanted
24 you to hear from someone who has been in these
25 facilities for many years and as someone who has a

1 sister who works in nursing homes and assisted living
2 for the last 20 years, and just my own personal
3 experience and knowledge during a recent illness.
4 It was suggested I might want to think about
5 an assisted living facility. So that, along with
6 some other things, compelled me to come here today to
7 talk to you.
8 My name is Linda Anthony, and I work for the
9 Disability Rights Network of Pennsylvania. DRN is a
10 statewide, nonprofit, federally-mandated organization
11 whose mission is to advance and protect the rights of
12 Pennsylvanians of all ages with disabilities.
13 Our clients are among those who may need
14 and/or want assisted living services that maximize
15 their independence while affording them appropriate
16 care. One day, I may be one of those clients.
17 You will hear today from many professionals
18 and providers who will testify in favor of and in
19 opposition to various parts of the proposed
20 regulations. But I want you to hear from me, because
21 I am out here, in the real world, living with a
22 disability and dealing with these facilities for the
23 last 25 years.
24 It does not matter whether you acquired your
25 disability, as I did, on an icy country road on the

1 way to work one morning, whether you were born with a
2 disability, or whether you acquire a disability as
3 you age.
4 From my experiences, I understand what it is
5 like for people who reach 80 or 90 years old and need
6 assistance for many aspects of their life. I know
7 what it takes to get around in a wheelchair, and I
8 know what I need to manage my bowel and bladder
9 routine, of which I no longer have any control but
10 which I have learned to manage from my day-to-day
11 living.
12 I know what it is like to be totally
13 dependent on others or equipment for breathing, for
14 staying healthy, for moving within my community, and
15 for having a life of my choosing.
16 I struggle every single day of my life, but
17 good assisted living residences can be the answer for
18 some of us struggling to keep some choices in our
19 life and stay out of nursing facilities.
20 We applaud the administration for requiring
21 facilities to have at least 250 square feet of living
22 space for new construction. That is the minimal
23 amount of space that I need to be able to maneuver
24 this wheelchair that I am using today.
25 Think about your routine in the morning as

1 you prepare for the day. Simply turning around to
2 face another area in the room requires a five-by-five
3 foot turning radius. The required 250 square feet
4 will still be tight for some people using wheelchairs
5 or walkers, but without this minimal amount, people
6 will be forced to back up, risking falls and other
7 damage, to be able to access all areas of their
8 living space.
9 Many people with disabilities who enter an
10 assisted living facility need some form of assistance
11 to manage their day-to-day activities. That is why
12 they appear at the door.
13 Whether that assistance is in the form of
14 using a wheelchair, a walker, or other mobility
15 device, they often seek out alternative living
16 arrangements because of their mobility needs.
17 Over 21 percent of the people who will be
18 living in assisted living facilities will use
19 wheelchairs, and another 44 percent will use
20 walkers.
21 And as individuals with disabilities age,
22 their mobility needs often increase and change from
23 one type of mobility aide to another, such as a
24 walker to a manual wheelchair, to a motorized
25 wheelchair or a scooter.

1 With over two-thirds of assisted living
2 residents needing accessibility from mobility aides
3 or transfer aides like a Hoyer lift, we strongly
4 support the requirement of 250 square feet per living
5 unit, including accessible bathrooms without
6 exception, for both new construction and existing
7 structures.
8 It is my fervent hope that you will reject
9 the industry's plea to waive this requirement to
10 allow for 175 square feet in the living unit in
11 existing structures. It is just too small to be able
12 to get around.
13 One of the most terrifying things for people
14 who use wheelchairs, walkers, or who simply cannot
15 move quickly is the fear that they will not be able
16 to get out of a building in a fire, and all too
17 tragically, here in Pennsylvania, people have
18 perished in buildings where there was no good
19 evacuation plan or poor signage and preparedness for
20 such a disaster or poor maintenance of a facility's
21 safeguards.
22 As a professional, I enter buildings almost
23 every day that I would have difficulty evacuating in
24 the event of a fire. As a wheelchair user, I trust
25 that professionals within the structure have done

1 their job of giving me a good path and a good plan
2 to escape. I accept these daily challenges and I
3 pray.
4 We applaud the administration for proposing
5 that fire safety approval be renewed every 3 years,
6 that all living units have a fire extinguisher and
7 smoke detector, and finally, that the facilities at
8 all times be under the supervision of a person who is
9 trained and knows how to operate and manage the
10 facility.
11 This is a vast improvement over what we have
12 seen in the personal-care-home system where a
13 qualified individual need only be present in the
14 facility 20 of the 168 hours in a week.
15 Lives in Pennsylvania will be lost when
16 fires and other disasters strike these
17 assisted living facilities if the regulations fail to
18 address older construction that does not meet current
19 fire or life safety or if the regulations grandfather
20 these older facilities so that they will never have
21 to come up to current standards for safety and
22 accessibility.
23 We support the Administration's commitment
24 to the idea that assisted living can and should be a
25 facility where people can "age in place," as

1 evidenced throughout these proposed regulations.
2 The regulation that the entire facility must
3 be air-conditioned is a good example. As a person
4 with a spinal-cord injury and a person who is aging
5 -- quickly -- I find it difficult to lower my body's
6 temperature once it has been exposed for any length
7 of time to extreme heat. This has caused a number of
8 health consequences.
9 Without this requirement of providing
10 air-conditioning for the entire facility, many
11 residents would not be able to function or maintain
12 their health.
13 People with multiple sclerosis or a history
14 of strokes, blood pressure problems, bedsores, and
15 other skin-related disorders cannot live without the
16 relief of an air-conditioned environment. It may
17 seem like a luxury to some, but it is a lifeline to
18 others.
19 We again applaud the Administration's
20 requirement that all living units must have
21 kitchenettes with counter space, cabinet, microwave,
22 refrigerator, and access to a sink.
23 Illness or just a really tough day may limit
24 my desire to leave my home or to share a meal.
25 Sometimes, all I want is a cup of soup, a cup of tea,

1 or a sandwich, or I just want to warm up something a
2 friend has delivered which I could not eat when it
3 arrived because I just could not eat right at that
4 moment.
5 Having the ability to access these small
6 amenities within my own "home" is very important to
7 me, my overall disposition, and ultimately my
8 health.
9 If the facility is truly to allow persons to
10 "age in place," it is imperative that we support the
11 regulation to require assistance with meals and
12 cueing for meals for residents who require this
13 assistance. This would allow people truly to "age in
14 place" as their abilities decrease.
15 Another reality for those with mobility
16 disorders is the development of a decubiti. These
17 are sores or holes in the skin that occur when there
18 is excessive pressure to one area of the body. I
19 have not met a person with a mobility disability who
20 does not know or who has not personally been
21 inflicted with the problem of a pressure sore,
22 whether due to poor seating, prolonged illness, or
23 prolonged lack of movement from one position.
24 I am extremely distressed that the proposed
25 regulations permit the facility to discharge a

1 resident because of a decubiti. A much better
2 approach would be to implement a plan as designed by
3 the person's physician, bringing in additional health
4 professionals as prescribed and/or, if necessary,
5 admit the person to a hospital.
6 Upon discharge, the person should be able to
7 return to his or her assisted living facility,
8 especially when he or she continues to pay rent while
9 he or she is in the hospital.
10 Likewise, some of the excludable conditions
11 provisions which permit rejection and discharge must
12 be made more fair and reasonable so that we can
13 protect the resident's ability to remain in the only
14 place that the resident calls home.
15 When a resident or family member is told
16 that the person will be able to "age in place," he or
17 she expects that when that person's mental capacity
18 begins to diminish as he or she gets older or new
19 disabling conditions begin to occur, the person will
20 be able to stay in the familiar surroundings he or
21 she now calls home.
22 Removing someone from familiar surroundings,
23 the upheaval of moving once again, and the individual
24 and the family member's frustration with finding new
25 and reliable housing arrangements are things that

1 only aggravate the cognitive impairments that older
2 adults endure.
3 We strongly support the Administration's
4 proposed regulation to require all assisted living
5 facilities to provide cognitive support services as
6 another assurance that the person will indeed be able
7 to "age in place."
8 One of many lessons that I have learned over
9 the last 25 years while having a spinal-cord injury
10 is the absolute lifesaving job of finding or training
11 a physician, specialized or otherwise, who will
12 listen to you, and I mean really listen to you.
13 Because of the cellulites that has plagued
14 me for 14 years, I have found an excellent physician,
15 an infection-control doctor, who has not only helped
16 me cut down the revolving door that so often
17 accompanies bouts of cellulites, but he has helped me
18 cut down the onslaught of very serious instances that
19 have often led to hospitalizations and dangerously
20 close calls with death.
21 Having access to the medical doctor who
22 treats me for general purposes is so enhanced by his
23 exposure and experience with me as a person with a
24 spinal-cord injury that having to go to a doctor who
25 is unaware of my past medical history has had some

1 dire consequences for me.
2 While we wholeheartedly support the proposed
3 regulation that will require assisted living
4 facilities to obtain medications prescribed for the
5 resident and to maintain an adequate amount of the
6 resident's medications on-site, we cannot support the
7 proposed regulations which give the facility total
8 control over where residents get all of their medical
9 care and supportive services. In fact, the proposed
10 regulations would allow a facility to force a
11 resident to use providers that the facility
12 chooses.
13 If I am a resident in an assisted living
14 facility and I become ill, I should have the
15 availability of outside health-care services,
16 especially when it prevents hospitalization or
17 further disabling consequences. Using outside
18 providers also provides a check-and-balance system
19 that the person is receiving adequate care and
20 support in the facility.
21 People must have the right to their choice
22 of providers. Although some would say a doctor is a
23 doctor is a doctor, for those of us living with a
24 disabling condition, it is all too often a matter of
25 life and death.

1 We thank you for allowing us to provide
2 comments on these regulations and look forward to the
3 development of yet one more option for people and
4 their families in meeting long-term-care needs and
5 supports.
6 Thank you.
7 CHAIRMAN MUNDY: Thank you. Thank you all.
8 You have given us a lot to think about.
9 Representative Gingrich.
10 REPRESENTATIVE GINGRICH: Thank you,
11 Madam Chairman.
12 And thank you all for your testimony. It is
13 so important and so enlightening as well.
14 First of all, is it Diane? I got my phone
15 here. I have got an 88-year-old dad who fell three
16 times during the night this week, an 85-year-old mom
17 who is bearing the burden of his care, but thank
18 goodness we have got 10 kids, 10 siblings to help
19 with the effort.
20 But we are making all those decisions, too,
21 so many of us in this room are taking this very
22 personally and trying to render things for ourselves
23 when the time comes.
24 Ms. Shafer, sometime when we have time,
25 let's talk about our professional backgrounds. I

1 have a couple of questions for you from your legal
2 testimony here.
3 First of all, I love the first question:
4 What's the difference? My goodness, this is what we
5 have been struggling with for all these many almost
6 two decades now, what is the difference between these
7 levels of care and particularly personal care and
8 assisted living, and that is what we all want to get
9 to.
10 So I was just curious about, I like your
11 comment about the bundling. Obviously, you know, if
12 we are going to compare apples to apples, we have got
13 to know what to tell people, and I have gone for many
14 years of trying to counsel people, too, and explain
15 how these systems work.
16 In fact, that is the main reason why I left
17 my position as a director of marketing for a large
18 CCRC, to help people understand and ferret through
19 this information. So bundling is kind of an
20 important issue here.
21 And I see what you put together as a
22 standard basic. Where did you come up with that? Is
23 that something that you have seen done in other State
24 statutes?
25 Not that I disagree; I think you have done a

1 comprehensive job of that. Just curious about that.
2 MS. SHAFER: Well, some of it,
3 Representative, was my own experience from what is
4 likely to be bundled and what is likely to be seen as
5 a standalone service or something for which a
6 fee-for-service would be applied.
7 But also, this particular group came up with
8 an excellent list, and part of the core services that
9 we felt as though were absolutely necessary as a
10 baseline indication of what is provided in
11 assisted living uniquely was the result of this
12 collaborative effort.
13 REPRESENTATIVE GINGRICH: Well, then I
14 commend the group.
15 And it is equally important that extended
16 services are made clear to people coming in, because
17 they are envisioning what needs they might have later
18 on---
19 MS. SHAFER: Right.
20 REPRESENTATIVE GINGRICH: ---and they are
21 going to want to know what is there, what is
22 accessible, and what that cost is as well.
23 MS. SHAFER: Correct.
24 REPRESENTATIVE GINGRICH: So I think those
25 are very important points, and I want to thank you

1 for bringing that out.
2 MS. SHAFER: Thank you.
3 CHAIRMAN MUNDY: Representative
4 McIlvaine Smith.
5 REPRESENTATIVE McILVAINE SMITH: Thank you,
6 Madam Chairman, and thank you all for being here
7 today also.
8 I wanted to follow up with Ms. Halperin,
9 that I really appreciated that chart that shows us,
10 you know, that the dog warden is getting 56 hours.
11 I was not aware of how many others, you know, have to
12 have hours and are regulated, et cetera, and
13 personal-care-home people and assisted living are
14 not.
15 But I have a personal experience also. When
16 my husband was in a nursing home, the problem is
17 keeping staff, because nobody can pay them the amount
18 of money, you know, to make a living wage to be able
19 to support themselves. And I hear this over and over
20 again, but I witnessed it firsthand. People were
21 coming and going, and you put all of that time and
22 energy and money into training these people, and if
23 you cannot afford to pay them, they are still going
24 to move on.
25 But I agree with you that we need to up our

1 services; we need to make sure people are trained.
2 But can you comment on my comment, please?
3 MS. HALPERIN: Well, frankly, I think that
4 everything I have heard from SEIU, for example, and
5 the direct-care workers that have been part of the
6 Pennsylvania Assisted Living Consumer Alliance and
7 talked about this issue speak to the fact that
8 workers that are well trained and workers that are
9 well supervised are less likely to leave. They stay;
10 they feel better. They feel more confident that they
11 know what to do and how to do it.
12 I would like to also, if you wouldn't mind,
13 let Diane speak to this also, because she ran an
14 entire direct-care workforce project.
15 REPRESENTATIVE McILVAINE SMITH: Sure.
16 MS. HALPERIN: But, you know, I do not think
17 we should sacrifice quality and care, and, you know,
18 I am fully supportive of finding funding streams to
19 help support, you know, this industry and ensuring
20 that care gets provided.
21 REPRESENTATIVE McILVAINE SMITH: And where
22 would those funding streams, where do you envision
23 them coming from, please?
24 MS. HALPERIN: Well, first of all, we
25 support the creation of an assisted living waiver.

1 We support the addition of personal-care services to
2 the Medicaid State plan to pay for the personal-care
3 services component for people who are in a nursing
4 facility and are clinically eligible. And we support
5 there being an assisted living facility SSI
6 supplement, similar to what we have in personal-care
7 homes but obviously with an adjusted amount to
8 account for, you know, the model of care.
9 REPRESENTATIVE McILVAINE SMITH: Okay.
10 Thank you.
11 And then, Diane, if you wanted to comment,
12 please.
13 MS. MENIO: Thank you.
14 Just last year, we wrapped up a 4-year
15 project called *"Better Jobs Better Care*
16 *Pennsylvania,"* which is part of a national initiative
17 and evaluated extensively by researchers at
18 Penn State. And I wanted to -- I do not have a lot
19 of information with me today, but I would really like
20 to send the results to the committee, if possible,
21 because what we were able to do is do enhanced
22 training and develop programs like team building.
23 We did this across the long-term-care
24 continuum of nursing homes, personal care, adult day
25 centers, and home care, and we had some really

1 positive results. And what we found was that when
2 direct-care workers were able to take a leadership
3 role, when they were able to get additional training,
4 they were much more satisfied in their work.
5 And there are retention and recruitment
6 statistics in this study, and I will send those to
7 you, because it does not always cost a lot of
8 money.
9 And one of the things that we really are
10 challenged by is understanding what the cost of
11 turnover is, and I know some of the providers are
12 well aware of the costs of turnover. So if we can
13 prevent turnover by providing better training and by
14 providing other programs that can help support
15 direct-care workers, because they are, they are on
16 their own oftentimes.
17 So we need more supportive programs, more
18 training, and I think some of the work that we have
19 done, as well as others across the country, will bear
20 that out, and I will send you the results of that
21 study.
22 MS. KULP: I would like to say something.
23 I actually, you know, run a small business
24 that provides benefits and a decent wage to home
25 health aides and also high-level training, and I have

1 to say that a lot of people think that you cannot be
2 successful in business and do that, and we have proof
3 that you can. So actually providing quality service,
4 training people, making sure that they have good
5 benefits, can really help your business be
6 successful.
7 And I think that is something that we have
8 to talk about, because I think a lot of small
9 businesses say, you know, we don't want that kind of
10 regulation, we don't want to have to train our
11 people, and I think that is a real mistake.
12 REPRESENTATIVE McILVAINE SMITH: I also
13 agree. I think that we should have training. I was
14 just wondering where the money was going to come
15 from.
16 But I also wanted to ask Diane, or actually
17 make a comment. You know, the marketing standards, I
18 totally agree with you. How little information we
19 get and it is all about through that time-share
20 mentality, you know, come on in and see what we have
21 and come on down. But I think that we are in a
22 crisis mode when we are searching for those places to
23 place our loved ones, and then it is very difficult
24 to make those kinds of decisions when you are in
25 crisis mode.

1 And I would just offer up as a comment that
2 I think it is more like -- and I do not mean to be
3 morbid about this -- but funeral planning, that we
4 actually have to stop and think that this is probably
5 where we are going to end up, and we have to take the
6 individual responsibility to look at these options
7 ahead of time instead of when we are in that crisis
8 mode.
9 But thank you for your testimony today, all
10 of you.
11 CHAIRMAN MUNDY: Representative Watson.
12 REPRESENTATIVE WATSON: Thank you,
13 Madam Chairman.
14 And thank you so much to each of you who
15 are testifying, and I have to do my thanking in my
16 order.
17 Ms. Anthony, thank you, because in all
18 honesty, I was one -- and Ms. Halperin and I have
19 gone a couple of times around and around -- is it
20 right to prescribe exact sizes, because I get
21 nervious about places that won't see the new
22 construction, and how could they ramp up to be
23 assisted living? But you have given me a different
24 perspective in terms of understanding what the square
25 footage can mean to certain folks and why and how it

1 is important. So I thank you for that. I like it
2 when I learn something new, and it is in my head now.
3 I get it better.
4 MS. ANTHONY: Thank you.
5 REPRESENTATIVE WATSON: At the same time,
6 and if I might with you, I was sitting here and
7 listening, I am very interested in the
8 marketing-standards concept that you talked about,
9 Diane, because I honestly think, and that is what the
10 Alzheimer's society -- they testified first -- that
11 is what got me involved both ways. And of course I
12 have spent, I guess I have been here almost 8 years
13 -- time flies -- but I have spent 7 of them now, I
14 guess, or we got the thing finally, but working on
15 assisted living.
16 When I started and asked, and Sharon was
17 kind enough to help me, but nobody else was
18 interested, and I would just make jokes about seeding
19 my future and finding a place for me and this and
20 that. But it just seemed that people did not quite
21 get how important this could be. We have now gotten
22 a law.
23 I wish the law had some more things that,
24 some of you, when you testified, I would lean over
25 and go, didn't we have that in the earlier version I

1 did? This was in that earlier version. But it is
2 what it is now, and it is the regs that will help us
3 to get all the places that we know where we want to
4 be.
5 And I would suspect that everybody in this
6 room does have the goal of protecting people, seeing
7 that they age in place, and that they are always
8 treated with dignity and respect, whether they are
9 fortunate enough to be in a family member's home,
10 whether they are in personal care, assisted living
11 now, or a nursing home.
12 So I think that we have to say that
13 outright. We all want that. How we get there or
14 what we envision how we get there, that is where we
15 have some disagreements.
16 But if I might do a little -- because I know
17 how slow government grinds and grinds. I was sitting
18 and looking and thinking, and I hate to put
19 Mr. Landis, representing AARP -- I have done it to
20 him before -- on the spot here, but I really wish
21 there was more with an organization like AARP
22 nationwide. And it also has that -- my husband gets
23 it, because he is older, but the monthly magazine.
24 Actually, it comes just to him. I am so delighted my
25 name is not on it, because I lie. But it comes to

1 him, and we need to do more for our, I will call it
2 our baby boomer generation, who have, if they are
3 lucky enough -- my parents died when I was 30 -- but
4 if they are lucky enough, they have parents to worry
5 about, and it is a great worry, and they are thinking
6 in terms of themselves and their future. We need to
7 do more education.
8 Grinding as slow as we do to come up with
9 the marketing standards, that I agree that we need
10 and things to do, we could do a better job of at
11 least educating ourselves and talking about it.
12 And I saw people, when my colleague,
13 Representative McIlvaine Smith, said, you know, we
14 have to talk about this, I leaned over and said, we
15 just took a vacation for a week, the first time we
16 have taken one in about 6 years. One of the things
17 my husband and I planned to do -- and we did -- was
18 that we took the tablet with us, and as we sat in the
19 sun, because I thought that would make me feel better
20 about it, we talked about funeral arrangements, how
21 we have to get it together, because we only have one
22 child and he has to know where everything is, and how
23 we expect we might end up and who should do what and
24 revising our wills, because it has to be done at some
25 point.

