

OFFICE OF STATE INSPECTOR GENERAL



EXECUTIVE SUMMARY

**OSIG Investigation of the Pennsylvania Department of Aging's
Monitoring of County-Based Agencies
That Investigate Allegations of Elder Abuse**

January 8, 2019

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OSIG Investigation of the Pennsylvania Department of Aging's Monitoring of County-Based Agencies That Investigate Allegations of Elder Abuse

In May 2017, the Office of State Inspector General (OSIG) investigated whether:

- (1) the Pennsylvania Department of Aging (PDA) is properly monitoring Pennsylvania's Area Agencies on Aging (AAAs), which are tasked with investigating allegations of abuse against older Pennsylvanians; and
- (2) PDA is enforcing its regulations, which require AAAs to categorize Reports of Need (RON) and complete subsequent investigations within the applicable timeframes, as required by Pennsylvania law and regulations.

BACKGROUND

PDA is responsible for directing the administration of the Older Adults Protective Services program for the prevention and treatment of elder abuse, neglect, exploitation, and abandonment. It also designs and implements a statewide reporting and investigative system to address the needs of older adults requiring protective services. Under Pennsylvania law, AAAs are required to conduct face-to-face interviews of alleged abused or neglected victims within 72 hours after receiving the RON, and complete investigations of the allegation(s) within 20 days after receiving the RON.

COOPERATION FROM THE DEPARTMENT OF AGING

During the course of the OSIG's investigation, PDA's Executive and program staff were cooperative and accommodating. PDA made staff available for interviews and provided requested information, documentation, and data within a timely fashion and in a manner that was conducive to the OSIG's independent analysis.

METHODOLOGY

The OSIG reviewed PDA's documentation from its monitoring reviews conducted in Dauphin, Delaware, Lawrence, and Westmoreland Counties (based on allegations that these counties particularly exemplified deficiencies in the AAAs' handling of elder protective services cases and PDA's oversight of the AAAs). The OSIG also interviewed 12 individuals with knowledge of the protective services program, consisting of current and former PDA employees; a Department of Human Services (DHS) employee who oversees Adult Protective Services; Temple University employees who offer training to AAA staff; and former employees of AAA protective services departments. Additionally, the OSIG reviewed PDA statewide database records of 18,275 RONs received by all AAAs in Fiscal Year 2016-2017.

SUMMARY OF FINDINGS

The OSIG’s investigation resulted in six findings:

Finding 1: *In 20.4% of the 18,275 cases (3,724), the AAAs failed to conduct a face-to-face interview of the alleged neglected or abused older adult within the required 72 hours.*

The OSIG investigation found that AAAs failed to conduct a face-to-face interview of the alleged abused or neglected older adult in 3,724 of the 18,275 reviewed cases (20.4% of the cases). The records show that the delay in some cases exceeded *one year*. See Table 1.

Table 1. Time Delay in 3,724 RONs for Which the Face-to-Face Visit Exceeded 72 Hours

TIME IN WHICH FACE-TO-FACE VISIT OCCURRED	NUMBER OF CASES
4 Days to 6 Days	1,603
7 Days to 10 Days	766
11 Days to 20 Days	619
21 Days to 100 Days	495
101 Days to 364 Days	71
** One Year or Greater	170

** NOTE: The OSIG recognizes that many of these entries might have resulted from an incorrect year being entered into the PDA database for the interview date. For example, many of these records show the interview took 365 or 366 days to occur, which would result from entering the wrong year (2017 rather than 2016) into the database in cases where the interview actually took place by the next day after the RON was received.

In another 4.8% percent of the 18,275 cases (875), the AAAs entered insufficient or incorrect data into the PDA database, preventing the OSIG (and PDA) from determining whether the face-to-face interview was completed within the required 72 hours.

Finding 2: *In 43% of the 18,275 cases (7,859), the AAAs did not determine whether the allegation of abuse was substantiated within the legally-required 20 days.*

The OSIG investigation found that in 7,859 of the 18,275 cases, the AAAs did not reach a determination within the legally-required 20 days. The “date of determination” is the date when the AAA determined whether the allegation(s) was substantiated or unsubstantiated. In more than 1,500 of the cases, the delay was greater than 100 days (See Table 2.)

Table 2. Time Delay in 7,859 RONs for Which the Determination Exceeded 20 Days

TOTAL TIME IN WHICH DETERMINATION MADE	NUMBER OF CASES
21 Days to 30 Days	2,186
31 Days to 40 Days	1,269
41 Days to 50 Days	920
51 Days to 64 Days	840
65 Days to 100 Days	1,095
Greater Than 100 Days	1,549

In another 6.2% of the 18,275 cases (1,151), the AAAs entered insufficient or incorrect data into the PDA database, preventing the OSIG (and PDA) from concluding whether the determination was made within the required 20 days.

Finding 3: PDA is neither requiring, nor offering, sufficient training to adequately prepare AAA staff to properly categorize and investigate RONS.

PDA regulations identify three distinct job responsibilities within AAAs’ protective services unit: Caseworkers, Supervisors, and Intake Workers. PDA, through a contract with Temple University’s Institute on Protective Services (Temple), provides protective services training to AAA staff. However, PDA and Temple staff told the OSIG that none of the groups receive sufficient training.

Intake Workers: AAA intake workers are often the first persons in the AAA informed of concerns regarding an older adult. They receive RONS to determine if the older adult is in need of protective services, and to determine the immediacy of the required response. The current protective services intake training is an Internet-based training module maintained by the Pennsylvania Association of AAAs; Temple does not participate in the training. Intake staff receive one initial training when hired, but *are not required* to receive subsequent refresher training. Temple staff told the OSIG that the training is outdated and does not reference current versions of the Intake form. Temple said that the case studies used within the training are not relevant to the actual RONS that staff currently receive