1 And right at this moment, both of us are
2 okay and healthy, and we figured that would probably
3 be the best time to do it. But the truth is, we
4 don't do that, and we were both terribly
5 uncomfortable doing it.
6 I would like to see then some of you get
7 together with organizations that have that public
8 relations arm or magazine, but do more in the way of
9 educating and talking about those things that
10 sometimes we do not know to talk about or we have not
11 gotten there, because for those who are fortunate
12 enough to have parents, they also might not -- they
13 don't want to contemplate the fact that mom or dad or
14 mom and dad cannot live by themselves, maybe in the
15 house that they grew up in as children, and it will
16 all be okay. And as adult children, we have to
17 recognize the natural cycle of events, and it might
18 happen. Or even, you know, they are going to need
19 somebody to help care for them.
20 So I would like to merge and put you two
21 together. I agree with the marketing standards, and
22 that got me to Michelle with the Alzheimer's group in
23 that the first people I met, a lady came in and had a
24 problem where she had her husband, because it was
25 marketed as "handling Alzheimer's patients." And I

1 am sure the facility really meant well, they thought
2 they knew, but -- and this will get to your training
3 -- they really couldn't match.
4 I had the opportunity as being deputy
5 administrator for the county to work on then what was
6 going to be Bucks County's new nursing facility,
7 Neshaminy Manor, the second version. And we put in a
8 unit, about 20, an Alzheimer's specifically and
9 dementia unit, and I worked on it and learned a lot
10 about lighting from above and shadow boxes and things
11 to do. But there was going to be a great deal more
12 training, and it is really a premier county facility.
13 I recommend anybody coming to see it, and that unit
14 does a wonderful job.
15 But that got me there, because the same
16 thing; we did not recognize that as separate, we did
17 not recognize the need for very specialized training.
18 And it is more than just having a concern and an
19 interest and not wanting to do a good job.
20 Someone said the point that a worker feels
21 better about himself or herself with the proper
22 training and feeling, and I think it raises the
23 concept of the profession, which we need to do,
24 because these are the very folks that we are
25 entrusting with the lives of people we care about the

1 most. They should have lots of training, and they
2 should have high standards, and certainly they should
3 be well paid.
4 I have been there for a long time. I have
5 never understood how our society works on paying, no
6 offense, but people to throw footballs or baseballs
7 or figure something else or be basically a
8 dysfunctional person but acting in a movie and we pay
9 them lots of money, but the people who take care of
10 our children or our parents, we do not value them.
11 I think that training and increased training
12 is helpful, because we recognize that circumstances
13 are just different. So I certainly agree that we can
14 go there. How far we get or if we get there all the
15 time, I don't know.
16 I was curious, though, could you at least
17 talk to others, and in light of regs that take some
18 time, can we all work together? I know our Chairman
19 would do that in a heartbeat, try to put you together
20 and do some networking that we can make things better
21 before, after, in spite of regulations? I think
22 we can do that to educate consumers, because that
23 baby boomer generation is large -- right now. At
24 least I know two people in it who are healthy.
25 But we need to have those talks, we need to

1 understand, we need to know the questions to ask, and
2 I would like to start from the presumption that most
3 providers are not trying to trick me, the consumer.
4 They don't know either, so let's get the dialogue
5 going and do it maybe outside of that.
6 Thank you.
7 CHAIRMAN MUNDY: Representative Cox.
8 REPRESENTATIVE COX: Thank you,
9 Madam Chairwoman.
10 I am not sure who to address my testimony or
11 my questions to. I want to thank you all for your
12 testimony.
13 When we first got the notice to these
14 regulations, I got through them a little bit and
15 talked to our staff. There are a few areas that
16 jumped out at me as I went through them, and anytime
17 I see new construction requirements or minimum
18 existing requirements for room sizes and things like
19 that, regardless of what type of facility it is, it
20 always makes me wonder, what is going to be the
21 impact on those who are currently trying to do this
22 business?
23 And I started asking questions of the
24 facilities in my district and elsewhere, and I
25 interact with these types of facilities. I learned

1 that most of them that I interacted with at least
2 don't meet those requirements of 175 square feet for
3 an existing structure.
4 And I look at that in two ways and I say,
5 well, is there not enough space currently and are
6 these people not able to get around? But at the same
7 time, my concern is that we take people who are
8 already operating in some capacity, and many who are
9 very interested in becoming an assisted living
10 facility, we are looking at them not being able to do
11 that even though they are otherwise very, very
12 qualified and able to do it in most of their areas.
13 So that is my first question, and that is
14 these space sizes. I came across the best practices
15 standard out there of 150 square feet for new
16 construction and 125 square feet for existing
17 construction. I think that actually came from our
18 department's own study of what is happening around
19 the country and what things have been put in place
20 elsewhere that seem to work. Can you add some more
21 to that, please?
22 MS. HALPERIN: I am happy to try.
23 First of all, I would like to just point out
24 and it is important to point out that no one is being
25 forced to become an assisted living facility as

1 "assisted living" is being defined now, okay?
2 We have an industry that has, you know, in
3 good foresight, in good marketing, taken advantage of
4 the opportunity to use a better name than
5 "personal-care home." They call themselves
6 assisted living, and maybe they have tried to design
7 themselves based on, you know, what assisted living
8 may have been defined as in other States.
9 But Pennsylvania does not have
10 assisted living yet. We have never gone through this
11 process before of actually defining what are
12 appropriate standards for a place that is going to
13 call itself "assisted living."
14 REPRESENTATIVE COX: Right.
15 MS. HALPERIN: No one is losing their
16 license. They can all continue to operate as
17 personal-care homes.
18 And I put to you, if we are actually going
19 to come up with what are the appropriate standards
20 for assisted living, you know, why should someone
21 who, just because they decided to use the name, get
22 swept in, you know, with the group simply because
23 they chose that as their marketing title and it has
24 been beneficial to them to choose it as their
25 marketing title?

1 And while I appreciate many have tried and
2 many do good jobs and many provide good services,
3 none of them meet standards that have been designed
4 for the population that we are now going to allow and
5 encourage to enter into these facilities, and things
6 like room size are critical.
7 I mean, the data Linda quoted of 65 percent
8 of assisted living facility residents using either a
9 wheelchair or a walker is from 1999. We do not have
10 more current data. That was the best that any of us
11 could find.
12 But you have got to know that to not have a
13 facility that is accessible, to have a home that is
14 cramped, I mean, right now we have 80-square-foot
15 sized rooms as a minimum requirement for a
16 personal-care home. That is less than what Federal
17 law requires for a jail cell, and that is what we
18 have for personal-care homes, and we need something
19 more. This is supposed to be a home.
20 And I would also like to point out that most
21 of the States that are trying to come at this now are
22 shooting for 220, and they are going higher. And
23 most of them are excluding things like alcoves and
24 vestibules and closets when they do their
25 calculation.

1 So, you know, I can also tell you that we
2 did an informal survey of about 25 places in the
3 Commonwealth that call themselves assisted living,
4 and not a single one of them had less than 250 square
5 feet for one of their single units -- not a single
6 one. In fact, many of them were up over 300 square
7 feet for a single unit. Of places randomly selected
8 in different counties and regions across the State,
9 they are calling themselves assisted living.
10 So I would also like to point out that
11 historically, grandfathering is a regulatory concept.
12 It is only appropriate when standards are being
13 changed or updated for an existing industry, like we
14 did with personal-care homes. There was
15 grandfathering 3 years ago when those
16 personal-care-home regulations were changed.
17 Grandfathering is not a technique that is
18 used when creating a completely brand-new licensing
19 structure, and that is what we are doing here. This
20 is supposed to be brand new. This is a whole new
21 population that is going to be allowed and expected
22 to be there, and their needs need to be able to be
23 served.
24 And then the last thing I would say is, I do
25 not think that grandfathering, I have a fundamental

1 problem with grandfathering as it exists even in
2 regulations when it is appropriate. Grandfathering
3 assumes that every place that has the right
4 square footage is doing a good job. Grandfathering
5 of staff assumes or administrative requirements
6 assume that every place that, you know, has an
7 administrator, that that administrator has had no
8 violations.
9 Case-by-case waivers, case-by-case
10 exceptions are more -- they feel much more
11 comfortable to me than, you know, a whole cloth
12 grandfathering of an entire group of facilities.
13 REPRESENTATIVE COX: And my question was not
14 in grandfathering per se so much as it was, when we
15 put that possibility of assisted living licensing out
16 there, the goal was to create another category, so to
17 speak, so that people had more options.
18 And one of the goals in the discussions that
19 we had on this committee was, can we get some of the
20 existing facilities to apply for licensing?
21 Things like this are going to prohibit, in
22 my mind, taking regulations and using them as a
23 hammer to keep certain things, certain facilities,
24 out or creating a wish list, so to speak, of what the
25 ideal facility is. I think it is going to hamper

1 some facilities that otherwise would have jumped on
2 and said, we would like to do this.
3 And again, I cannot comment on, you know,
4 all of the, I guess, 200 that you said you surveyed
5 or visited or whatever that meet---
6 MS. HALPERIN: It is only 25.
7 REPRESENTATIVE COX: Pardon me?
8 MS. HALPERIN: It was 25 facilities that we
9 polled, just informally.
10 REPRESENTATIVE COX: Okay. I am mixing
11 numbers in my head, I guess.
12 I cannot comment on all those, obviously. I
13 only visited about three. But those that I have
14 talked to, regulations like this in conjunction with
15 some of the other staffing requirements and things
16 like that are going to keep some of these facilities
17 that looked and said, yes, that is something we would
18 like, we have kind of called ourselves that, we would
19 like to, you know, stand for approval, so to speak,
20 some of these things are going to keep really, really
21 good operating facilities, because they have rooms
22 that are 160 square feet in an existing or that are
23 170 square feet in an existing building, and again, I
24 am not suggesting where we go, that just there is a
25 concern about keeping really good facilities from

1 meeting this specification and preventing them from
2 offering this service.
3 The second item stems a little bit from
4 Ms. Anthony's testimony regarding the kitchenettes.
5 I completely understand what you are talking
6 about, and one of the reasons I stay in specific
7 types of hotels on vacation is the availability of a
8 kitchenette. There is a convenience to that. There
9 is that independence where you do not have to go
10 anywhere for certain things, and I can only imagine
11 that that would be that much more convenient on a
12 day-to-day basis for a very long period of time.
13 Again, my question, though, becomes, what
14 about, many people go into these types of facilities,
15 and especially going from a personal-care home to an
16 assisted living, many people go into that type of
17 setting because they have some levels of dementia or
18 they are unstable and they use a cane or they use a
19 walker.
20 I am trying to think of, do we really want
21 everybody to have access to a microwave, and they
22 might want to do something for 30 seconds and they do
23 it for 3 minutes and they end up severely burning
24 themselves.
25 I am not trying to keep kitchenettes out of

1 the entire scenario, but I am wondering if we cannot
2 come somewhere in the middle to say, 25 percent,
3 30 percent, 50 percent of your units must have
4 kitchenettes to allow people to be properly
5 placed.
6 And again, it is a safety concern that I am
7 having for those that may have other issues that keep
8 them from operating that type of equipment safely.
9 So I am hoping to find a balance there, not
10 to keep the kitchenettes out altogether, but perhaps
11 can we come somewhere in between where it does not
12 potentially endanger some people that may have types
13 of illnesses that may prevent them from using those
14 properly?
15 MS. ANTHONY: I think that you have to
16 approach this in a commonsense sort of way.
17 If there is someone in a unit and that is a
18 danger, then I believe that you could make it
19 possible to remove those dangers, either remove the
20 microwave, or if the person does not use it and has
21 dementia and can't use it, just take it out of the
22 room.
23 But I want to go back to, one of the things
24 that you just said about is this whole issue is
25 safety. I guess you have to be in a wheelchair to

1 understand the space thing that you were discussing
2 with Alissa.
3 Many times when I have to get something off
4 of a shelf or out of a drawer, it means positioning
5 my wheelchair in such a way that I am alongside it.
6 Or that because it is up here, I cannot approach it
7 directly; I have to get beside it. So there is a lot
8 of things and space that you need to get around in a
9 wheelchair.
10 And mine is a manual and relatively small,
11 and I can tell you from visiting existing
12 assisted living residences, which are licensed as
13 personal-care homes but are calling themselves
14 assisted living, I have already had -- we call it the
15 dance of the wheelchairs.
16 I have an aunt and uncle who live in an
17 assisted living facility. When I go to their place,
18 I have to get out in the hall for them to cross over
19 the room to get to the other side, and, you know, it
20 is just a kind of ridiculous situation in a small
21 space that is now allowed because they are licensed
22 as personal-care homes.
23 So I hope you can understand, or, you know,
24 maybe you could try a wheelchair for awhile, but you
25 would understand that the standard of 250 is a

1 minimal amount, especially if you are saying to me
2 that we want you to come in, we want to give you our
3 services, and we want you to call this home. Well,
4 if you cannot turn around, if you have to back up, if
5 you have to move out in the hallway in order for
6 someone to come in and visit you, if I am very ill
7 and I need a Hoyer lift brought in to get me out of
8 bed, I mean, it becomes so cumbersome in a space
9 smaller than 250 square feet.
10 Frankly, I think that is extremely low, but
11 like I said, it is still going to be tight for some
12 people, but if personal-care homes choose to become
13 assisted living residences, as Alissa said, they can
14 choose to do that, but they should do it with the
15 regulations as stated.
16 And it is my hope that you stay with the 250
17 and not allow the 175, because as I said, I am
18 already having problems, when I go into an
19 assisted living facility in the living unit that
20 people are in, in terms of being able to move around
21 in that room with them.
22 And secondly, in the area of the
23 kitchenette, not everybody -- like I said, if there
24 is a danger of them using the microwave, remove the
25 microwave. I mean, I think that in consultation with

1 the family, the physician, and all of that, you can
2 make some amendments to a person's living unit if it
3 is going to put them in danger.
4 So I think it is a practical approach to it
5 and a more commonsense approach that could be used.
6 REPRESENTATIVE COX: And again, I am not
7 saying not to have a percentage of the units meet
8 those types of requirements with kitchenettes with
9 that larger space.
10 In the personal-care home that I visited
11 most recently, I can count on one hand the number of
12 people I saw who were either in a wheelchair or even
13 using a walker. They were getting around; they were
14 mobile.
15 I asked the question to them, would you use
16 a kitchenette if you had one in your room? They said
17 no; one of the reasons I came here is because meals
18 are provided to me and because I do not trust myself
19 with a microwave or I don't want the headache of
20 having to prepare my own meals.
21 So while I understand that many may use it
22 or that some may use it, my concern is that blanket
23 policy to say that all units must have kitchenettes.
24 I mean, you are already talking about a safety issue
25 where, you know, somebody who cannot use a microwave,

1 take it out. Well, if they took it out, they would
2 be violating the regulation because the regulation
3 requires that--- Do you see where I am going with
4 this though?
5 MS. HALPERIN: No, no, I---
6 REPRESENTATIVE COX: The blanket regulation
7 is, in my mind, blanket regulations are always
8 dangerous. I would rather have a standard that we
9 shoot for for a certain percentage and say, this is
10 the minimum you need to have, the minimum number of
11 units that must meet the 250 square foot requirement
12 to make sure that we have room for that type of
13 population.
14 And again, I did not see a lot -- and maybe
15 it was just the type of facility I was in -- I did
16 not see a lot that were unable to get around without
17 using a walker or a wheelchair. I do not think I saw
18 any in a wheelchair. I saw literally probably three
19 or four using walkers.
20 MS. ANTHONY: I will let Alissa answer the
21 question, because I see it. But I did want to say to
22 you, sometimes you do not see people running around
23 in wheelchairs or walkers because they cannot get
24 around too well, they cannot push their own manual
25 wheelchair, and they don't get motorized wheelchairs

1 in these facilities.
2 MS. SHAFER: Representative Cox, just to
3 make this somewhat of a reality, because we throw
4 around this number of 175 square feet, and I have
5 worked for 16 years in a long-term-care facility. I
6 have worked for a wonderful, wonderful CCRC. I am
7 pro-industry. I know it is a business. I know what
8 it is like to try to make a budget and to try to
9 serve the residents.
10 This facility that I worked in lovingly
11 tried to take care of them, but I have watched people
12 in a double room with a curtain between them who were
13 otherwise six inches away from each other. If you
14 are talking about 175 square feet, it is 17 1/2 feet
15 by 10 feet. If you put a bed and one chair next to
16 the bed and maybe a nightstand crammed in the corner,
17 that is about all the space you have.
18 So if that were a single room, we struggled
19 and struggled to try to take our double rooms and
20 make our budget fit a single-room profile, and it was
21 really difficult.
22 I mean, I have tremendous empathy for the
23 industry in trying to accept and embrace making
24 things bigger where they do not have the square
25 footage to do it, and frankly, their budgets will not

1 allow the increase, because the single biggest
2 expense for the industry is the money that they pay
3 to their employees, and their employees deserve a
4 living wage.
5 So it is, in many ways, this is both a
6 philosophical argument and a practical argument, and
7 the philosophical argument hinges upon the will of
8 the people in the Commonwealth: Do we want to maybe
9 subsidize the extension of these services to our most
10 frail and vulnerable population? Do we want to honor
11 our elderly by helping them in some regard and
12 helping the industry to help them? That is a
13 possibility in my mind.
14 I cannot get out of my mind the times that
15 my residents had to be that close to one another, had
16 to crawl over one another to get into the bathroom
17 and that kind of situation. It is untenable.
18 When you have one resident who is living
19 with another resident who is beginning to lose their
20 mental capacity, they root through the other person's
21 belongings, and that upsets the other person. But
22 while we are trying to programatically deal with it,
23 we need the support and help and partnership of our
24 Commonwealth, our Legislature, our agencies, to help
25 everyone solve this dilemma.

1 MS. ANTHONY: Can I also add -- I have to
2 say this. This is not -- okay; an example.
3 My aunt and uncle put themselves in an
4 assisting living facility. That facility gets
5 $75,000 a year for those two people that live in one
6 unit -- $75,000 a year for one room.
7 I do not see that they are going to be
8 hurting by being forced to make the rooms slightly
9 bigger because there is money being made here. And
10 if you are offering yourself up as a place where
11 people can come to live out their lives, then I think
12 they deserve the dignity to have the space to get
13 around.
14 And as she said, 10 by 17, I don't know if
15 you have seen a room like that, but she is absolutely
16 right. When you put a bed and a bedside table, that
17 barely leaves me enough room to get in position to
18 transfer onto the bed. If you add to that someone
19 who now needs a Hoyer lift to be picked up out of the
20 wheelchair and onto the bed, you are leaving
21 absolutely no room whatsoever.
22 So you are ultimately kind of sentencing
23 the person to stay in this little tiny room that they
24 are supposed to call home for the rest of their
25 lives.

1 REPRESENTATIVE COX: And again, my
2 commentary -- and I will make this my last one so
3 that other people can ask questions that they have --
4 my concern is that we use that blanket for everyone
5 and not allow facilities that would otherwise be able
6 to offer at least a portion of their facility as an
7 assisted living facility. Some of these places are
8 going to have to shut down completely because they
9 don't meet -- you know, if they want to be
10 assisted living---
11 MS. ANTHONY: They can continue to be
12 personal-care homes.
13 REPRESENTATIVE COX: That is what I am
14 saying. If they want to and they otherwise can
15 qualify in every other way, these space restrictions
16 would require them essentially to shut down so that
17 they can rebuild if they don't meet the 175. It is
18 not like you can knock out a closet and say now that
19 is living space because it is no longer an enclosed
20 closet. There is only so much you can do.
21 So there are facilities that I have spoken
22 with that probably are not even going to look at
23 doing the assisted living. There is one that does
24 not want to go down this road because of the immense
25 costs that this comes to.

1 They did tell me that if they could take a
2 portion of their building and turn one wing into a
3 facility that had the larger 250 or 220 or whatever
4 it ends up being, they said they would be likely to
5 try to serve as an assisted living facility. But
6 financially, they cannot afford to completely shut
7 down in order to make that transition.
8 And again, I do not want to -- the dialogue
9 does not necessarily have to continue on this, but I
10 would really love to see us develop something where
11 we say a percentage of a facility must have those
12 larger requirements, a percentage must have
13 kitchenettes, again, because most people -- not most
14 people; I do not want to categorize -- but many
15 people do not want access to a kitchenette.
16 MS. ANTHONY: I would love to argue that
17 with you, but that is another day.
18 REPRESENTATIVE COX: Well, then why don't
19 you come down? I mean, some of the people I talked
20 to were actually in the homes that I was in.
21 But I would like to strike a balance, and I
22 think we can. I think these regulations go so far
23 and require so much that we are going to prevent a
24 lot of facilities from making a transition that we
25 otherwise could enable them.

1 Thank you.
2 CHAIRMAN MUNDY: Representative Samuelson.
3 REPRESENTATIVE SAMUELSON: Thank you.
4 I guess to offer a point, a counterpoint.
5 My thought is that if we are having
6 assisted living regulations, they should apply to
7 all. When you start making exceptions, you go down a
8 very difficult path.
9 Just think of the new smoking law in
10 Pennsylvania. Right now, we have a smoking law that
11 covers 95 percent of Pennsylvania that has to be
12 smoke-free, but there are exceptions for certain
13 restaurants and certain hotels and certain casinos.
14 And in that law, the casino could even apply, if they
15 have a financial hardship -- they can have smoking on
16 25 percent of the casino floor. If the casino has a
17 financial hardship, they can have smoking on
18 50 percent of the casino floor. It seems like a much
19 better smoking law would have been the stronger House
20 version that passed in the summer of 2007.
21 Having said that, the law is good, but we
22 need to make some improvements, and I think when you
23 start making exceptions--- When we make child-care
24 regulations, we do not have exceptions for certain
25 facilities that might not be able to afford it.

1 And there is a lot of talk this week in the
2 news that we may need more regulation of Wall Street.
3 I think both Presidential candidates are talking
4 about more regulation of Wall Street, but they are
5 not talking about making exceptions for the ones that
6 are there that might not be able to deal with the new
7 regulation.
8 I think the fairest thing for our consumers
9 and our citizens would be that if we have a new
10 regulation about the size of a room in an
11 assisted living facility, that should apply to all,
12 and that is the fairest for the citizens.
13 So I just wanted to offer that as a
14 counterpoint.
15 MS. ANTHONY: Thank you.
16 CHAIRMAN MUNDY: Thank you.
17 We are about a half hour behind now, but I
18 think the dialogue has been very productive, and I do
19 appreciate your testimony very much. Thank you.
20 MS. ANTHONY: Okay. Thank you.
21 MS. HALPERIN: Thank you.
22 CHAIRMAN MUNDY: Our next panel consists of
23 the Pennsylvania Association for Non-Profit Homes for
24 the Aging, PANPHA; the Pennsylvania Health Care
25 Association, otherwise known as PHCA; and the

1 Pennsylvania Assisted Living Association, otherwise
2 known as PALA.
3 We hear a lot from these folks on a regular
4 basis, and we look forward to hearing your testimony.
5 DR. SHAPIRO: Good morning.
6 CHAIRMAN MUNDY: Good morning.
7 DR. SHAPIRO: Chairman Mundy, Chairman
8 Hennessey, and members of the committee, we all
9 appreciate the opportunity to appear before you today
10 to discuss the proposed assisted living regulations
11 published in the Pennsylvania Bulletin.
12 My name is Stuart Shapiro, and I am
13 President and CEO of the Pennsylvania Health Care
14 Association. PHCA is a statewide advocacy
15 organization for the Commonwealth's elderly and
16 disabled residents and their care providers.
17 On my left is Russ McDaid, the
18 Vice President of PANPHA, a statewide association
19 representing nonprofit senior service providers; and
20 to my right is Tim Coughlin, who is President and CEO
21 of LifeServices Management, and he is representing
22 PALA, which also represents assisted living
23 providers, personal-care-home providers, and the
24 residents who are in them.
25 I should note, however, that Mr. Coughlin

1 is himself an owner and operator of five
2 assisted living communities here in Pennsylvania
3 and three in Ohio.
4 After more than a decade of discussion and
5 debate, the Pennsylvania Legislature passed landmark
6 assisted living legislation in the summer of 2007.
7 Act 56 created a framework, and I must say
8 an excellent framework, for a system of licensure and
9 regulation that has the potential to provide
10 consumers an important housing and services
11 alternative along the continuum of long-term care.
12 We will shortly discuss how that potential may never
13 become a reality.
14 Russ and I were personally involved in
15 discussions with many members of this committee and
16 other members of the Legislature as this legislation
17 was being developed, and we, on behalf of our
18 members, as well as PALA's, want to thank
19 Chairman Mundy, Chairman Hennessey, and committee
20 members, especially Representatives Watson and
21 Gingrich, for their efforts over the years on this
22 subject. Likewise, we would like to thank Senators
23 Vance and Erickson for their work on this. So thank
24 you to each of you, to your staff -- well-deserved
25 credit for this legislation.

1 As you recognize, PHCA, PANPHA, and PALA
2 strongly and enthusiastically endorse this
3 assisted living legislation. Pennsylvanians want
4 this new option along the continuum of long-term
5 care.
6 In addition to providing a needed level of
7 housing and services, assisted living also has the
8 potential to stretch the Commonwealth's dollar
9 further if care for lower-acuity individuals can be
10 safely and effectively delivered in an
11 assisted living facility rather than in a nursing
12 home. And we, just like the consumer panel you heard
13 before you, want the residents to live in a safe,
14 comfortable, quality environment.
15 Act 56 directed the department to adopt
16 regulations establishing licensing standards as well
17 as numerous other provisions. Our three associations
18 were part of a short-term working group convened by
19 DPW, during which many important issues concerning
20 these regulations were discussed among providers,
21 among consumers, advocates, and government agencies.
22 And while we learned a great deal from each
23 other, and we did, unfortunately this endeavor, as it
24 was designed, did not allow for consensus to be
25 built. And therefore, what really has come out in

1 these regulations is that significant reality-based
2 provider concerns were not addressed in the
3 regulations as published.
4 Because our associations and our members
5 believe deeply in the value of assisted living, we
6 collectively have been working tirelessly to see this
7 program implemented in a manner that will encourage
8 this sector to develop to serve a senior population
9 and a disabled population here in Pennsylvania.
10 Despite the optimism, and quite frankly, the
11 good intentions on the part of the Department of
12 Public Welfare, we believe that the proposed
13 regulations are likely to raise the costs of
14 assisted living in Pennsylvania so greatly that they
15 will suffocate development of assisted living and
16 ensure that the potential for a vibrant
17 assisted living sector will not become a reality in
18 Pennsylvania.
19 In fact, we believe that the proposed
20 regulations would result in few high-quality
21 personal-care homes converting to assisted living,
22 and we are told that by our members.
23 We are also told that few, if any, new
24 assisted residences would be built if these
25 regulations became a reality. And the net result

1 would be that few, if any, Medicaid individuals would
2 ever become residents in these facilities because the
3 physical plant, the space, the staffing, and the
4 licensing-fee mandates in the proposed regulations
5 will require charges to the Medicaid program far in
6 excess of what I believe the Commonwealth is likely
7 to pay or the Federal government is likely to
8 approve.
9 In fact, I hope that this committee will ask
10 my friend and colleague, a woman I greatly respect,
11 Secretary Richman, a simple question: Whether the
12 department has done any analysis of what the charges
13 to the Medicaid program are likely to be if the
14 providers must meet the space, the staffing, and
15 the program requirements in the proposed
16 regulations?
17 We have gathered data on this -- it is
18 included in our testimony; it is the last page -- we
19 have gathered data, and it was startling to us. We
20 called some of our experienced members who have built
21 in this State and other States and we asked them
22 simple questions.
23 So I hope that you will ask the department
24 whether they in fact, because it is the department
25 that will pay them under Medicaid, what they believe

1 and how they have put together those numbers. I
2 think it would be very instructive, and we would all
3 learn from that.
4 The fourth point is that many
5 nursing-home-eligible individuals currently on
6 Medicaid living in personal-care homes will be
7 required to shift to nursing homes when they need
8 certain health-care services because of an inadequate
9 supply of assisted living services.
10 We all know that there are many individuals
11 today in personal-care homes who might, if it were
12 looked at carefully, come under the definition of
13 "nursing-home eligible." If you had a new system,
14 many of these individuals might need to move into a
15 nursing home.
16 And finally, and this is a serious problem,
17 and we are going to present more details of this as
18 we go through the testimony, that an undesirable
19 two-tiered system of assisted living may become a
20 living reality in which only the wealthy will be
21 served. That is something that we share this
22 concern, again, with the panel that you heard from
23 earlier.
24 Each of our associations has prepared
25 detailed comments on the proposed regulations, which

1 we believe, in many cases, do not conform to the
2 statute that you wrote and passed and, in certain
3 instances, exceed what we believe was the clear
4 legislative intent.
5 This morning, however, the three of us will
6 provide comments on a very limited number of
7 overarching issues, including space requirements;
8 staffing and training; licensing fees; dual licensure
9 of personal-care homes and assisted living, an issue
10 that was ignored; and policies related to informed
11 consent, transfer and discharge, and excludable
12 conditions.
13 Tim will first review the space and
14 staffing, Russ will then discuss licensure issues, I
15 will discuss informed consent and transfers, and then
16 Russ will present a few concluding comments, and we
17 hope to do this all as quickly as possible.
18 Tim.
19 MR. COUGHLIN: Good afternoon.
20 As the space requirements for resident
21 living units, we certainly support the need for
22 assisted living residences to offer each resident
23 comfortable, home-like space that provides them the
24 degree of privacy they desire and the independence to
25 live their life in the manner they choose.

1 Act 56 requires that each living unit
2 contain, and I quote, "a private bathroom, living and
3 bedroom space, kitchen capacity, which may mean
4 electrical outlets to have small appliances, closets,
5 and adequate space for storage and a door with a
6 lock."
7 However, when that element of the act is
8 translated into proposed regulation minimums of
9 250 square feet for new construction, excluding
10 bathrooms and closets, and 175 square feet for
11 existing residences, we will have created what most
12 service providers characterize to us as the single
13 greatest barrier to convert to Pennsylvania's
14 assisted living licensure and the single greatest
15 barrier to expand assisted living through new
16 construction.
17 Part of DPW's stakeholders' process included
18 the review of "best practice" assisted living
19 licensure activities across the country, remembering
20 that most States in America are years ahead of the
21 Commonwealth in creating, regulating, and expanding
22 the assisted living industry.
23 Consistent with that process, we have
24 provided you an exhibit of a national map, to my
25 left, that reflects "best practice" minimum

1 square footage licensure requirements of
2 assisted living on a State-by-State basis.
3 One can readily see by the deep blue on this
4 display that the most common minimum square footage
5 requirements under licensure in other States for a
6 living unit is 100 square feet or less.
7 Over 70 percent of the States have a minimum
8 requirement of 100 square feet or less, and
9 80 percent have a requirement of 150 square feet or
10 less.
11 If Pennsylvania establishes 250 square feet
12 on new construction as the minimum, we will have
13 succeeded in becoming one of only two States in
14 America with that high of a requirement, and we will
15 have created an insurmountable barrier to new
16 construction rather than, as what we think we want to
17 do, create an attractive opportunity to stimulate
18 growth in assisted living supply in our
19 Commonwealth.
20 Our company's construction division, for
21 example, is currently constructing our 68-living-unit
22 prototype today in the State of Ohio. They ran a
23 cost estimate on expanding our living-unit models to
24 the Pennsylvania proposed minimums, and it added
25 $1.2 million to our current construction costs of

1 $4.2 million.
2 That action alone would push our community
3 prices beyond what we believe middle-income older
4 people view themselves as able to afford.
5 We would not build in a State requiring that
6 minimum, and PALA believes that most other
7 assisted living providers would decide the same.
8 Similarly, our association's 300 members,
9 many anxious to be more appropriately licensed as
10 assisted living providers, tell us that their
11 existing stock will not meet the 175 square foot
12 minimum requirement, and this includes providers who
13 are nationally recognized in the industry today.
14 The assisted living industry in America
15 offers consumers different choices in the types of
16 residential settings available so that those
17 consumers can have choices about what is best for
18 them as a quality of life and what is affordable to
19 them.
20 We encourage Pennsylvania to follow the
21 "best practice" standard on this issue by
22 establishing 150 square feet as the minimum for new
23 construction and 125 square feet as the minimum for
24 assisted living providers currently licensed as
25 personal-care homes.

1 If we establish those requirements, we still
2 will have placed Pennsylvania in the top tier
3 nationally as requiring the most living space
4 possible, yet we will have created an option that is
5 affordable for many, if not all.
6 There are a number of other more modest but
7 important elements to physical requirements in the
8 draft regulations, but for the sake of time, we have
9 communicated those in our formal comments on the
10 regulations, and we would refer you to them for
11 consideration.
12 As to staff and training requirements,
13 including the qualifications and responsibilities of
14 administrators, we direct our comments to major
15 obstacles within Section 2800.51 through 2800.69
16 entitled "Staffing."
17 All of us certainly want to ensure that
18 administrators and direct-care staff are available
19 and appropriately trained in providing services and
20 care to our residents, and many of the qualification
21 and training requirements proposed properly
22 contribute to that objective.
23 While we address compliance to that
24 standard, though, we must remember, too, that Act 56
25 intends us to create the capability that residences

1 are dually licensed as both assisted living
2 residences and personal-care homes.
3 Finally, we need to ensure that while the
4 regulations provide for the appropriate staffing and
5 expertise to provide services and care, so must the
6 regulations, too, consider the need to keep
7 requirements such that assisted living residences
8 remain as affordable as possible to as many consumers
9 as possible, including Pennsylvania as an eventual
10 purchaser of assisted living services under a
11 Medicaid waiver program.
12 With those objectives in mind, it is
13 imperative that existing licensed personal-care-home
14 administrators, direct-care staff, and
15 medication-administration aides in the existing
16 licensed personal-care homes be grandfathered into
17 the assisted living regulations.
18 The dedicated care professionals currently
19 in these positions throughout the Commonwealth are
20 some of the best trained and most experienced
21 personnel available to an assisted living industry.
22 Why would we leave them out, particularly when so
23 many of them have advocated for so long for an
24 assisted living option?
25 As a practical matter as well, the

1 responsibilities of an assisted living administrator
2 and its direct-care staff are generally the same as a
3 personal-care-home administrator and personal-care
4 home direct-care staff. And if one of our objectives
5 is to create dual licensing capability, this
6 grandfathering action needs to be taken.
7 Secondly, the qualification requirements for
8 an administrator from this point forward need to
9 recognize capable managers who may not have secondary
10 education credentials, yet have significant operating
11 experience in the service and care of people.
12 Next door, the State of Ohio -- again, for
13 example -- where a thriving assisted living industry
14 exists, the qualifications for administrators include
15 postsecondary education requirements or -- or -- a
16 minimum of hours of direct operating experience of
17 a senior housing, senior care, or health-care
18 facility.
19 Finally, the requirement that the
20 administrator or a designee with the exact same
21 training as the administrator be present in the
22 assisted living residence 24 hours a day, 7 days a
23 week, is simply unreasonable.
24 The standards for that administrator
25 presence, and to that of that designee in the absence

1 of the administrator, that currently exist in the
2 2600 regulations have worked well in personal-care
3 homes and need to be replicated here. They
4 effectively work, they are reasonable, and they avoid
5 the addition of unnecessary administrative costs
6 layered into the eventual pricing of assisted living
7 residence services.
8 While there are other more modest, yet
9 important, issues in this area, for the sake of time,
10 we have communicated those to you in our formal
11 comments on the regs, and we would refer others to
12 them for consideration.
13 Thank you.
14 MR. McDAID: Thank you, Russ and Stuart.
15 I will now talk about two issues relating to
16 licensure, one dealing with the licensure fees and
17 the second, and we believe most importantly, dealing
18 with dual licensure.
19 I will go off the testimony and just speak
20 very briefly about the licensure fees for the sake of
21 time.
22 As many of you know, as we were negotiating
23 the legislation, we all acknowledged, the provider
24 community acknowledged, that the licensure fees that
25 exist in Act 185 for personal-care homes were dated.

1 They were 20 years old, and $15 for a license through
2 $50 for a license was probably a number that we
3 needed to address and discuss how we would arrive at
4 a reasonable licensure-fee standard.
5 That was left open to interpretation in the
6 statute, and we think that the licensure fees that
7 were established in the regulations as published are
8 anything but reasonable.
9 A 100-bed assisted living facility under the
10 regulations would pay $11,000 a year for a license.
11 As you can see in the chart that we distributed -- it
12 was also part of PANPHA's submitted testimony or
13 submitted comment to the IRRC, I might add -- that
14 would place us as the most costly State in the
15 nation that we can find for licensure and clearly
16 way outside what appears to be the normal licensure
17 fee.
18 We think the quality assurance function is
19 extremely important. We think that it is important
20 that licensure be taken very seriously. However, we
21 do think it is a government core function to bear
22 some of that burden, and that burden should be
23 balanced with the provider community's "skin in the
24 game," if you will.
25 So what we have proposed in our detailed

1 regulations, you can see, is a $500 licensure fee
2 plus $10 a bed, to be capped at $1,000 for an annual
3 license, which we believe would put Pennsylvania in
4 the same category as many of our competitor States.
5 It would be a very significant increase over what the
6 current licensure fees are in personal care and
7 establish a reasonable licensure fee here in
8 Pennsylvania.
9 I would be happy to answer questions on that
10 afterwards, but I really want to get to dual
11 licensure fees, because that is the most important
12 key here.
13 We have heard from our collective
14 membership, and you have heard from Representative
15 Cox and others the concerns about square footage. Is
16 it too small? Is it too large? What is it? What
17 isn't it?
18 What we can tell you is to the extent that
19 square footage will be a key area of discussion under
20 whether you go after an assisted living license or
21 not, our providers, many providers, will be left on
22 the sideline if it continues to be an all-or-nothing
23 proposition from the department as it relates to
24 licensure.
25 As you can see in my testimony, and I will

1 read the piece of the act that relates to licensure,
2 which says, Section 1021(c) of the act outlines that
3 "...all inspections of residences dually licensed as
4 Assisted Living Residences and Personal Care Homes
5 shall be conducted by a team of surveyors comprised
6 of both personal care home and assisted living
7 residence surveyors."
8 Now, that says two things to us as the
9 provider community: one, the Legislature clearly
10 intended for some dual licensure to occur; and
11 secondly, it outlines how those surveys might
12 happen.
13 We acknowledge that there are a number of
14 areas that are open to debate and discussion on the
15 issue of dual licensure. Can we license suites of
16 rooms or individual rooms? Does that make any
17 sense?
18 You will see in our formal position that
19 that is our desire. It is up to you to determine,
20 you know, whether you think that is a model that can
21 work.
22 We are very concerned about what we
23 currently see in the regulation, which is you will
24 have one license under one roof, whether you are a
25 personal care or assisted living.

1 Frankly, PANPHA did a survey of our
2 membership, and 40 percent of our members have
3 existing stock that falls under the department's
4 grandfathered requirement for square footage of
5 175 square feet for existing facilities.
6 So as the regulation currently reads, those
7 locations, even if that is a half dozen rooms or
8 50 percent of their 60 rooms or whatever it might be
9 in an individual case, will not be able to seek
10 assisted living licensure for those rooms that do
11 meet whatever the eventual requirement is, because
12 there is no allowance for dual licensure in the
13 regulation.
14 We think that is a very significant problem,
15 and regardless of where we all end out on what
16 appropriate square footage is or isn't, it will
17 create significant access barriers for those
18 currently being served in assisted living
19 facilities.
20 So in closing, as you will see in our
21 testimony, we strongly urge the department to follow
22 the act as passed and develop a framework for dual
23 licensure.
24 We think that this is a statutory provision
25 that is very clearly there. It was very clearly

1 allowed for, almost to the point of where I would say
2 intended.
3 And most importantly, we think there are a
4 lot of high-quality providers out there who have
5 square footage and have the amenities, regardless of
6 where we end up, who seek assisted living licensure,
7 that will be left on the sideline if this is required
8 to be one roof-one license and all of your physical
9 plant needs to meet the assisted living requirements
10 or you do not go after assisted living licensure.
11 Thank you, and now I will turn it over to
12 Stuart for issues around informed consent and
13 transfer and discharge.
14 DR. SHAPIRO: Let me just conclude my
15 portion by talking about informed consent agreements,
16 discharge and transfer policies, and the exception
17 process as it relates to excludable conditions.
18 I have in part been given this
19 responsibility among the three of us because my
20 professional background allows me to bring a
21 practical, clinical perspective to this discussion.
22 I have always believed that consumers or
23 patient input is an essential component of the
24 doctor/patient relationship. Consumers have the
25 right to make decisions on what treatment they will

1 or will not receive.
2 Likewise, health-care providers who deliver
3 care at assisted living residences as well as the
4 assisted living residence itself must also have the
5 ability to determine what they will or will not
6 provide and whether they believe that they can do it
7 safely.
8 The proposed requirements in the
9 department's regulation for each of these sections
10 distorts -- and that is the only way to describe it
11 -- the statutory requirements of Act 56, which were
12 developed after thoughtful and lengthy discussions.
13 And frankly, I have talked to many of our members who
14 will likely discourage providers from participating
15 in the assisted living program.
16 The proposed regulations for informed
17 consent, transfer and discharge, and dealing with
18 exceptions relating to excludable conditions are
19 cumbersome to implement, and as written, make it
20 difficult for an assisted living facility
21 administrator to effectively manage his or her
22 facility.
23 The proposed regulations severely limit
24 health-care providers and the facility from providing
25 clinical services based on their best professional

1 judgment, which likewise may limit their ability to
2 safely and effectively care for their residents.
3 While consumer and resident input is
4 necessary and appropriate, final clinical judgment
5 must be in the hands of health-care professionals.
6 In spite of the provisions in the proposed
7 regulations to the contrary, the statute supports
8 this concept. The statute is crystal clear on this
9 concept.
10 The proposed regulations impose the extreme
11 precondition on a residence to make a determination
12 that residents or staff are at "imminent risk of
13 substantial harm" -- that is a quote -- "imminent
14 risk of substantial harm" before it may initiate
15 actions to address a, quote, "dangerous," end quote,
16 situation caused by a resident.
17 This standard, which is similar to that used
18 in involuntary commitments for mental health
19 treatment, is so inflexible that it does not allow
20 providers to ensure the personal security and safety
21 of residents and staff who have appropriately managed
22 their own liability.
23 While a high threshold properly -- and I
24 emphasis "properly" -- exists before someone may be
25 subject to involuntary treatment, such a standard is

1 assuredly inappropriate in the context of a residence
2 having to react promptly and effectively to a
3 dangerous situation caused by a resident in terms of
4 either an informed consent agreement or a transfer
5 and discharge.
6 Our proposed revisions provide the
7 residence, which is ultimately responsible and
8 potentially liable for actions occurring in the
9 facility, the operational flexibility to address the
10 presenting problem.
11 The proposed regulations reverse the clear
12 statutory intent of the legislation as it relates to
13 releasing the residents, quote, "from liability for
14 adverse outcomes resulting from actions consistent
15 with the terms of the informed consent agreement."
16 We have submitted language which reinstates, we
17 believe, the intent of the statute.
18 In terms of transfer and discharge, the
19 proposed requirements exceed once again the statutory
20 requirements and similarly will discourage potential
21 entrants from participating in the assisted living
22 program.
23 The proposed regulations do not include a
24 process for transferring in an emergent and dangerous
25 situation. We have suggested such a provision and

1 also removed the burdensome regulatory requirements
2 on a residence before a resident may be transferred
3 or discharged.
4 Of course, the resident should have great
5 input into the discussion. They should be part of
6 the process, and we provide a way to simplify the
7 overall process.
8 In terms of the sections relating to
9 exceptions and excludable conditions, we have again
10 proposed revisions that establish a process which
11 further ensures the protection of the health and
12 safety and the welfare of the resident.
13 This is achieved in part by requiring that
14 the process for reviewing and determining an
15 exception request by the department is made
16 expeditiously, which is now not in the regulations,
17 by qualified practitioners with experience specific
18 to the population that would reside in an
19 assisted living population, whether they be elderly
20 or whether they be disabled.
21 As you will see by reviewing each of our
22 written submissions to the department, we have
23 submitted proposed revisions in almost every case
24 that outline processes that are equitable for both
25 the resident and the residence and support the belief

1 that resident input is necessary and appropriate in
2 virtually all processes.
3 We believe that we have provided various
4 frameworks that successfully balance the rights of
5 the residents, the rights of the residence, and the
6 residence's obligation to the resident whom we are
7 talking about and to the residents and the staff in
8 general.
9 Now I am going to turn it back to Russ for
10 some concluding remarks.
11 MR. McDAID: Thank you, Stuart and Tim,
12 and thank you, committee -- Chairman Mundy, Chairman
13 Hennessey, and distinguished members -- for listening
14 to our concerns.
15 As we hope you heard from our collective
16 concerns, there are numerous provisions of the
17 proposed regulation that we think threaten the very
18 access to high-quality assisted living that the
19 statute intended to foster.
20 When the department convened the working
21 group on which Stuart and I sat 1 year ago, roughly,
22 they noted it was the department's goal to have these
23 regulations approved and ready for implementation by
24 November 30, 2008.
25 Everything that we did as a working group

1 and everything that they have done since has been
2 about meeting that goal, hitting that date certain,
3 November 30, 2008, rather than making certain that
4 this regulation worked for the consumers who might
5 reside in assisted living and the providers who may
6 or may not show up to the table to provide that
7 assisted living.
8 When last I checked the IRRC Web site, there
9 were more than 200 comments and counting on, I would
10 like to say both sides of the issue, but I have now
11 learned that I think there are four sides to this
12 issue, not just two as I originally thought.
13 The comments are from everywhere, and we are
14 hopeful that the department takes those very
15 seriously, because we are, in essence, creating a new
16 level of care. And we do not believe the time frame
17 that was indicated either by the department to us or
18 a briefing to the Legislature, we understand, where
19 we were going to turn around comments or a final
20 regulation within 5 days of the IRRC finishing their
21 review, I believe, is appropriate. We just do not
22 think it is possible that the department can complete
23 a thorough, thoughtful review of the comments in that
24 time frame.
25 And as you heard today, that issue is too

1 important. I mean, there are a number of open
2 issues, and they have all been hit already -- the
3 square footage piece. Are these units where people
4 will receive care, or are they to be designed to be
5 apartments and have all the amenities therein? That
6 is a bigger distinction.
7 You know, we certainly, when you hear our
8 comments on square footage, are not making any
9 comment to what is appropriate for an apartment
10 unit for a younger individual living with a
11 disability.
12 The fact is, though, the lion's share of the
13 population in assisted living residences, both in
14 Pennsylvania and nationally, will be frail seniors.
15 That is a much different physical environment that is
16 needed and a much different entity, if you will, to
17 regulate. That is something that we think that you
18 as policymakers and the IRRC are going to have to
19 wrestle with.
20 We have given you our thoughts, and we would
21 be more than happy to participate in whatever
22 discussions come out of this hearing or beyond as
23 we move forward and grapple with those important
24 issues.
25 With that, I will wrap up and ask if you

1 have any questions for us. Thank you.
2 CHAIRMAN MUNDY: Thank you, gentlemen.
3 Questions from the committee?
4 Representative Gingrich.
5 REPRESENTATIVE GINGRICH: Thank you,
6 Madam Chairman, and I know we are running very late,
7 so.
8 But I do want to thank you folks very much
9 for some enlightening discussion here, and cost is a
10 reality. I think we have all come to realize this in
11 choosing whether or not, you know, some of the
12 facilities you would think would be eligible to
13 access this license will or will not choose to do so,
14 and you have addressed some of those with the fees,
15 which are a very, very significant increase from what
16 the providers are dealing with now. We are looking
17 at the square footage issue, which we are still
18 trying to figure out what makes sense there.
19 So we are looking at a couple of things,
20 either an environment for only people that have a
21 great deal of money that will be able to spend the
22 rest of their life and are able to do that, or an
23 early path to Medicaid and into a nursing home. So
24 these are real, real issues, so I appreciate you
25 bringing them up.

1 And I am really looking forward to hearing
2 from our Secretary and so thrilled to see she sat
3 through all of this with us. I would like to get
4 some answers on the dual licensing thing. You know,
5 the statute obviously refers to that. The
6 regulations appear to be more silent than anything on
7 that.
8 So I just need some clarification on that.
9 I appreciate you pointing out the importance of it.
10 Thank you, guys, all of you.
11 CHAIRMAN MUNDY: Representative Watson.
12 REPRESENTATIVE WATSON: Thank you,
13 Madam Chairman.
14 Sorry; a little microphone disfunction, or
15 mine.
16 Gentlemen, thank you very much.
17 Again, my quest right now is just some
18 better understanding.
19 If I might then, Mr. Coughlin, you referred
20 to the fact, and I know that Dr. Shapiro did, too,
21 about we would not see, the way the proposed
22 regulations are configured, it is your contention and
23 you, as really involved in the industry, would not
24 see new facilities built. Am I correct?
25 MR. COUGHLIN: If we were to require the

1 250 square foot minimum, that would be my company's
2 opinion and that is PALA's opinion.
3 REPRESENTATIVE WATSON: Okay.
4 MR. COUGHLIN: I mean, as a practical
5 matter, again, I have listened to all the testimony,
6 and I have been impressed with everything.
7 Particularly I would share with you, it was
8 Ms. Anthony, I believe, that was talking about the
9 square footage requirement of 250 square feet for
10 people with wheelchairs to be able to accommodate.
11 I mean, as a practical matter, the authors
12 of this legislation were wise in creating living-unit
13 accommodations that give the industry a chance to
14 create choices for seniors.
15 Everything is being characterized as a
16 resident living unit being a private apartment home,
17 and while we would suggest that many will end up as a
18 product in that regard, there are other types of
19 assisted living residences with other philosophies
20 that still meet your fundamental philosophy and do
21 not offer that space as a specific private apartment
22 home.
23 I have had a chance to see within the last
24 few weeks a beautiful facility that is referred to as
25 a "cottage," and they have what you would

1 characterize as master bedrooms with private baths,
2 and in a very, very private home-like environment.
3 Fifteen to twenty residents live together
4 and share a living room and share a dining room and
5 share access to a central kitchen, and they are able
6 to care for the kinds of residents that we are
7 describing in these regulations in terms of acuity.
8 Why would we exclude those folks? I mean,
9 as a practical matter, the map shows the standard for
10 what is going on in what is relatively a reasonably
11 sophisticated industry nationally and is yet to be
12 licensed and stimulated in the way of growth here in
13 Pennsylvania.
14 It works in those States, and it results in
15 residents having choices, and they make those
16 choices.
17 You know, we have residents who visit us and
18 choose us because they view our apartments as the
19 most spacious they have seen in their communities and
20 their neighborhoods where they live. Others do not
21 have an interest in that space and prefer a smaller
22 space and prefer a more affordable choice. We need
23 to give them that option.
24 That would be our fundamental point of
25 view.

1 DR. SHAPIRO: And let me just put a number
2 on this thing.
3 We have asked what it would cost to build a
4 250 square foot residence. Now, in some places, the
5 market is going to determine that they will build a
6 300 square feet, 400 square feet, 600 square feet,
7 and they will serve people who can afford to pay
8 that.
9 But if you mandate 250 square feet, in 2008
10 dollars inflated at 5 percent annually in
11 construction costs, and they are going up by more
12 than that, we have gotten answers from four providers
13 across the State and one in the Philadelphia area,
14 and it is attached as Appendix II. In the
15 Philadelphia area, it is going to be almost $7,000 a
16 month for 250 square feet.
17 Now, there are people who will pay that
18 willingly and the market will drive that, but I do
19 not believe that the Medicaid program is likely to do
20 that.
21 The same across the State, the average
22 across the State, it is $5,000 in 2008 dollars.
23 Again, I do not think the Medicaid program is going
24 to be able to afford that, and therefore, I think the
25 net effect is that you are going to see individuals,

1 these facilities, excluding people on Medicaid, which
2 is not something anybody wants.
3 MR. COUGHLIN: I mean, I guess just as a
4 final dovetail comment on Stu, I mean, we appreciate
5 that when most older people will be moving into
6 assisted living residences, they are using most of
7 their personal monthly income, and they are using
8 their life savings, largely expressed as their home
9 equity, to subsidize the difference in terms of the
10 cost of care and their monthly income.
11 When you move that square footage up, when
12 you lay in these regulations that add to that cost
13 and push that price up, you are also putting older
14 people in a situation where they are going to be
15 spending their own assets more rapidly and converting
16 and looking to convert to Medicaid more rapidly.
17 We have heard a lot today about the word
18 "balance," and that is what we need to do now with
19 these regulations, is balance that, create a
20 circumstance where older people can use their own
21 personal income and their own personal assets as
22 prudently as possible to purchase the care for as
23 long as possible, and when they no longer have the
24 resources to continue their care in what has now
25 become their home, Medicaid then steps in.

1 I mean, as a practical matter, that is what
2 a lot of this is going to be about. And so we have
3 to be careful about what we create as the
4 assisted living product, because it will have cost
5 implications substantially to the Commonwealth of
6 Pennsylvania.
7 REPRESENTATIVE WATSON: That answers, I
8 think, my question. Does it make me feel the least
9 bit better?
10 My concern has always been, and I had this
11 discussion with at least one member of a previous
12 panel again and again, that I did not want to do
13 anything that would preclude -- I live in the
14 southeast. I live in Bucks County. In my
15 legislative district, I have a wonderful
16 assisted living facility, NewSeasons. I go there
17 regularly, and I even said, they even do birthday
18 parties where it was the first place I ever saw a
19 chocolate fountain. I was willing to tell them my
20 true age to go back and have a birthday party and get
21 the chocolate fountain.
22 But I have been in the rooms, and I am not
23 sure that they meet that requirement, but they are
24 lovely, and all the public facilities and all. It
25 really is like walking into somebody's very, very

1 attractive home.
2 And I have been there to watch care, and I
3 know they made accommodations for someone who, she
4 lived longer -- she was an older lady but was still
5 in pretty good health. Her son was past retirement
6 age, using his retirement to help keep her. So now,
7 and we heard an earlier story, they moved her to I
8 guess what you would call a semi-private, but they
9 didn't put somebody in, but they could charge her at
10 a cheaper rate. So I have watched all that and known
11 they have made accommodations.
12 I always worry, though, that in other parts
13 of Pennsylvania -- central, particularly
14 northwestern, and places where I knew that incomes
15 were less -- that they would not ever see something
16 the likes of what folks in my area were fortunate
17 enough to possibly be able to afford and exist.
18 Now you are telling me you would not even
19 build perhaps new ones necessarily in the southeast
20 but definitely in other places, and I thought that we
21 would have some facilities that were larger that
22 would exist that would take a particular wing and
23 kind of reconvert so that that would be
24 assisted living but still on the same, let's say
25 parcel of ground, so that if I needed, if I were in

1 personal care and wanted to move up, I didn't
2 actually have to go to a new place; I just went to a
3 new part of my home.
4 I happen to be familiar with some of that
5 idea, and I do not know, Russ can explain better than
6 I. I just know the system in the Presbyterian Care
7 System, and essentially that was something that was
8 done years ago, was so that you didn't actually have
9 to move within your system from one particular home
10 to another; you just went to a different wing. And
11 my grandmother was in there, and I knew that seemed
12 to work, before I ever did this job or paid attention
13 -- I was just, you know, a consumer -- I knew that
14 seemed to work well.
15 Are you suggesting to me then that that will
16 not happen geographically in other places and I will
17 not see new facilities built, I mean, that I would
18 like to see that everybody had an opportunity for
19 who needed it? Is that what I am getting out of
20 this?
21 MR. McDAID: Yes, I think we are suggesting
22 both.
23 I think clearly as the regulations are
24 currently drafted on the dual licensure, that model
25 where, you know, that is licensed personal care today

1 but is a different level of care, and you
2 acknowledged it, that when you were in that same wing
3 it was a different level of care being provided in
4 those other units, that that couldn't happen under
5 these regulations because everything, theoretically,
6 on that site, there would be one license when you
7 walk in, and if everything didn't meet it, you would
8 not be able to be assisted living.
9 That, again, and as several of you know,
10 Secretary Richman is coming after us; she may have
11 some clarification on that. That is the only way we
12 think that you can read the regulation.
13 On the issue of square footage in other
14 regions, I can tell you, I told you that 40 percent
15 of our members had some stock that wouldn't meet the
16 grandfathered square footage of 175 square feet.
17 Many of them come from the areas that you are
18 concerned about.
19 And when we say some stock, some of them
20 told us how much and some of them didn't. Some of
21 them I have no idea whether that is a corner, it is
22 two rooms, and the rest of them meet it.
23 I do know that, I heard from one yesterday
24 in Erie that 74 percent of their units would not meet
25 the 175 square foot minimum; another in the Venango

1 County area that has 60 percent of their units that
2 would not meet the square footage minimum. And
3 Mr. Coughlin is located in that area, so he may be
4 able to tell you, you know, with some more
5 specificity than I can about those other markets.
6 But Pennsylvania has a number of markets,
7 and you are right, the economic realities vary across
8 the State.
9 REPRESENTATIVE WATSON: Madam Chairman, can
10 I just make one quick last question? Thank you.
11 MR. COUGHLIN: If I could just comment.
12 Just one more point, two more points, actually, in
13 response to your last comment, Representative Watson.
14 First of all, I would share with you that
15 NewSeasons is a member of our association, and we
16 have heard from NewSeasons and they have told us that
17 their existing stock will not meet the proposed
18 existing stock regulation. They have voiced concern
19 to us and have asked us to represent them today.
20 Secondly, I think the question may
21 inadvertently imply that if we establish these
22 square footages as the minimum, that is all that will
23 ever get built, and that is not the case at all.
24 Older people certainly want space, and they
25 want, often, not all older people, but often they

1 want space as spacious as possible. The market will
2 respond to that. You will see that happen.
3 I would not suggest that whatever you
4 establish as the minimum is all that happens in
5 Pennsylvania with new construction. People,
6 providers, first and foremost, will be responding to
7 the interests of the buyer. But at the same time, we
8 want to be sure that the minimums are not excluding
9 good providers in choices that older people generally
10 want.
11 I have talked with families who have
12 residents who are struggling with dementia who want
13 their loved one to be able to function as
14 independently as possible in her apartment, in her
15 room, in her home, and in some of those cases, a more
16 modest amount of space. It still is very workable,
17 is very helpful to that person, and helps that person
18 do things independently that they cannot do normally
19 with more space.
20 REPRESENTATIVE WATSON: I thank you for
21 that.
22 And very briefly, I just have concerns and
23 learned a lot relating to folks who have
24 disabilities, either born with them or somehow come
25 upon them. But they are not what I call my seniors;

1 they are still "the happening" folks, not the real
2 frail elderly that you keep talking about that may
3 possibly end up at some point wheelchair bound.
4 Is there anything in the industry or around
5 the nation that says I would build facilities in
6 assisted living for those folks, because some of
7 their other needs, and I will call it psychological,
8 emotional, and everything else, social, might be very
9 different. If I am 45 or 50, it is different than
10 when I am 85 and frail and in a facility and maybe in
11 a wheelchair. I will, of course, lie and say I am
12 only 80. But very seriously, I am in a different
13 place and a different mindset and whatever.
14 Does anybody build that they could have a
15 bigger room but do more for folks because they are at
16 a different place in the whole lifespan? It is just
17 that they are wheelchair bound or something like
18 that.
19 DR. SHAPIRO: Russ?
20 REPRESENTATIVE WATSON: Do they ever do
21 anything like separate areas?
22 I am thinking in terms of then that would
23 allow for bigger rooms, you know, for folks like that
24 versus other folks who, as you said, which is true
25 with some dementia, you scale things down because it

1 is manageable, make it small.
2 DR. SHAPIRO: I cannot answer your question
3 explicitly, because I do not know. But I can say
4 that we ought to be designing facilities that can
5 accommodate different people with different needs,
6 and we may not need to have all things identical in
7 every facility.
8 How do you do this? I don't know, but we
9 must assure that we do address the needs of the
10 handicapped, which is a different population. But
11 how that mix and match, I have not figured out, and I
12 hope the Secretary has more and better thoughts on
13 that than I do.
14 REPRESENTATIVE WATSON: Thank you very much.
15 Thank you, Madam Chairman, for giving me the
16 time.
17 CHAIRMAN MUNDY: Sure.
18 Representative Hennessey.
19 REPRESENTATIVE HENNESSEY: Thank you,
20 Madam Chairman.
21 Dr. Shapiro, preliminary notes to the
22 proposed regs indicated an assumption on DPW's part
23 that 7 percent, 100 out of 1,450 personal-care homes,
24 would likely seek to upgrade.
25 I am wondering if you could tell us, do you

1 have any sense of how many nursing homes would likely
2 seek to have part of their facilities, assuming that
3 we wrestle with the dual licensure issue, also
4 classified as assisted living?
5 And I will tell you why I am asking the
6 question. The assumption from DPW in followup
7 material is that it could be 7 percent for 100 units
8 in the first year -- or 100 companies, I guess, with
9 personal-care homes -- and 50 in each of the
10 following 3 years. Essentially, that is 16 percent
11 of the personal-care homes across the State stepping
12 up to become assisted living and meeting the
13 requirements.
14 I do not know whether that is enough. I do
15 not know whether or not if we add in those nursing
16 homes that would reclassify part of their facilities
17 to assisted living, whether that total then gives us
18 enough inventory to take care of all the need for
19 assisted living in Pennsylvania.
20 DR. SHAPIRO: We have done some modeling.
21 All I can do is talk about the general modeling.
22 REPRESENTATIVE HENNESSEY: I saw your
23 assumptions about costs, but I am just wondering
24 about numbers.
25 DR. SHAPIRO: Yes.

1 REPRESENTATIVE HENNESSEY: All right.
2 DR. SHAPIRO: We have looked at and the
3 department has looked at the individuals who are in
4 nursing homes today, and there are some, but a very
5 small number of individuals, who today are in nursing
6 homes who would go into assisted living. The numbers
7 are going to be small, so we do not see a wholesale
8 shift for a capacity need from those in nursing homes
9 today. We think the shift is going to come from the
10 personal-care homes that we will convert, and we
11 think the regulations, because of the way they are
12 written, are going to limit that conversion.
13 And the limits -- and I am really talking
14 about the Medicaid population -- we do not see these
15 numbers being very high in the very, very short run.
16 We see some, but the cost limits are going to be very
17 prohibitive, and I think that is what is going to
18 control that rate of migration.
19 And we have got some modeling that we are
20 going to be prepared to talk about in the next
21 several weeks that will look at this in terms of the
22 demand and moving in both directions.
23 REPRESENTATIVE HENNESSEY: Okay. Well, then
24 let me see if I understand.
25 What you are telling us is if 7 percent or

1 100 personal-care homes in Pennsylvania actually step
2 up and become assisted living homes, and then
3 followed by 50 and 50 and 50 in the 3 years that
4 succeed, is that going to be enough assisted living
5 rooms out there to take care of the people who need
6 assisted living?
7 DR. SHAPIRO: I am not sure of that answer
8 yet. I do not want to give you an answer today
9 because the work is not done. And I would like to
10 see the department's work on how they got those
11 numbers, but I am not in a position to say whether
12 they are right or they are wrong.
13 REPRESENTATIVE HENNESSEY: Okay.
14 Let me shift to regulation 142, if I could,
15 and that allows the assisted living institutions, as
16 I read it, to restrict their residents' medical care
17 to one of the home's preferred doctors who are
18 medical providers. And there is primary care and
19 there is supplemental care and supplementary, and
20 I guess you could even talk about equipment
21 providers.
22 It would seem to me then that the statute is
23 trying to give seniors a broader array of choices,
24 but in terms of their medical care, that regulation
25 would seem to restrict the choices, a very basic

1 choice, of which doctor they can go to. And it seems
2 under the informed consent clause that basically they
3 would be surrendering their right to go to a doctor
4 of their choosing or a doctor who is part of the
5 network that they are insured by and instead be
6 forced to use the residence's, the institution's
7 choice of doctors.
8 Now, tell me if that is what the reg says.
9 That is how I am interpreting it. Is that what was
10 intended, and if that is the case, tell us why, why
11 that is important from an institution's point of
12 view.
13 DR. SHAPIRO: That is certainly the way the
14 statute is written. And if someone wants to go---
15 REPRESENTATIVE HENNESSEY: Do you think that
16 is right or wrong? Just tell me if it is a good idea
17 or a bad idea.
18 DR. SHAPIRO: Well, if someone who is in an
19 assisted living residence wants to go to a private
20 doctor that is paid for by their insurance, and most
21 of the time it will be, because they are older, under
22 Medicare, there is nothing in the statute that would
23 prohibit that.
24 But in terms of the providing of the
25 supplemental health services in the facility, which

1 are, by and large, being provided either by the
2 facility or by an outside provider, in order to run
3 it in an efficient way that works with the systems,
4 the supplemental health-care providers would have to
5 be approved by the residence. And do I think that is
6 a good idea? Absolutely.
7 And if you were to go, because we are now
8 talking about the delivery of health services. If we
9 are now going to talk about you want to go to a
10 surgery center to have a minor surgical procedure,
11 you can't pick your doctor for that facility; they
12 have a list of doctors. They have a list of
13 providers that are allowed to work there.
14 This is the way the health-care system works
15 for the delivery of health-care services. If you go
16 into your local hospital in Chester County, you
17 cannot pick a doctor who is not on the staff there.
18 You cannot have a radiologist come in to do a
19 radiological procedure, or a physical therapist. If
20 they have a physical therapist there, if they are not
21 there, then -- so it is the way the system works.
22 It is the only way to run it in an
23 efficient, orderly, systematic way, and that is why I
24 believe the writers of the statute wrote it exactly
25 like that.

1 REPRESENTATIVE HENNESSEY: If I am a
2 resident in an assisted living facility and I have
3 always gone to Dr. Kane for my medical services,
4 medical treatment, and I choose and I am able to
5 leave the facility and go to Dr. Kane, this
6 regulation does not stop me---
7 DR. SHAPIRO: It absolutely -- I do not read
8 that as that regulation stopping you from going to
9 have a doctor's appointment, just like any---
10 REPRESENTATIVE HENNESSEY: No, that's --
11 because it is primary care or because it is
12 supplemental health care?
13 DR. SHAPIRO: It is not delivered in the
14 facility. So if you want to go, just like if you
15 want to go to your barber, then you can go to your
16 barber.
17 REPRESENTATIVE HENNESSEY: Okay, but it says
18 a residence, an institution, may require the
19 residents thereof to use providers of supplemental
20 health-care services approved or designated by the
21 residence. It does not say who are willing to, you
22 know, provide those services provided in their
23 residence. It does not seem to allow a resident
24 to choose to go outside to see his or her family
25 doctor.

1 DR. SHAPIRO: I do not think there is a
2 residence in America that would want to try to limit
3 going to outside providers. That is not the intent
4 of the drafters, I do not believe, and I think that
5 if your reading of it is the way -- that, to me, is
6 not something that certainly I, and I have not talked
7 specifically to either Russ or Tim about that, but
8 that we certainly do not have an objection to -- to
9 you making that modification.
10 MR. COUGHLIN: Representative, if I could
11 add to Dr. Shapiro's opinions just a little bit.
12 I mean, as a practical matter, when we read
13 the term "supplemental health provider," we assume
14 that we are talking about health providers that would
15 be coming to the assisted living residence and
16 augmenting the core services that the assisted living
17 provider is providing.
18 It is a routine---
19 REPRESENTATIVE HENNESSEY: Like a supplier
20 of oxygen, for example?
21 MR. COUGHLIN: Exactly, Representative.
22 It is a routine activity, as an example --
23 holding our company out as an example -- it is a
24 routine activity in our communities right now in
25 Pennsylvania that we have home health agencies coming

1 in, with Allied Therapy. We have others involved in
2 the community who are chosen by the residents to
3 augment the services that we provide.
4 Now, with that said, we do have some
5 policies that we need those outside providers to meet
6 before they begin service to our resident to the
7 extent that we are held responsible as the primary
8 parties in a duty of care to those residents.
9 You know, we have to be sure, as an example,
10 even in personal-care-home licensing and regulations,
11 as I understand it, you know, if that care is
12 provided, that is happening under our licensure and
13 we are viewed as responsible for the care that that
14 resident is getting.
15 You know, our general policies as an
16 assisted living community is we want to be sure that
17 any outside home health staff that come into our
18 community have criminal background record checks done
19 and that they meet the requirements of our
20 caregivers. We want to make sure that when home
21 health agencies come in, they talk with us in advance
22 of seeing the resident so we can update them on our
23 points of view of their health care, and they talk
24 with us when they go out so we understand what they
25 did.

1 One of the most complex things in the care
2 of older people who are dealing with multiple chronic
3 conditions is coordination of care among multiple
4 health providers.
5 And PALA's comments -- and I think I can
6 speak generally for all of us at the table today --
7 is our interest is to be sure that, A, we have got
8 the ability to coordinate that care to be sure that
9 certain standards are met to give the resident the
10 greatest opportunity of choice, but not to let a
11 situation get created where care is happening from
12 an inadequate provider to folks who we are primarily
13 responsible for and could be being placed at
14 risk.
15 REPRESENTATIVE HENNESSEY: Okay. I agree
16 with the way you describe your interpretation of the
17 reg. I just do not think the reg says that, and I
18 think it probably needs to be looked at by DPW and
19 IRRC to find out whether or not we can reword it in a
20 way that supports the way you gentlemen have
21 described it to us.
22 I think that's the right way; I just don't
23 think it says it here. Whoever put pen to paper and
24 drafted that reg I don't think did it as artfully as
25 you have done it in your testimony.

1 MR. COUGHLIN: Well, I don't know about how
2 artfully, but I think, Representative, it stands as a
3 fine example that all of us in this room have been
4 waiting decades to get here, and we have all done a
5 great job to get it this far.
6 And as Russ and Stu commented a few minutes
7 ago, let us slow it down only enough that we can get
8 through a debate and a consensus of these things,
9 clarifying and resolving those kinds of issues, as
10 opposed to meeting some kind of self-imposed
11 deadline.
12 We want a chance, we want a chance to
13 resolve this better for you.
14 REPRESENTATIVE HENNESSEY: Thank you.
15 CHAIRMAN MUNDY: Representative Curry.
16 REPRESENTATIVE CURRY: Thank you,
17 Dr. Shapiro. I think I have answered my own question
18 with your answer earlier.
19 But if there is a conflict between the
20 consumer and the doctor and the residence, can they
21 go outside to their own doctor?
22 You were talking about a consumer has the
23 right to make decisions on what treatment they will
24 get, but the doctor or the facility has the right to
25 make that decision. So I guess if there is a

1 conflict, they go outside?
2 DR. SHAPIRO: No; I think the way it is
3 established is if the resident wants to go to their
4 doctor, they are welcome to go to their doctor.
5 Their doctor will prescribe what they -- it is
6 services that will be provided by the facility of
7 which the facility is liable and which is
8 delivering.
9 If the doctor in the facility and the doctor
10 outside are in conflict, they need to resolve that in
11 the best interests of the individual. And doctors
12 disagree all the time, and they would discuss this
13 and try to work that out.
14 So that is generally not an issue. But the
15 facility is -- if a doctor on the outside says, I
16 want the individual to get XYZ medications, and the
17 facility says, I do not think we should prescribe or
18 give those medications, there is a conflict that will
19 need to be resolved, and there is a mechanism in the
20 regulations that we have proposed to resolve those
21 issues.
22 REPRESENTATIVE CURRY: We don't have that
23 before us, though, do we?
24 DR. SHAPIRO: It was in our comments that we
25 submitted.

1 REPRESENTATIVE CURRY: Not today.
2 DR. SHAPIRO: We submitted a 90-page
3 document of comments on the regulations---
4 REPRESENTATIVE CURRY: But they are not here
5 today.
6 DR. SHAPIRO: No, that is not here today.
7 REPRESENTATIVE CURRY: Okay. So somebody
8 could go outside or go to their own physician.
9 But you do say that the physician and the
10 resident have the ability to determine whether they
11 are going to provide that service or not?
12 DR. SHAPIRO: Absolutely.
13 REPRESENTATIVE CURRY: Yeah; okay.
14 And the consumer could ask for something
15 else?
16 DR. SHAPIRO: They could go someplace else,
17 but the ultimate care delivered, while that person is
18 a resident, there needs to be an informed consent
19 agreement that they are in agreement with.
20 But you cannot make a health-care provider
21 do something that they are not comfortable doing. I
22 will give you an example.
23 Your doctor says to you, I think you need
24 X care and go over to a specialist to get that care.
25 That specialist looks at you and says, I do not think

1 you need that care, or that care is dangerous; I'm
2 not going to do it. Then you have to go someplace
3 else to get that care.
4 You cannot force a provider to do something
5 that he or she or a resident thinks is wrong. That
6 is not the way--- No one is going to take on that
7 liability if they ultimately think it is wrong.
8 REPRESENTATIVE CURRY: And so you resolve
9 the conflict by the patient getting their own
10 physician to come in?
11 DR. SHAPIRO: No. You may resolve it that
12 way, if there is an informed consent agreement. Or
13 in the end, if the residence is not comfortable with
14 the care that someone is recommending or someone
15 desires, there is a detailed process outlined. But
16 then, frankly, that person would be discharged, just
17 like they would in a hospital or anyplace else.
18 You can't force a provider, in my view, to
19 deliver care that the provider thinks is either
20 unsafe or bad. You just can't.
21 REPRESENTATIVE CURRY: Okay. And where is
22 this document that it is spelled out?
23 DR. SHAPIRO: It is in our comments to the
24 proposed regulations, and I am glad to get you a copy
25 of those.

1 REPRESENTATIVE CURRY: Okay. Thank you.
2 DR. SHAPIRO: In fact, I believe it is,
3 frankly, already in the mail, because we have mailed
4 them to every member of this committee. So you
5 should have it in your office today.
6 REPRESENTATIVE CURRY: Okay. Thank you.
7 CHAIRMAN MUNDY: Thank you for your
8 testimony. I really appreciate it.
9 Our next testifier is Mr. John Schwab,
10 Director of The Hickman in West Chester,
11 Pennsylvania.
12 Ladies and gentlemen, while our next
13 testifier takes a seat, we are behind, and I would
14 rather not break for lunch. I get cranky when I get
15 hungry. And the committee knows they do not want me
16 to get cranky.
17 So I am hoping that we can be clear and
18 concise in our questions and answers.
19 MR. SCHWAB: Madam Chairman, I will try and
20 be quick.
21 CHAIRMAN MUNDY: Mr. Schwab, thank you for
22 coming, and you may proceed.
23 MR. SCHWAB: Chairwoman Mundy and
24 Chairman Hennessey and members of the committee, I
25 thank you very much for the opportunity to address

1 you today.
2 My name is John Schwab, and I'm the Director
3 of The Hickman. It is a licensed personal-care home
4 in West Chester sponsored by the Religious Society of
5 Friends, the Quakers.
6 We have 65 residents and have been providing
7 personal-care services to the elderly for 117 years.
8 Over that time, The Hickman has committed to serve
9 the low- to moderate-income population. Until just
10 recently, 72 percent of our residents met the Federal
11 criteria of 60 percent or lower of the Area Median
12 Income. Currently, it is at 55 percent.
13 In recent years, two trends have challenged
14 our ability to maintain our commitment to serve a
15 low- to moderate-income population, and they are the
16 general costs of doing business, such as insurances,
17 utilities, and labor costs, and secondly, the cost of
18 complying with regulations.
19 In over 30 hours of meetings, The Hickman's
20 Legislative Committee, comprised of three staff
21 members and nine residents, has studied Chapter 2800,
22 Assisted Living Residence Regulations. We have
23 collected the attached comments, feeling that in many
24 cases, the regulations are unduly strict or will lead
25 to unnecessary expenditures.

1 Such regulations will likely put
2 assisted living residences out of the financial reach
3 of all but the wealthy, leaving the much larger group
4 of low- to medium-income people unable to access
5 them.
6 Existing personal-care homes with plans to
7 devote a floor or a wing or maybe just a set of rooms
8 to assisted living may find implementing these
9 regulations financially prohibitive.
10 It is important for you to understand that a
11 vital aspect of an assisted living residence is that
12 it cares for the needs of all qualified people in a
13 home-like, comfortable environment. The proposed
14 assisted living regulations represent another layer
15 of oversight that will add additional costs.
16 We understand the increased complexities
17 associated with providing supplemental health-care
18 services and the need for more comprehensive and
19 costly requirements, but we would be negligent in not
20 pointing out those regulations that, in our opinion,
21 add to the cost without necessarily adding to the
22 health, welfare, and safety of our residents.
23 The requirement for 250-square-foot rooms,
24 not including a bathroom or closet, along with the
25 kitchen requirement, is a particular concern. In our

1 market area, the building cost is at $147 per
2 square foot. A 200-square-foot room with a
3 six-by-eight bathroom and a two-by-six closet would
4 equal 310 square feet and cost about $45,570 to
5 build.
6 This cost will be passed on to consumers,
7 adding to the ever-increasing cost of care. There is
8 no doubt that many consumers will want this larger or
9 a larger accommodation and will be able and willing
10 to pay for it, but it is equally true that many
11 consumers will not want that larger unit and will not
12 be able or willing to pay for it.
13 The marketplace will always accommodate
14 those that can afford whatever they want. Our
15 concern is for those consumers who will be denied
16 access to assisted living residences because their
17 income is too high for government subsidies but too
18 low to afford private-pay assisted living.
19 A lower square-foot requirement will allow
20 more units to be built for the same amount of capital
21 costs and will allow access and choice to those who
22 either prefer or require lower costs.
23 The alternative, of course, is for
24 government to subsidize the thousands of units that
25 would be necessary to ensure access to

1 assisted living residences for every Pennsylvanian in
2 need.
3 Today, you have heard from many fine
4 individuals and groups, each with their own concerns
5 and points of view. What I would like to do is to
6 ask you to consider the 1999 report titled
7 "*Assisted Living: Long-Term Care and Services*
8 *Discussion Session Findings*." I realize that 1999
9 might have been a long time ago, but I think their
10 findings are as relevant today, actually I think even
11 more so, than they were in '99.
12 This report was drafted by the management
13 consulting firm Dostalik ET AL, under contract with
14 the Pennsylvania Intra-Governmental Council on
15 Long Term Care.
16 Dostalik was commissioned to conduct a
17 series of 12 structured discussion groups across the
18 State. Hundreds of individuals participated, many of
19 them elderly consumers of senior services.
20 In their report they stated that, and I
21 quote, "Based on the consistency of messages
22 heard, they believe this report is an accurate
23 portrayal of what a cross-section of people across
24 Pennsylvania think and want with regard to
25 assisted living."

1 The report identified six issues around
2 which the participants' messages were centered:
3 consumer choice; defining "assisted living"; aging in
4 place; shared or negotiated risk; regulation and
5 quality of care; and funding -- many of the issues we
6 have heard about today.
7 Act 56 represents much progress in
8 addressing the above. I think it has done a
9 phenomenal job in addressing much of the above.
10 I would like to briefly touch on three of
11 the messages in hopes that we will not lose sight of
12 what those participants have told us.
13 Consumer choice, and I am quoting from the
14 report:
15 "In almost all cases, the philosophy of
16 consumer choice drove the participants' responses.
17 Time and time again, the aspect of consumers having
18 control, making decisions for themselves, and taking
19 responsibility for the consequences rose to the
20 surface. In fact, for many participants the appeal
21 of assisted living was based on the aspect of having
22 choices, particularly when the Council's definitions
23 of assisted living services and assisted living
24 residence, which incorporate choice, were shared with
25 the participants," end of quote.

1 Clearly, consumers do not want a system that
2 is so regulated and regimented that consumers are
3 left with little or no choice.
4 Regulation and quality of care, another
5 message from the discussion groups, and again I
6 quote:
7 "The majority of participants believed that
8 quality is best handled by a combination of consumers
9 and government, with minimum regulation serving as a
10 starting point and guiding, not dictating, quality of
11 care. They believed that while this base of
12 practical regulation is important, it is the
13 consumers' feedback that should be the defining
14 factor. There was overwhelming agreement that the
15 nursing facility model for quality is not working,
16 due to the experiences participants had with what
17 they perceived as less than appropriate quality.
18 "Participants believed that regulation
19 should provide a practical and sensible base-line
20 from which consumer input and satisfaction feedback
21 would then drive the level of quality," end of
22 quote.
23 I ask that you consider this feedback and
24 avoid the temptation to regulate quality out of the
25 assisted living system by prescribing for every

1 possible resident type and scenario.
2 They addressed funding in the report and
3 wrote, and I quote:
4 "Participants of the discussion groups
5 resoundingly felt that there must be a reallocation
6 of funds from the nursing facilities to
7 community-base services. However, they also
8 felt that mere reallocation would not be enough;
9 there must be additional funding sources
10 developed."
11 I cannot stress enough my concern that we
12 are creating a system of care that will serve a
13 handful of very poor, those lucky enough to get a
14 waiver, and the very rich, while the ever-growing
15 population of low- and moderate-income consumers will
16 never be able to afford to live in an assisted living
17 residence.
18 By my calculations, a new assisted living
19 residence in southeast Pennsylvania will cost
20 consumers somewhere between $5,000 to $7,000 a month,
21 and that is $60,000 to $84,000 a year.
22 My additional comments are related to
23 specific sections of the regulations, and I do not
24 need to go over them now.
25 Thank you.

1 CHAIRMAN MUNDY: Thank you very much,
2 Mr. Schwab.
3 REPRESENTATIVE HENNESSEY: Thank you very
4 much.
5 CHAIRMAN MUNDY: Can you tell me what the
6 current square footage of The Hickman is?
7 MR. SCHWAB: When I looked at that, I think
8 it was 54 of our 67 units met the 175-foot
9 requirement but did not have kitchenettes.
10 A much, much smaller percentage, I think
11 there was really about 16 or 18 rooms that met the
12 250-square-foot requirement.
13 CHAIRMAN MUNDY: Okay. Thank you.
14 Questions?
15 Representative McIlvaine Smith.
16 REPRESENTATIVE McILVAINE SMITH: Thank you,
17 Madam Chairwoman.
18 I want to thank John Schwab for being here
19 today. I am very familiar with The Hickman. It is
20 just a block away from my office, and being a Quaker,
21 I appreciate the Friends service to the low- and
22 moderate-income consumer. They have done a great job
23 in our community.
24 I wanted to ask, John, did you plan, before
25 these regulations came into being, had you planned on

1 adding assisted living to The Hickman?
2 MR. SCHWAB: In '07, we worked with a
3 consultant and developed, it was about a
4 60,000-square-foot building to replace one of our
5 existing buildings. And at the time, we had designed
6 it to be that the second and third floor would have a
7 total of, I think it was around 24 units of
8 assisted living, and the first floor was going to be
9 16 units of Alzheimer's care and dementia care. We
10 based that on the program elements of the
11 personal-care-home program.
12 So the numbers I used, now, those units were
13 much more generous than the 250, because we were
14 looking at market-rate personal care, but as I tried
15 to subtract out some of the additional square
16 footage, convert it to kitchenettes, and then add in
17 a layer of additional requirements, I was not -- I
18 was slightly over, a little bit over the expected
19 monthly costs that we had proposed.
20 REPRESENTATIVE McILVAINE SMITH: So you
21 decided then not to do it, not to pursue it, because
22 it would not be cost-effective and people wouldn't be
23 able to afford it?
24 MR. SCHWAB: Well, with the new layer of
25 assisted living regulations driving the costs up to

1 these new numbers, it takes you way over the income
2 bracket that we desire to serve.
3 Sixty percent of the median income in our
4 southeast Pennsylvania is income just under $32,000 a
5 year, and we would be looking at something like
6 $60,000 to $84,000 a year to live there. So we are
7 definitely rethinking that and looking at alternative
8 ways of possibly accomplishing the same thing in a
9 more affordable manner.
10 REPRESENTATIVE McILVAINE SMITH: So, and I
11 just want to make this clear, when I first met you
12 years ago, I remember thinking that you were an
13 assisted living facility, and when I came into the
14 House last year, when I heard that there was already
15 legislation coming down about creating this new level
16 of care, I kept thinking, but we already have
17 assisted living, and then I found out that it is
18 actually personal-care homes that we have. And I
19 think, at least in the southeast, we confuse our
20 terminology. We refer to our personal-care homes as
21 "assisted living."
22 And I just have to quickly, and I know that
23 the Chairwoman is getting hungrier by the moment, but
24 I have to refer back to Jacqueline Shafer, you know,
25 the question: What is the difference between

1 personal care and assisted living? And that is where
2 I sort of started from way back when, and I still am
3 a little bit confused.
4 But I just wanted to ask one final question
5 of you. You know, when these regulations are set
6 and, you know, we finalize them, et cetera, how will
7 they change your operation or how will it impact your
8 residence and how will it impact our immediate area
9 in West Chester?
10 MR. SCHWAB: Well, one of the dilemmas we
11 are faced with is and another stated mission of
12 ours is to serve people, for providing all the needs
13 they have for their declining years, and that has
14 always been interpreted, ever since 1891, until
15 death.
16 Now, we have certain limitations, and we had
17 looked forward to the option of doing assisted living
18 with a dementia program thinking that probably
19 another 60, 75 percent of the residents that had to
20 leave us for nursing-home care or dementia care would
21 not have to with the assisted living. But I am
22 really rethinking that entirely now.
23 We are really -- I am encouraging our board
24 to look towards a more independent model and try and
25 create an aging-in-place system of care.

1 REPRESENTATIVE McILVAINE SMITH: Yes. I
2 appreciate it. Thank you, John.
3 Just my final comment on that. You know, we
4 have independent living places -- that I guess they
5 call them senior living; I don't know what they call
6 them -- but it is where a lot of people go when they
7 just want to live with a lot of other people, sort of
8 like an apartment house. And then you get to move
9 into the personal-care home, and now we are going to
10 have this new level of care called assisted living,
11 and then eventually the nursing-care home and finally
12 the funeral home.
13 But I really believe, you know, that we have
14 got to make it easier for people to, as John just
15 said, to age in place, and I know that Friends down
16 in, and Crosslands -- I cannot remember what their
17 independent living place is called. My one aunt
18 lived there, and I have an aunt still living at
19 Crosslands, which is the next step up, which is the
20 "assisted living," quote, unquote, and then---
21 MR. SCHWAB: Kendal.
22 REPRESENTATIVE McILVAINE SMITH: ---Kendal,
23 which is the nursing-home care, and I really think
24 that is the proper model.
25 And Hershey's Mill, which is the other end

1 of the spectrum, because it is a very wealthy area or
2 a wealthy community, and it is called Hershey's Mill,
3 and that is where people live independently. And
4 then they move into the Wellington, which is a very
5 fancy, fancy place, sort of like a plaza, you know,
6 as their assisted living. And now they are just
7 creating a nursing home right there.
8 So again, they will be aging in place, and
9 that is the model I would like to see us do more and
10 more of. And I know that philosophical versus the
11 practical really is very clear to me here. It is
12 going to be hard to bring those two together.
13 But I thank you for your testify today.
14 Thank you, Madam Chairwoman.
15 MR. SCHWAB: Thank you.
16 CHAIRMAN MUNDY: Thank you, Mr. Schwab. We
17 appreciate your being here. We appreciate your
18 testimony.
19 MR. SCHWAB: Thank you.
20 CHAIRMAN MUNDY: Next is the University of
21 Pittsburgh Medical Center Senior Communities,
22 Daniel Grant, Vice President of Operations.
23 MR. GRANT: Good afternoon, Chairman Mundy
24 and the members of the committee.
25 I would like to thank you for the

1 opportunity to speak today about the proposed
2 assisted living residence regulations.
3 My name is Dan Grant. I am the
4 Vice President of Operations for UPMC Senior
5 Communities.
6 UPMC is the region's largest employer with
7 over 48,000 employees and more than $7 billion in
8 revenue. UPMC comprises 20 hospitals, 400 outpatient
9 sites and physician offices, and senior-care services
10 provided throughout the UPMC Senior Communities and
11 community- and home-based services.
12 The UPMC Senior Communities is southwestern
13 Pennsylvania's only provider of senior housing owned
14 and operated by an academic medical center.
15 We truly offer a continuum of care, which
16 includes not only 4 skilled nursing facilities,
17 totaling 532 beds, but also 6 independent facilities
18 and 5 personal-care facilities totaling over
19 500 beds.
20 On an annual basis, UPMC hospitals
21 discharged over 167,000 patients, and about
22 25 percent go directly into skilled-care facilities.
23 Our owned facilities accept the majority of these
24 patients.
25 Increasingly, our skilled nursing admissions

1 are truly "post acute," short-stay patients who
2 require specific skilled services before they are
3 discharged to homes. It is apparent to us that many
4 of the traditional, quote, "long-term residents" can
5 be cared for elsewhere.
6 During my 30-year career in health care, I
7 have had the opportunity to function as a
8 critical-care nurse in the civilian sector and served
9 21 years in the Pennsylvania Air National Guard
10 Medical Squadron as a nurse caring for military
11 members in both the States and overseas.
12 My experience includes various management
13 and administrative positions in acute-care hospitals
14 and the long-term-care industry. I believe my
15 experience provides me a unique perspective with
16 regard to continuum of health care, and most
17 importantly, the basic function of what the
18 regulations address, which is the provision of
19 quality resident care.
20 Over the years, certain aspects of the
21 health-care services has shifted from acute hospitals
22 to lower levels of care, including long-term acute
23 care, LTAC; transitional-care units, TCUs;
24 rehabilitation hospitals; skilled nursing facilities;
25 and home health.

1 It is not unexpected to the UPMC Health
2 System that the long-term-care resident traditionally
3 found in skilled nursing facilities can be
4 transitioned to a lower level of care. It is in this
5 context that we acknowledge the need for regulatory
6 oversight of the assisted living.
7 We applaud the Commonwealth for adopting the
8 goals and providing choice to consumers of protecting
9 our senior citizens and their families and assuring
10 consistency and integrity in the industry.
11 We have previously submitted detailed
12 comments on the regulatory language. I will not
13 review all the specifics here, but as an interested
14 and active stakeholder in senior-care services, we
15 would request the members of the committee to
16 consider our concerns.
17 Our comments focus on the concern that
18 regulations apply a mandated approach to residential
19 services, significant administrative burdens, and
20 a substantial increase in operation costs while
21 having minimal effect on improving the care delivery
22 system.
23 Further, the regulations, while demanding
24 significant cost increases, provide no funding of
25 care which has previously been provided in skilled

1 care. Assisted living is today a private-pay
2 product. Incremental costs that result from these
3 requirements will be passed directly to the
4 consumers, making this a less accessible product than
5 it is today.
6 Moreover, the regulations promulgate a
7 medical model environment rather than a social model
8 atmosphere desired by consumers. The nature of the
9 regulations is much akin to those placed in the
10 skilled nursing facilities, and in some cases, more
11 prescriptive than skilled care. This, we suggest,
12 will make assisted living less attractive, not only
13 from a provider perspective but from a consumer's
14 perspective as well.
15 While we respect the goal of ensuring
16 quality of care and resident safety, we have concerns
17 that these regulations will institutionalize a
18 flexible alternative to long-term skilled nursing
19 care.
20 The purpose of the proposed regulations was
21 to adopt minimum standards for issuance of licensure
22 for assisted living residences operated in the
23 Commonwealth. From a policy perspective, moving
24 services to lower levels of care is typically pursued
25 as a means of public cost reductions; in this case,

1 reduced Medicaid expense in skilled nursing care.
2 To achieve this policy goal, however,
3 requires policymakers to allow providers to in fact
4 maintain a lower cost setting. In these regulations,
5 the expectation for increased service levels is not
6 accompanied by a corresponding increase in financial
7 support.
8 When we contrast the proposed regulations
9 against those designed for skilled care, many of the
10 assisted living regulations exceed that which is
11 required in facilities that provide the highest level
12 of long-term care.
13 To comply with the regulations, facilities
14 must provide higher levels of care and services and
15 increase operational costs, higher utilization of
16 employer resources, and costly physical plant
17 upgrades.
18 We realize skilled nursing services will not
19 go away. They will, however, continue to become more
20 focused on acutely ill individuals, those recovering
21 from acute hospitalization for short stays, those
22 suffering from significant dementia or neurological
23 conditions, and potentially those receiving hospice
24 care. These are the residents who generally will not
25 come into assisted living facilities.

1 We suggest that the prescriptive nature of
2 the current regulations is designed not for the
3 majority of the residents but potentially for the
4 minority.
5 The regulations identify as exceptions
6 residents requiring tracheotomy, intermittent
7 intravenous therapy, skilled care, stage III and IV
8 wounds, and even mechanical ventilation.
9 We would suggest to you that care for these
10 conditions would be provided to assisted living
11 residents much as they are in a homebound patient,
12 through certified home health agencies, infusion
13 therapy providers, and the like.
14 Their skilled care would be paid through
15 their health insurance, as it would be for a
16 home-based patient. These services are overseen by
17 the Department of Health. That said, the services
18 provided directly by the assisted living facility are
19 truly personal-care services and should be regulated
20 at that level.
21 While we certainly recognize the need for
22 oversight for the purpose of resident safety, our
23 concern is with the level of regulations. In many
24 ways, the requirements push assisted living from the
25 home-like environment to one of skilled care.

1 To safely and competently care for certain
2 residents in assisted living and meet regulatory
3 compliance, facilities must seek higher skilled
4 staff, expensive equipment, and supplies to assure
5 quality care. All of this is being regulated without
6 identified funding mechanisms, which makes it
7 difficult for us as providers to evaluate
8 participation in the level of care.
9 We have concerns about the cost increases
10 associated with regulatory compliance. These
11 increases include physical plant requirements such as
12 room sizes, which we feel should be determined by the
13 marketplace. Also, staffing requirements such as
14 registered nurses and dieticians as well as staff to
15 provide escort service and administrative functions
16 contribute significantly to the cost of the
17 services.
18 These increased costs of development and
19 operations will lead to higher resident fees,
20 ultimately leading to less access for seniors. Until
21 the Commonwealth is able to identify a source of
22 payment for these higher services, we should be
23 concerned about keeping regulatory costs in check
24 with the private-pay consumer's ability to absorb
25 them.

1 Other areas of concern include maintaining
2 flexibility and resident rights. An example of this
3 is the bundling of services, which eliminates the
4 ability of the provider to offer choice in serving a
5 resident's individual needs.
6 The informed consent process should be
7 initiated long before the standard of "imminent risk
8 of substantial harm." No resident should be
9 permitted to be placed in any risk of harm.
10 Additional language should be added in the
11 waiver section to include the possibility of
12 providing a waiver for an aspect of the regulations
13 for which the provider and the resident have signed
14 an informed consent agreement.
15 UPMC Senior Communities values this
16 opportunity to provide public testimony on these
17 regulations and appreciate your consideration of
18 our concerns and the views of the proposed
19 regulations.
20 As we finalize this decisionmaking process
21 as advocates, regulators, lawmakers, and providers, I
22 want to leave you with one last comment: We must and
23 cannot fail the elderly of the future, for they are
24 us.
25 CHAIRMAN MUNDY: Thank you, Mr. Grant.

1 Questions?
2 Thank you. We appreciate your testimony.
3 Our final testifier this afternoon is the
4 terrific Secretary of Public Welfare, the Honorable
5 Estelle Richman.
6 And while she is coming to the table, we are
7 going to do a couple-minute stretch. The
8 stenographer's and probably my own legs could use a
9 stretch.
10 (A recess was taken.)
11 CHAIRMAN MUNDY: I think that we will
12 reconvene.
13 Madam Secretary, you may proceed whenever
14 you are ready.
15 SECRETARY RICHMAN: Thank you.
16 Good afternoon, Chairman Mundy,
17 Chairman Hennessey, committee members, and staff.
18 I am Estelle Richman, the Secretary of the
19 Department of Public Welfare. I am joined today by
20 Mike Hall, Deputy Secretary for the Office of
21 Long Term Living.
22 First, I want to thank you for convening
23 this meeting today to discuss the proposed
24 assisted living regulations. As you know, this
25 regulation is the culmination of more than a decade's

1 work by many of you and your staffs and the many
2 stakeholders we have heard from today.
3 Act 56 was enacted on July 25, 2007, and
4 directs the Department of Public Welfare to adopt
5 regulations establishing minimum licensing standards
6 for assisted living residences which meet or exceed
7 standards established for personal-care homes while
8 making other specific requirements.
9 Assisted living residences are a combination
10 of housing and supportive services and are designed
11 to allow people to age in place, maintain their
12 independence, and exercise decisionmaking and
13 personal choice.
14 The implementation of this law will give
15 consumers more options to "age in place" by adding
16 assisted living to the Commonwealth's
17 long-term-living continuum. Act 56 recognizes that
18 assisted living residences are a significant
19 long-term-care resource.
20 Today, I want to discuss the drafting
21 process and highlight some of the key elements of the
22 proposed regulation. I will also provide my reaction
23 to previous testimony you have heard today. Deputy
24 Secretary Hall and I would then gladly answer any
25 questions you may have.

1 Act 56's passage in July 2007 marked the end
2 of a 12-year legislative debate on assisted living.
3 Before this law was enacted, Pennsylvania was one of
4 a handful of States without a definition for
5 "assisted living." It took bipartisanship leadership
6 from both chambers, key industry support, and help
7 from consumer organizations and stakeholders to
8 achieve consensus and to put a bill on the Governor's
9 desk.
10 The next step was to begin work on
11 regulations. Drawing from the spirit of last year's
12 dialogue, I invited more than 35 stakeholders to
13 participate in a work group to draft this proposed
14 regulation.
15 Those invited included advocates for people
16 with disabilities, older adults, consumers, unions,
17 the elder law bar, public housing agencies,
18 for-profit and not-for-profit long-term-care nursing
19 facilities, and many others.
20 We convened a series of nine stakeholder
21 meetings beginning in October of 2007 and ending in
22 April 2008. Meetings were half-day or day-long
23 sessions with two or three subject areas on the
24 agenda covering a broad array of topics, such as
25 residents' rights, training requirements, and the

1 minimum square footage in a living unit.
2 Prior to each meeting, my staff would
3 investigate these topics and prepare comparisons with
4 other States. They would also identify the relevant
5 sections in Pennsylvania's personal-care-home
6 regulations, which would serve as our baseline
7 throughout the process.
8 This information was shared in advance with
9 the work group as well as any suggestions from the
10 work group members. The stakeholder meetings were
11 full of rich dialogue and vigorous debate, resulting
12 in some outright disagreement and other areas of
13 compromise.
14 To allow for open debate and reflection, we
15 had an e-mail address where all work-group members
16 could submit written comment that could be read by
17 all other members.
18 Deputy Secretary Hall and his team made
19 grids of every comment from the meetings and written
20 submissions and convened weekly meetings to analyze
21 these comments and prepare a draft regulation.
22 Interim draft regulations were circulated to
23 the stakeholder group, and where disagreement
24 remained, staff took note. A balance was struck in
25 each of the three draft regulations circulated, with

1 each version moving closer to the draft you see
2 today.
3 In short, the process for drafting the
4 regulation featured a substantial amount of public
5 input from a wide range of stakeholders. All of this
6 input took place before the regulations were
7 presented to the Independent Regulatory Review
8 Commission, and the formal public comment period
9 began.
10 I believe from the department's standpoint,
11 the resulting proposed regulations strike a
12 compromise between consumers, providers, and
13 advocates. As you know, assisted living enables
14 individuals with or without health needs the
15 opportunity to live in a home-like setting and "age
16 in place" as their care needs evolve. This adds a
17 key piece to our long-term-living continuum by
18 providing an option in between home-based care and
19 care in an institution.
20 We have heard quite a bit today about
21 specific provisions of the proposed regulations. I
22 do not want to rehash ground we have already gone
23 over, but I would like to touch briefly upon a couple
24 of elements of the proposed regulations that make the
25 package worthy of your support.

1 First, the regulations will help consumers
2 understand their options and make better decisions
3 about where they want to live.
4 Many businesses, usually personal-care
5 homes, are already calling themselves
6 assisted living. The level of service provided is
7 highly variable and consumers are often confused
8 about what they are buying.
9 This new licensure category will clarify
10 this market for consumers and their families and help
11 them make better choices about their long-term-living
12 options.
13 The proposed regulations will also support
14 people's desire of living in the community as long as
15 possible. Assisted living allows consumers to
16 receive a different level of services as their needs
17 change. Our continuum of care is currently limited
18 for consumers requiring a nursing-home level of
19 care.
20 Assisted living offers consumers with higher
21 needs a less restrictive alternative, namely
22 nursing-home-type care in a home-type setting.
23 There are some limitations, such as for
24 persons who require 24-hour skilled care, but even
25 for these individuals, there are provisions to allow

1 exceptions if a consumer wishes to remain in their
2 unit with agreement from the residence.
3 In addition, the proposed regulations
4 clearly define the kinds of services that
5 assisted living residences must provide.
6 Assisted living residences are required to
7 be able to provide for all of their residents' core
8 service needs, such as assistance with meals,
9 bathing, dressing, eating, laundry, transportation,
10 and medication management.
11 Assisted living also goes beyond the
12 personal-care-home standard by allowing individuals
13 requiring the care in or of a nursing facility to age
14 in place and receive supplemental health-care
15 services.
16 The proposed regulations also strike a good
17 balance, defining the minimum standards for an
18 assisted living residence. The proposed regulations
19 require a private room, bathroom, and residents
20 cannot be required to share a living unit.
21 Living units are required to be a minimum
22 of 175 square feet for existing construction, or
23 250 square feet for new construction, and have
24 lockable doors and kitchen capacity where
25 appropriate.

1 In some, the regulations create a more
2 apartment-like setting that is clearly different
3 from other alternatives that may be more like
4 personal-care or medical institutions.
5 This has been an extremely controversial
6 area, but I believe that we achieved a balance.
7 I also want to note that the proposed
8 regulations have special provisions to meet the
9 needs of residents with Alzheimer's disease and
10 dementia.
11 Many older Pennsylvanians have dementia and
12 require special programming and care to address their
13 cognitive needs. Often times, these elders have
14 limited physical needs but require supervision around
15 the clock.
16 The proposed assisted living regulations
17 create a special-care designation that consumers can
18 look to for Alzheimer's and dementia care. This
19 higher standard will require specialized staff
20 training, services, activities, and security measures
21 for residences that wish to serve this population.
22 Finally, the proposed regulations establish
23 reasonable fees that will be used to protect public
24 and resident safety. The licensure fee is $500 per
25 residence with a $105 assessment per bed. The

1 revenue generated from these fees will be used to
2 fund licensing and inspection operations.
3 By setting fees at a reasonable level, the
4 regulations assure adequate funding that will allow
5 the department to inspect, regulate, and certify
6 their residents are safe within assisted living
7 residences.
8 As you are aware, the public comment period
9 ended Monday. We have received in excess of
10 175 letters containing multiple comments, and my
11 staff has already begun an intensive review.
12 I anticipate that there will still be some
13 changes ahead, but I believe this compromise before
14 you today is very close to achieving the right
15 balance for Pennsylvania.
16 You have heard some lively divergent
17 opinions on these proposed regulations. Some say the
18 square footage requirements are too high, others
19 assert that room sizes are too low. Some say
20 staffing qualifications and retraining requirements
21 are too strict, others assert our staffing standards
22 are too lenient.
23 The strongly held points of view heard at
24 the opposite ends of the spectrum are nearly
25 irreconcilable, but we have worked hard to strike a

1 fair balance to find the reasonable middle ground and
2 to learn from the experience of other States and to
3 place Pennsylvania squarely in the mainstream.
4 I thank you for the opportunity to address
5 your committee today, and I will be glad, along with
6 my colleague, Deputy Secretary Hall, to answer any
7 questions at this time.
8 CHAIRMAN MUNDY: Thank you, Madam Secretary,
9 and I want to thank you sincerely for sitting and
10 listening through all of the testimony provided
11 today.
12 It is the first time in my memory that we
13 have ever had, in any hearing that I have ever
14 been at in 18 years, to have a Secretary and a
15 Deputy Secretary sit through an entire public comment
16 hearing, and I think that is terrific.
17 SECRETARY RICHMAN: As you know, this has
18 been a highly controversial area, and despite the, I
19 believe good work of the task force, there clearly is
20 a wide spread of opinions, and I think you have heard
21 how widespread those opinions are this morning or
22 today.
23 And certainly I have heard from them in many
24 ways and through many levels of communication, but
25 still, this is a very important area. This is a

1 critical -- we are at a critical point, and we are
2 going to decide over the next few weeks whether or
3 not we move ahead or whether we add year 13.
4 CHAIRMAN MUNDY: Well, I do not envy you
5 that task, because from what we heard today, I
6 totally agree with you that there are some issues
7 that are simply irreconcilable, and to strike that
8 middle ground, that balance, between the rights of
9 consumers and the health and safety and comfort of
10 consumers and then the industry, who is going to have
11 to invest in or, you know, begin this new industry
12 called assisted living, to strike that balance is
13 going to be difficult.
14 I want to begin by asking you about this map
15 that was given to us that shows the square footage
16 requirements in the various States. And as you can
17 see from the map -- first of all, I am assuming that
18 you agree with what is portrayed here?
19 DEPUTY SECRETARY HALL: Well, the first
20 thing that I would say, Chairman Mundy, is that just
21 as we struggle in Pennsylvania with what the term
22 "assisted living" means, the assisted living as it
23 is applied in these other States is not an
24 apples-to-apples comparison either. And we need to
25 be cautious that in a number of these States, what

1 they are describing as the model does not look a
2 whole lot like what we are trying to describe here in
3 Pennsylvania.
4 That having been said, as Secretary Richman
5 pointed out a moment ago, there are more than a few
6 points of view that believe that where we have set
7 the square footage requirements are inadequate and
8 that they should be higher -- you heard testimony to
9 that effect this morning -- and others who think that
10 they should be lower.
11 The approach that we took, setting up a
12 two-tiered approach that recognizes the realities of
13 existing providers, recognizes the costs that would
14 come with having to retrofit those buildings -- to
15 tear out walls, to install plumbing, to change wiring
16 for existing construction -- and the effect that that
17 would have on the affordability of assisted living,
18 the willingness of providers to participate in the
19 process, led us to propose in these regulations this
20 two-tiered approach, which we think is a very
21 reasonable compromise between the divergent points of
22 view.
23 Existing providers, existing construction,
24 would face obstacles that somebody planning a new
25 assisted living facility from the ground up would not

1 have to contend with. And even as you look at this
2 map, I observe that there are a good nine States that
3 have set standards that are higher than the 175 that
4 we have in this regulation for existing construction
5 -- Louisiana, Iowa, Vermont, Arizona, Oregon, Kansas,
6 Kentucky. And then it is a little bit unclear
7 exactly what the regulatory definitions are in these
8 other States, but I think that Wisconsin and
9 West Virginia very fall into that bucket as well.
10 We are not alone in having had the debate
11 about what is necessary to provide a space that can
12 give consumers the privacy and the apartment-like
13 environment that we are trying to create.
14 We are not alone in having the debate of
15 trying to figure out how you accommodate people's
16 mobility needs as they become more frail.
17 We are not alone in having done the
18 calculation about how much room is left over after
19 you get done putting the bed and the side table in
20 there.
21 And I think where we have come down here is
22 not at the top of the pile and not at the bottom of
23 the pile, but it is a place that is consistent with
24 the debates that other States have gone through and
25 the decisions that they have made.

1 CHAIRMAN MUNDY: Having said that,
2 250 square feet does appear to be at the top for new
3 construction, at the top of the -- I mean, Louisiana
4 is the only State that I see that even has the same
5 at 250. Others have 240, 220--- Oh; I am sorry.
6 No, that is right -- 225 for Vermont.
7 How do you respond to the industry that is
8 saying that that will require $5,000 to $7,000 per
9 month in fees and that that is going to be --
10 certainly Medicaid is not going to be willing to pay
11 that much money for these rooms or apartments or
12 facilities. How do you respond to that?
13 DEPUTY SECRETARY HALL: Well, as you heard
14 today from several witnesses who testified to the
15 committee, the numbers that are portrayed on the map
16 represent a standard, a regulatory minimum, that has
17 been put in place in those other jurisdictions.
18 It does not represent, it does not represent
19 the choices that providers are making in how they
20 build, how large they build assisted living
21 facilities, how much square footage they think
22 consumers are going to expect.
23 You asked and got some answers to questions
24 I think today from John and from some other folks
25 about what their own facilities look like.

1 PANPHA did a survey of their members. I
2 think they make a reference to this, and the comments
3 that they submitted indicated that 40 percent of
4 their members had units that would miss the mark.
5 We acknowledge that, but I think that it is
6 also the case that there are facilities that have
7 buildings and units today that have already been
8 built to the standard that we are proposing here. We
9 do not think that this is beyond the edge of where
10 the market is already moving.
11 SECRETARY RICHMAN: Let me just add on.
12 I think that the comment that the gentleman
13 from the University of Pittsburgh made at the end was
14 probably one that I keep in mind all the time.
15 We are building the system for us. We are
16 actually building it probably for people a little
17 younger than I am, for the baby boomers and younger.
18 As someone who is going to be 65 in about a
19 month, I do not consider myself already in the
20 current age group. But we are really looking at,
21 where is the system going to be in 10, 20, and 30
22 years? And many of us through our lifetime have seen
23 what has been in the past, and we are reaching for a
24 higher standard.
25 Once you put a law in place, you are not

1 saying everything is going to stay the same. We
2 already know that there is going to have to be a
3 change in the system.
4 These regulations in any part of this, which
5 this was a critical part, will submit to get us to
6 the future, not to have to come back every year and
7 say, ah, we put it at 150, but we really now think
8 people need a little bit more; let's change the
9 regulation, let's change the law, just to maybe go a
10 little bit further. We did not see it as an
11 every-year passthrough and that people change their
12 mind. This is building to the future.
13 It was never conceptualized that
14 100 percent, 90 percent, 80 percent, 50 percent
15 of our personal-care homes would move to
16 assisted living. We knew some would meet that higher
17 standard and many would not.
18 So the goal was to be able to build a
19 standard that is going to take us out through the
20 baby boomers, know that we are going to be on the
21 higher end of that, and begin to work towards, how do
22 we begin to finance?
23 It is not going to be a perfect Medicaid
24 system in the beginning, but it will be a goal for us
25 and it will become a choice for people as they begin

1 to age to that system.
2 DEPUTY SECRETARY HALL: And the only other
3 thing I would say, Chairman Mundy, is that even as we
4 proposed the 250 square feet, we knew that that would
5 be viewed by numerous stakeholders as not being
6 enough, the number that they would have preferred to
7 see being 300 or 350.
8 We thought that 250 was appropriate to
9 respect the philosophy of assisted living that we
10 were trying to create and was not out of line with
11 what is happening in the marketplace.
12 CHAIRMAN MUNDY: The thing that I liked most
13 about assisted living and the reason that I worked so
14 hard to help get the bill passed was because for the
15 first time, it would enable us to use Medicaid
16 dollars for assisted living, because currently, the
17 only people who get assisted living are those who can
18 afford it, and that tends to be the real higher end
19 income people.
20 So my concern is that the 250 requirement
21 for new construction, and even the 175 for existing
22 construction, will still not enable Medicaid people
23 to live in those nice assisted living facilities, and
24 could you please comment on whether you agree with
25 that or not?

1 SECRETARY RICHMAN: Go ahead.
2 DEPUTY SECRETARY HALL: I would say that we
3 do not agree with that.
4 CHAIRMAN MUNDY: Okay.
5 DEPUTY SECRETARY HALL: We have looked
6 carefully at -- we just had a conversation in the
7 last little while about square footage and where we
8 tried to position ourselves relative to other parts
9 of the country. But we also have been paying close
10 attention to where the reimbursement rates are
11 for assisted living, where other States have been
12 setting those reimbursement rates in their Medicaid
13 programs.
14 There was a study that was conducted
15 nationwide by MetLife where they surveyed something
16 like 880 assisted living facilities across the
17 country on what their average daily charges were, and
18 what we are learning from that is that where we are
19 hoping to position the assisted living waiver in
20 Pennsylvania is very close to what appears to be
21 happening on a national basis.
22 We have expected that the reimbursement
23 rates for the assisted living waiver -- and I want to
24 hasten to point out that we have not filed it yet
25 with CMS, so we are still some months away from

1 knowing exactly how it will shape up or what will be
2 approved. And you are aware also, I think, that we
3 will have appropriations requests in this coming
4 budgetary session to support the waiver costs.
5 But we have anticipated that for a single
6 room, that the Medicaid waiver reimbursement rate
7 would be somewhere in the neighborhood of $90 to $100
8 and then there would be a higher tier for people who
9 have higher care needs or for Alzheimer's or dementia
10 care on a daily basis.
11 According to the study that was done by
12 Metropolitan Life, the average daily rate right now
13 nationwide of the facilities that they surveyed is
14 running at about $99 a day, and the average daily
15 rate for Alzheimer's and dementia care in those
16 facilities is running at about $140 a day.
17 So we think that we are going to be able to
18 position the waiver to support what we are commonly
19 finding in the marketplace today. And as I said, we
20 think that where we have set the compromise approach
21 that we have taken for square footage on existing and
22 new construction we think is consistent with that as
23 well.
24 CHAIRMAN MUNDY: Would you comment on the
25 issue of dual licensure? Why not allow a facility to

1 have both personal care and assisted living in the
2 same facility?
3 DEPUTY SECRETARY HALL: I think it is
4 important for us to -- I am going to try and be clear
5 about what we think dual licensure means, because we
6 do not have a philosophical opposition to this.
7 We have anticipated, as Mr. Shapiro, I
8 think, pointed out, going all the way back to the
9 discussion when we were drafting the legislation,
10 that you would have facilities that would seek to
11 have part of the facility licensed as personal care
12 and part of the facility licensed as assisted living.
13 And I believe that you heard both Secretary Richman
14 and I state to the committee in the past that we are
15 committed to making sure that in the course of doing
16 survey and certification of those facilities, that we
17 would coordinate and require collaboration between
18 our personal-care home staff and our assisted living
19 staff so that facilities did not feel like they
20 were being pulled in conflicting or confusing
21 directions.
22 I anticipate and we think that the
23 regulations allow for facilities to come to us and
24 say, we would like to have a portion of the facility
25 that has rooms that meet the requirements licensed as

1 assisted living, even as another portion of the
2 facility, even as another portion of the facility
3 remains licensed as personal care.
4 That might be a business decision that the
5 facility makes because they want to be able to offer
6 both services, it might be a practical decision they
7 make based upon retrofitting costs or whatever, and
8 that we would regulate, we would license in that
9 way.
10 What we have been reluctant to support is
11 the idea that a particular room would be licensed as
12 both assisted living and personal care and that the
13 regulators would not know on any particular day, are
14 you personal care today or are you assisted living?
15 And we are cautious about how we ought to
16 handle a situation where assisted living rooms and
17 personal-care rooms are intermixed on the same floor
18 in the same way, that 1, 3, 5, and 7 are
19 assisted living, 2, 4, 6, and 8 are personal care.
20 Again, from the standpoint of being clear with
21 consumers, clear with the caregiving staff within
22 those facilities, and clear from a regulatory
23 standpoint which services are being delivered, and
24 things as elemental as residents' rights and the
25 changes and the differences between those two

1 standards that our regulation -- I mean, these
2 regulations very clearly set and anticipate a higher
3 bar, a higher standard. They anticipate that we will
4 be providing services on an ongoing aging-in-place
5 basis to people who normally we would not see in
6 personal care.
7 So I think from the Commonwealth's
8 perspective, we want to make sure that we know who is
9 receiving those services and entitled to those rights
10 and protections.
11 CHAIRMAN MUNDY: That is very helpful.
12 Thank you.
13 So just to be clear, you do envision dual
14 licensure, but you are concerned about the dual
15 licensure, different rooms on the same floor
16 or---
17 DEPUTY SECRETARY HALL: I think--- Go
18 ahead.
19 SECRETARY RICHMAN: There are facilities
20 that have several buildings within a framework.
21 You know, to have a building designated as
22 their assisted living building versus a personal-care
23 building versus a continuing-care building versus a
24 nursing home can all exist under the same provider at
25 the same time.

1 But if we are going that route that room A,
2 B, and C are one type of room for this client, and
3 different for another client are four more rooms on
4 that same floor, that is not a feasible construction
5 for us.
6 CHAIRMAN MUNDY: All right. You are very
7 clear that the existing regulation as proposed does
8 allow for the dual licensure that you are describing?
9 One building---
10 DEPUTY SECRETARY HALL: We had intended and
11 had in mind all along that that is how we would
12 approach it, in the way that I have described it.
13 And in fact we have already begun
14 discussions between our licensing staff and the
15 licensing staff at the division that does
16 personal-care homes to start the necessary
17 cross-training and collaboration. We wouldn't be
18 doing that if we were opposed in all respects to
19 dual licensure.
20 CHAIRMAN MUNDY: Okay.
21 On the issue of staff training, staff and
22 administrator training, I certainly understand
23 grandfathering existing facilities, which are very
24 expensive to retrofit, but I really do not understand
25 how we could not require -- and maybe I am wrong

1 about the regulation as proposed, but it is my
2 understanding that the training of the staff is
3 grandfathered as well as the facility, and I do not
4 understand why it would be necessary not to require
5 existing staff in a personal-care home that wants
6 to be an assisted living facility to come up to
7 the new standard for assisted living with the
8 training.
9 Can you explain that to me? Why not require
10 an administrator to get the additional training
11 necessary to deal with the higher level of acuity
12 that you are going to be seeing in the
13 assisted living facility?
14 DEPUTY SECRETARY HALL: Well---
15 CHAIRMAN MUNDY: And maybe even give it or
16 require it over time. It does not have to be within,
17 you know, the first 30 days. But can you speak to
18 that, please?
19 DEPUTY SECRETARY HALL: Yes.
20 This was one of those areas where we, first
21 of all, recognized, that we looked at the baseline
22 that had been established in the 2600 regulations,
23 which the statute required us to start from.
24 CHAIRMAN MUNDY: Those are the personal-care
25 homes.

1 DEPUTY SECRETARY HALL: The
2 personal-care-home regs.
3 And then tried to determine the
4 appropriateness of adding on and requiring, in this
5 case, higher certification requirements or higher
6 training requirements if somebody sought licensure as
7 assisted living.
8 We had a discussion about this at one of our
9 work group sessions and heard some strongly held
10 points of view about the need to have higher
11 standards given the aging-in-place philosophy. And
12 at the same time we heard from representatives of
13 PALA and PANPHA and PHCA, who testified here today,
14 about the training and expertise that many of their
15 staff already have.
16 But this is an area, frankly, where we were
17 trying to figure out and wind up in a place that
18 would not--- Well, let me step back for a moment.
19 This is an area, and there are others as
20 well, where we I think draw fire almost no matter
21 which direction we go in.
22 If we set the requirements, the educational
23 requirements, and the requirement for how many hours
24 a day an administrator must be on site at
25 assisted living residences, we hear criticism that it

1 is administratively burdensome and costly and
2 excessive. And yet if we do not put that regulation
3 there, then the concern that is heard is that there
4 is inadequate oversight and supervision of the
5 staff who are there and that residents might be at
6 risk.
7 Similarly with respect to training. The
8 concern has been that if we do not set higher
9 training requirements, that the staff might not have
10 the skills to provide the kind of care that is
11 anticipated, while at the same time, anytime you move
12 in the direction of increasing training requirements,
13 people in the industry are concerned that it means
14 additional costs that they are going to have to
15 absorb.
16 What we did here was to try and set a
17 standard based upon the 2600 regs that seemed
18 reasonable and workable, with an anticipation that at
19 some point in the future, as we gain more experience
20 with assisted living, that we would revisit the issue
21 of training.
22 CHAIRMAN MUNDY: Okay. I will accept that
23 for now.
24 And another issue that really struck me was
25 the timing for the assessment and care plans. Review

1 for me again what the requirement is in the proposed
2 regs for doing an assessment of need and crafting a
3 care plan.
4 DEPUTY SECRETARY HALL: Well, as you heard
5 this morning, the regulation as submitted to the IRRC
6 requires that the assessment be completed after
7 admission, I think within the first 15 days, and
8 that the care plan is developed within 30 days after
9 that.
10 As you may know, even after we submitted the
11 rules to the IRRC, Secretary Richman invited many of
12 the people, not all, but many of the people who had
13 been in the work group and many of the people who
14 testified here today to come in and meet with us and
15 share with us their lingering concerns and
16 reservations about the regulations, and that process
17 itself, that process itself was helpful and
18 instructive to us in pointing up some things that we
19 do intend to address as we move to the final draft of
20 the regulations.
21 This is an area where we heard comments that
22 if you have somebody who is going through the process
23 of seeking placement in an assisted living facility
24 in a nonemergency situation, that you ought to be
25 able to do an assessment up front and that that

1 individual and families ought to know what they can
2 expect in terms of the services they are going to
3 receive for their money before they start their first
4 day of care. But also recognizing that not every
5 family and not every consumer has the luxury of
6 advance planning, that some people come in and some
7 families are facing emergency situations and finding
8 placement is priority one. So we intend to modify
9 the regulations to recognize those distinctions.
10 CHAIRMAN MUNDY: Good. I certainly would
11 agree with that.
12 And, of course, the issue of the ombudsman
13 and the funding for the ombudsman I think is another
14 significant issue.
15 Clarify for me the role of the ombudsman in
16 the ranks, and then, if you would, address the issues
17 that were raised here today about the ombudsman being
18 the advocate for the patient or the client or the
19 resident and now having to somehow mediate between
20 the facility and the resident; and also the funding
21 issues that were raised, which I think are
22 significant.
23 DEPUTY SECRETARY HALL: Well, let me say
24 first that philosophically, this is an issue that is
25 near and dear to my heart, because I myself am a

1 former State ombudsman for long-term care and worked
2 in nursing homes and personal-care homes. And I have
3 a deep familiarity with the provisions of the
4 Older Americans Act and the philosophy of the
5 Ombudsman Program.
6 As we worked on these regulations, we were
7 -- I just want to share with you a moment where we
8 were coming from when we started developing some of
9 these provisions.
10 We were mindful of the fact that there are
11 some number of residents in nursing homes who are not
12 necessarily going to have intact families nearby.
13 Many of them might be alone or have children who live
14 hundreds or thousands of miles away. Some of them
15 might be suffering from cognitive impairments that
16 would interfere with their ability to look out for
17 themselves, to protect their own rights, to speak up
18 or to object when that is necessary, and recognizing
19 that in some of those cases, that impairment also
20 interferes with their ability to know who to contact
21 or how to go about contacting somebody or even to
22 follow through if the information is given to you.
23 The Ombudsman Program plays an important
24 role in our long-term-care facilities, which will
25 include assisted living here in Pennsylvania, in

1 advocating for our residents and keeping their eyes
2 open for the things that are happening that ought not
3 to happen and for looking out -- I mean, the
4 Ombudsman Program was originally established to
5 advocate for residents who are in our nursing homes
6 today, and yet, as many of you know, a staggeringly
7 high number of people who are in our nursing homes on
8 any given day have cognitive impairment diagnoses.
9 So by definition, the Ombudsman Program often
10 advocates for people who may not be able to speak for
11 themselves.
12 That having been said, we thought that there
13 were certain situations when an individual was
14 objecting to something that a facility was proposing
15 and an informed consent agreement might be a way to
16 resolve that, where having an ombudsman by the
17 resident's side would help to level the playing field
18 in the discussions and negotiations.
19 We thought that in situations where a
20 facility was proposing to transfer or discharge a
21 resident involuntarily, that an ombudsman could help
22 to be a watchdog for making sure that those transfers
23 and discharges were not happening in violation of the
24 rules or for reasons that are not permitted under the
25 rules.

1 I think it is correct to say that in the
2 draft of the regulations that we have filed, we
3 describe a role that crosses over into doing more
4 mediation. And in the final draft of the regulations
5 that we will file in response to the written comments
6 we received and the personal meetings we have had and
7 the testimony that you have heard here today, that
8 while we want the Ombudsman Program to continue to
9 act as an advocate for the residents in those crucial
10 situations, we are going to make some revisions to
11 ensure that they are fully consistent with the
12 Older Americans Act and do not call for the ombudsman
13 to be in a conflicted dilemma between the resident
14 and the facility.
15 CHAIRMAN MUNDY: Great.
16 And finally, the issue of an appeal process.
17 There is no appeal process if a resident is being
18 discharged against his or her will in the proposed
19 regs, and why not, and what is wrong with an appeals
20 process?
21 DEPUTY SECRETARY HALL: Well, depending on
22 your perspective, you are asking the right or the
23 wrong person about this, because if I had my way, we
24 would have a clearly articulated process where
25 individuals would be permitted to file an appeal with

1 the department or with our licensing group objecting
2 to a transfer or a discharge, and that that would
3 then generate an investigation by us and ultimately
4 the right to have a hearing before the Board of
5 Hearings and Appeals.
6 And the staff who are sitting behind me can
7 confirm that that is -- in fact, I wrote a version of
8 these regulations that describe pretty much what I
9 just said to you, only to be informed, correctly and
10 with soberness by our General Counsel, that we can
11 only -- we cannot create appellate processes by
12 regulation, that they can only be created by statute,
13 and that were we to include the language which I had
14 proposed describing this appeals process, that it
15 would almost certainly be a cause for an objection by
16 IRRC.
17 So what we have here instead is, with that
18 limitation, our best effort to try and make sure that
19 the residents, the consumers of assisted living, are
20 not all out on their own in the face of a proposed
21 transfer or discharge, and what we did instead was to
22 try, through notification of the Ombudsman Program,
23 to bring another set of eyes into the process that
24 would allow the ombudsman to talk to the consumer,
25 ascertain whether or not the consumer is objecting,

1 and then help connect the consumer with the licensing
2 division.
3 The licensing division could then do an
4 investigation as to whether or not the transfer is in
5 conformance with the regulations or whether it is
6 improper and they could take regulatory action on
7 that basis.
8 Is it our preferred and best way to do it?
9 No, it isn't, but given the limitations we have in
10 Pennsylvania law, we thought it was a pretty
11 reasonable second approach.
12 SECRETARY RICHMAN: It was also the first
13 thing I spotted and sent the staff back to the wall
14 and said, I want it anyhow; can't you figure out a
15 way to get around the wall?
16 And they did work on that, and the choices
17 that were made were to try to put something as much
18 as we could in its place, but I am also considering
19 going back for an amendment. I really believe having
20 an appeal process is essential, and if it should have
21 been in the original bill and we missed it, then we
22 just need to go back and try to figure out how to fix
23 it.
24 CHAIRMAN MUNDY: We will work on that with
25 you.

1 Representative Watson.
2 REPRESENTATIVE WATSON: Thank you,
3 Madam Chairman.
4 Though I have to note this, Madam Chairman,
5 I will just beef it up since you asked most of the
6 questions I wanted to ask.
7 I would note, Deputy Secretary Hall and
8 Madam Secretary, that a previous iteration of
9 assisted living, I think it was House Bill 420, which
10 was last term, one of mine, we had talked to folks
11 then. It would have been in statute. We put the
12 appeal process in there. I wanted that to be in
13 because I thought that was pretty important.
14 SECRETARY RICHMAN: You are right.
15 REPRESENTATIVE WATSON: So an amendment
16 might indeed be in order.
17 If I might, though, because you have talked
18 at length and we have heard providers, and I was a
19 little disturbed, we had a private sidebar about that
20 I would like to have that long-term-care continuum
21 available in all parts of Pennsylvania rather than
22 where I happen to be blessed to live, in Bucks County
23 it will ultimately be available, but I worry about
24 the other parts of Pennsylvania that I visited but
25 that I don't live or represent.

1 In light of that, we talked about while
2 there will always be personal-care homes -- just a
3 comment -- and that is thriving and that offering
4 will stay, then there is some mix up, because a
5 couple of providers that I know of personal-care
6 homes asked me if they would still be able, even if
7 there are assisted living licensures, as
8 personal-care homes they will still be able to bring
9 in nursing-care services for their residents?
10 DEPUTY SECRETARY HALL: It is not our
11 intention with these regulations to disturb the
12 current approach that personal-care homes take.
13 I should say also, Representative Watson,
14 and you will recall, I think, that we talked about
15 this at either some of the briefings or on the
16 hearings on the bill itself last year, that we are
17 planning and even now are working with the
18 Pennsylvania Housing Finance Agency and with housing
19 authorities around the State to use these
20 assisted living regulations in combination with
21 housing finance dollars to make it possible for
22 us to build under the auspices of the housing
23 authorities' assisted living residences that
24 would be available to people of low and moderate
25 incomes.

1 And in fact we included representatives from
2 the Housing Finance Agency and the Philadelphia
3 Housing Authority on the work group that developed
4 the regs.
5 REPRESENTATIVE WATSON: That makes me very
6 happy. I think that is fine. Mike seems to be
7 working.
8 My perennial question that has concerned me
9 since the 2600 regs were introduced and put in place,
10 and that is the concern that as we upgrade, as we
11 should, and as we move to the future, as we should,
12 that the folks that we hire and have as inspectors
13 and it takes them longer to do an appropriate
14 inspection of a facility, as it should, they need
15 even more training.
16 And we ran into a problem before that we did
17 not have enough people because it was -- as the
18 Secretary and I discussed, it was a simple math
19 problem that even I could understand in terms of
20 hours and number of people. And I have repeatedly
21 said and I will ask it again, in the course -- and we
22 will assume that we will find this wonderful land of
23 compromise and the regs will go through for
24 assisted living and we still have the dual, and when
25 you referred to dual licensure, you referred to

1 cross-training.
2 My specific question would be, are you
3 planning, will it be in a budget request, have you
4 done another math calculation, Madam Secretary, that
5 you always talk about, so that we have enough folks
6 properly trained to do inspections of assisted living
7 facilities, also the personal care, but that we do
8 them in a timely fashion, that we keep up to date and
9 current and that folks, consumers, can expect that
10 that is going on?
11 SECRETARY RICHMAN: Let me answer that
12 question in two ways.
13 Yes, we are going to -- you will probably
14 see a budget indication that we are planning this.
15 But I have to go back to the rates we are
16 charging. You know, whatever we do is a tax burden,
17 and it has to come out of tax dollars. We felt that
18 at the rate we were making the charge for licensing,
19 there was no way to be able to support the wide range
20 of things we are doing.
21 We still will be bearing, through tax
22 dollars, the bulk of the cost of making sure things
23 are done timely, people are well trained, and that we
24 can respond in a very timely way to any complaint or
25 problem.

1 However, we also believed that we needed to
2 increase significantly the amount of money that was
3 going to be involved in licensing from people who are
4 providing those homes.
5 We do realize it is a significant increase,
6 but this is a new area. We are beginning to build it
7 up. And the tax dollars from the general public
8 that may not use this facility will still be the
9 base of the majority, by far, of the dollars that we
10 will use to bring it in. But we are increasing the
11 skin in the game on the other side fairly
12 significantly.
13 DEPUTY SECRETARY HALL: Representative
14 Watson, I think as you are alluding to and the
15 question that you asked as well, you will remember
16 that we were working with this committee to pass
17 these regulations in the crucible of the controversy
18 last year around personal-care homes and the stories
19 within the Philadelphia Inquirer, the concerns that
20 there were not a sufficient number of inspectors,
21 that their caseload ratios were too high, and that
22 facilities were not being visited often enough. And
23 we felt that it was important in designing these
24 regulations and in setting the rates to not repeat
25 the mistakes of the past.

1 SECRETARY RICHMAN: It was a tough year on
2 personal care. I do not plan to ever do it again.
3 DEPUTY SECRETARY HALL: I should inform you
4 that in the budget that just passed this last July,
5 the Legislature included funding for 11 staff to
6 license and regulate assisted living.
7 That is based upon our initial projections
8 in the facilities that would be licensed in the early
9 years, and we anticipate that we would ramp up the
10 number of inspectors as the number of facilities
11 grows.
12 I think Representative Hennessey's question,
13 if more people come into the pool, nursing homes that
14 convert or more new construction, then we will need
15 to add staff to meet that demand.
16 REPRESENTATIVE WATSON: Thank you very much.
17 Thank you, Madam Chairman.
18 SECRETARY RICHMAN: Excuse me,
19 Madam Chairman.
20 Unfortunately in not watching the time, I
21 have a meeting at 3 o'clock I am not going to be able
22 to change, so Mike Hall and the rest of my team will
23 be here and I am sure will be able to answer any of
24 your questions. But if there are things that people
25 have specifically for me, I probably have about

1 another 10 minutes.
2 CHAIRMAN MUNDY: Well, thank you so much.
3 We certainly couldn't have asked for any more of your
4 time than we got, so we appreciate your being here as
5 long as you could.
6 Representative Gingrich.
7 REPRESENTATIVE GINGRICH: Thank you,
8 Madam Chairman.
9 Thank you, Madam Secretary.
10 First, I would like to apologize to any of
11 our guests who are as cold as I am. And our
12 nimble-fingered stenographer that probably has
13 arthritic fingers by now.
14 Again, just wonderful, wonderful dialogue,
15 and our Madam Chairman did pretty much consolidate a
16 lot of the questions that were lingering, that I know
17 you were listening to as well. Clarity was necessary
18 and important today. And you covered all of the
19 things that remained for me except the things we just
20 aren't going to be able to change.
21 What I would like to know is, when we get to
22 the final version of the regs, will we see what we
23 just talked about now, a lot of these clarifications
24 with regard to the dual licensure, because there was
25 a lot of ambiguity on that for me coming in, the

1 ombudsman's role, the whole assessment and care
2 plans, the fact that we can't have this neutral arm,
3 that appeal arm that we were looking for.
4 Are you going to have that spelled out more
5 clearly so we have much less confusion when we are
6 looking at the final regs? Can I count on seeing
7 them that way?
8 DEPUTY SECRETARY HALL: I anticipate that as
9 we prepare the final revisions and work with the IRRC
10 on those, that we will be preparing a document that
11 highlights the changes that we have made, and we
12 would be pleased to share that with the members of
13 the committee.
14 REPRESENTATIVE GINGRICH: Thank you, and
15 anything else you heard today that was just as
16 important.
17 SECRETARY RICHMAN: And we understand that
18 where it is unclear, that we will try to specifically
19 not only make it clear but make sure that we draw
20 your attention to that.
21 CHAIRMAN MUNDY: Representative Hennessey.
22 REPRESENTATIVE HENNESSEY: Thank you,
23 Madam Chairman.
24 Madam Secretary, thank you, and Mike, for
25 being here the whole time. I appreciate it and I

1 think we all do.
2 There are a couple of things that sort of
3 boil down at this point in the hearing to relatively
4 simple questions, from my part.
5 We have heard, actually in the DPW
6 estimates, maybe 15, maybe 20 percent of the
7 personal-care homes over the course of 4 years are
8 expected to convert to assisted living.
9 We have also heard from a lot of people in
10 terms of the nursing-home industry that nursing homes
11 are not necessarily likely to slide back and try to
12 ask for assisted living licensure for part of their
13 facilities.
14 If we are really just looking at 20 percent
15 of the personal-care homes across the State which
16 might convert, you know, upgrade to assisted living,
17 and, you know, if the building industry does not take
18 off and we do not have a lot of new construction of
19 assisted living -- in fact, even if we do, but that
20 is going to be years away -- how are we going to deal
21 with people over the short term who need
22 assisted living and yet we are not flexible enough
23 to allow the personal-care homes to qualify for
24 that?
25 It just seems to me that we are building in

1 a shortage of assisted living homes in the near term,
2 and we know that our senior population is burgeoning,
3 so we are going to have much more demand than we can
4 supply.
5 SECRETARY RICHMAN: You know -- and I will
6 let Mike address this, too -- I think to some degree,
7 one of the options we have in there is still
8 encouraging people to stay in their own home and
9 bringing in home and nursing transition help.
10 So that really our first choice is to try to
11 keep you in your very own home and to bring in the
12 level of support, and that is where we have been
13 placing many of our waiver dollars and many of our
14 dollars, to keep you there. And in reality, that is
15 where most people want to be.
16 REPRESENTATIVE HENNESSEY: And I think we
17 have seen a substantial shift in that regard, and
18 that part seems to be working.
19 SECRETARY RICHMAN: And that part is
20 working. But I think we still have a large number of
21 people, at least I get the backlash of a large number
22 of people who feel that they are urged towards
23 nursing homes for many reasons and still want to see
24 more services in their own home. So we will still
25 try to rebalance on that level.

1 And that is where you see so much of the
2 pressure on the Department of Aging, in being able to
3 make sure that there is adequate funding and support
4 for the AAAs and being able to make sure there is
5 enough support for people to stay in their own homes.
6 So while I think we have made progress, I think we
7 still have a ways to go in that level.
8 The next one is that gap between personal
9 care and nursing homes, and that is what this is
10 meant to do. Right now, we are really existing --
11 and Pennsylvania has existed for much longer than
12 many other States -- really existed without an
13 assisted living alternative. We have been existing
14 pretty much on just personal care.
15 We would like to begin to move away. I'm
16 not sure the move-away will be overnight, but I think
17 it will be a gradual, hopefully smooth move-away.
18 This is not meant to stop people. It is
19 meant, though, to be able to gradually move towards a
20 very vibrant and energized assisted living.
21 The question I think we all face is, how do
22 we fund it, how do we pay for it, and how do we make
23 sure it is not for the rich only? And I think that
24 is where we are going to struggle, because we know
25 that tax dollars are limited, so we have to, you

1 know, whether you are talking about Federal taxes or
2 State taxes, you are still talking about taxes to the
3 common man.
4 REPRESENTATIVE HENNESSEY: There seems to be
5 built into this, and especially in Mike's comments
6 with the idea that if we build it, they will come.
7 Like the old Kevin Costner movie---
8 SECRETARY RICHMAN: Yes; I remember.
9 REPRESENTATIVE HENNESSEY: ---"Field of
10 Dreams."
11 SECRETARY RICHMAN: "Field of Dreams."
12 REPRESENTATIVE HENNESSEY: The problem is,
13 we do not build them. It is not -- the Commonwealth
14 is not going to be out there building assisted living
15 institutions, you know.
16 SECRETARY RICHMAN: That is correct.
17 REPRESENTATIVE HENNESSEY: So we are relying
18 on the private sector to go out and build it, and if
19 they do not build it and we have this aging
20 population coming towards us, we know we are going to
21 need assisted living and yet we can't -- what we are
22 hearing from the private industry side, I think, is
23 that we can't afford to build what you want us to
24 build.
25 And, I mean, that has got to come to a

1 critical point sometime very soon, in the next couple
2 of years, where if we do not get the assumed building
3 boom for assisted living, then we are really between
4 a rock and a hard place and we do not have any way to
5 resolve it.
6 DEPUTY SECRETARY HALL: Well, Representative
7 Hennessey, let me say that we have not intended to
8 place a limit or suppress the number of facilities
9 that would be assisted living. The numbers that have
10 been cited were our best estimates of how many would
11 be positioned with very little modification to seek
12 assisted licensing and might choose to do so out of
13 the gate.
14 Our number could be low, it could be way
15 low, and the number that might seek licensure could
16 be higher than that. Our number might be higher than
17 what it will turn out to be, but I do not think that
18 will be the case.
19 We did have in mind wanting to make sure
20 that Pennsylvania did not get in over its head in
21 opening up assisted living and then suddenly finding
22 itself with way more providers in a more complicated
23 regulatory environment than we were prepared to deal
24 with.
25 But I think that we frankly would welcome,

1 we would welcome robust growth in this area. But
2 what we have done here is we have tried to work with
3 some pretty clear directives that this committee was
4 instrumental in giving us in the passage of last
5 year's legislation.
6 Even in the preamble of that legislation,
7 the mandate to us is to create an environment that
8 ensures privacy, lockable doors, a home-like,
9 apartment-like environment, private bath, ability to
10 dine in your own room. It does not anticipate
11 multi-bedrooms. It does not anticipate small spaces.
12 It does not anticipate that people would be going
13 down the hallway and sharing showers and bathrooms or
14 it would be doing communal dining. We have settings
15 where that is available today, but that is not what
16 we have described in assisted living.
17 So I think the question for us going forward
18 is, have we in these regulations described a model
19 philosophically that the Legislature has wanted, and
20 are we in tune with what will happen in the market or
21 not? And I think we are all going to find that out
22 in the next couple of years.
23 REPRESENTATIVE HENNESSEY: Okay. Thank you.
24 Just to move on. I see you are anxious to go, and I
25 don't want to hold you up.

1 SECRETARY RICHMAN: Yes.
2 REPRESENTATIVE HENNESSEY: Could we solve
3 some of the problems in terms of the grandfathering
4 of existing buildings by simply adopting a sort of an
5 averaging concept?
6 Instead of saying that every unit has to be
7 175 square feet, if something is 160 square feet but
8 the person who it is available to has no disability,
9 does not have a wheelchair and a need for a
10 wheelchair now, couldn't we allow them to use that as
11 a residential unit as opposed to simply taking it out
12 of the equation altogether, with the idea that they
13 would charge less for it, and then if it is my
14 apartment and my unit and I later decide that I need
15 or somebody says that I need to use a wheelchair,
16 can't I move to another unit in the complex that is
17 bigger and gives me that space?
18 I am thinking, when I first was married, I
19 rented an apartment, and if I rented upstairs on the
20 top floor, I paid a premium; if I rented downstairs
21 near the air-conditioning and the heating unit where
22 the noise, you know, was enough to wake you up
23 through the night, then I paid a lesser amount. But
24 the market adjusted for the vagaries of the
25 apartments that were available within the complex by

1 doing that. If you were farther back from the road
2 and away from the road noise, you paid more of a
3 premium for that.
4 SECRETARY RICHMAN: Right.
5 REPRESENTATIVE HENNESSEY: It just seems to
6 me if we said -- because we are hearing from all
7 these homes that we think are good homes that are
8 saying they just cannot meet this requirement. If we
9 told them that their average had to be 175, some of
10 them might be 190, some might be 160, but rather than
11 take the 160 square foot one off the marketplace
12 totally, it would seem to me that we could amend
13 these regulations by saying the average has to be
14 those kinds of square footages.
15 And maybe you allow a variation of
16 10 percent, or if you are worried that somebody is
17 going to come in and say, I've got a 90-square-foot
18 apartment unit that I want to rent. I do not think
19 that would happen, but I think we could get some,
20 just by using an averaging concept, we could get some
21 flexibility, and maybe we would bring some of those
22 personal-care homes back into the fold and they
23 actually do convert, because they do that.
24 SECRETARY RICHMAN: I mean, clearly, we are
25 going to take all of the feedback we are getting

1 today, all of it, and begin to read through it again
2 and look at what we can do.
3 But let me give you an example of one of the
4 things. I had a personal-care operator come to me
5 and say that she had in her home, in the house,
6 three women who were living on the first floor of the
7 house, and the ceilings were only 6 feet. Well, we
8 have a standard that the ceilings have to be higher,
9 but all of the women were between 5 feet and 5 feet 2
10 and had been living there for a long period of time.
11 And the question was, was I going to force them to
12 move out or to move somewhere else when the standard
13 was set higher?
14 No; I didn't. It was an exception that we
15 were able to make. This was their home. And we did
16 put a stipulation in that if anyone of a normal
17 height or a higher height moved in, then they would
18 not be able to be there. But it didn't make any
19 sense to me to take these elder women -- I hate that
20 term; that is me---
21 REPRESENTATIVE HENNESSEY: Shorter women.
22 SECRETARY RICHMAN: Shorter women, and force
23 them to move because we had set a standard that did
24 not really apply to them.
25 So we are still, I mean, the purpose of

1 these kinds of hearings, the purpose of the public,
2 is to be able to listen to the feedback from all
3 different sectors. We have listened, we believe,
4 from a very strong constituency of advocates and
5 consumers, and we have heard that voice and we very
6 much agree in many of the things they put forward
7 about mobility. We have listened to the providers
8 and what they have said. We have tried to come in
9 the middle and cut this baby a little bit, but that
10 does not mean we aren't still listening.
11 DEPUTY SECRETARY HALL: And, Representative
12 Hennessey---
13 REPRESENTATIVE HENNESSEY: If I could, thank
14 you very much. I appreciate the fact that you stuck
15 around as long as you did.
16 SECRETARY RICHMAN: Thank you.
17 CHAIRMAN MUNDY: Thank you, Madam Secretary.
18 We appreciate it.
19 DEPUTY SECRETARY HALL: We certainly would
20 take that suggestion under careful consideration.
21 But I know Estelle will remember another
22 case that she and I were involved in recently where a
23 nursing home had been built about 10 years ago, and
24 the nursing home regulations that the Department of
25 Health has specify, again, a certain minimum number

1 of square feet for those rooms.
2 And I think probably through an error on the
3 part of the architect or engineer, one of the rooms
4 wound up 1 foot smaller in narrowness than it was
5 supposed to be. And the facility asked for an
6 exception to that rule so that it could be certified,
7 because in all other respects, it met the code and
8 really didn't have a significant effect on quality of
9 life, and struggled for a number of years to have
10 that issue addressed.
11 When we learned about it, both Estelle and I
12 made a decision that we were going to grant a waiver
13 in that request, because it did not in any way
14 violate the philosophy that we were trying to
15 achieve. The fact that the room was 9 feet wide
16 instead of 10 feet was a de minimis issue for us, and
17 I think that is the philosophy we would bring to this
18 as well.
19 REPRESENTATIVE HENNESSEY: Just so you know,
20 I mean, when I talked to individuals and groups prior
21 to this hearing, what people have said to me was that
22 the statute itself had lots of flexibility in it, and
23 they liked that, and then the regs come along and
24 basically grind it down to, these are the absolute
25 requirements.

1 I do not see anything in the regs that talk
2 about variances being issued or exemptions being
3 granted. Maybe if you added something that talked
4 about that, maybe people wouldn't see them as being
5 as inflexible as they are complaining about.
6 Maybe that person that had a 140-square-foot
7 unit might think that, you know, he could still keep
8 it on the market and not disqualify it.
9 DEPUTY SECRETARY HALL: Well, I think the
10 question will come down to, and you alluded to this a
11 few moments ago, I mean, how much of a variance do
12 you allow before it gets to a point where it doesn't
13 look like what you started out with?
14 CHAIRMAN MUNDY: Can you just address, there
15 is the possibility for waivers in the regs. Am I
16 correct? I thought there was the opportunity for
17 waivers.
18 DEPUTY SECRETARY HALL: Yes.
19 CHAIRMAN MUNDY: But they would be granted
20 on a case-by-case basis.
21 DEPUTY SECRETARY HALL: On a case-by-case
22 basis, and that is what I was referring to.
23 REPRESENTATIVE HENNESSEY: So waivers, when
24 you use the waiver, you are talking about an
25 individual -- like in a zoning matter we call it a

1 variance.

2 DEPUTY SECRETARY HALL: Right.

3 REPRESENTATIVE HENNESSEY: So it is not an
4 across-the-board waiver; it is actually a
5 case-by-case issue?

6 DEPUTY SECRETARY HALL: Right.

7 REPRESENTATIVE HENNESSEY: Okay.

8 DEPUTY SECRETARY HALL: That is what I was
9 referring to.

10 REPRESENTATIVE HENNESSEY: Okay. I will
11 relook at that section.

12 DEPUTY SECRETARY HALL: Okay.

13 REPRESENTATIVE HENNESSEY: One final thing,
14 if I could.

15 You mentioned that dual licensure is allowed
16 in the regs. I couldn't find it. Other people have
17 talked to me and they said they can't find it. Can
18 you point to it? Where is it that we are -- tell me
19 what section we are misreading.

20 DEPUTY SECRETARY HALL: I think it is -- I
21 will reiterate that we have had in mind that there
22 would be circumstances under which we would permit
23 it, as I have said to Chairman Mundy's testimony.

24 I think the regulations are not explicit
25 about that, and this is an area that we should

1 clarify when we go to final.
2 REPRESENTATIVE HENNESSEY: Okay. So it is
3 not a misreading, it is just a---
4 DEPUTY SECRETARY HALL: Yes, but I just want
5 people to know that they should not infer or read
6 from this that we were opposed to it.
7 REPRESENTATIVE HENNESSEY: Okay. Thank you.
8 Thank you, Madam Chairman.
9 CHAIRMAN MUNDY: Well, I want to thank all
10 of the testifiers who are still here for their
11 excellent input today, and I especially want to thank
12 Secretary Richman and Mike Hall, Deputy Secretary
13 Hall, for being here the entire time to listen to all
14 of you.
15 And I do look forward to some revisions to
16 the regs. So in that regard, I think this hearing
17 was extremely productive.
18 And again, I thank you all.
19
20 (The hearing concluded at 2:56 p.m.)
21
22
23
24
25

1 I hereby certify that the proceedings and
2 evidence are contained fully and accurately in the
3 notes taken by me on the within proceedings and that
4 this is a correct transcript of the same.
5
6
7 _________________________
Debra B. Miller, Reporter
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25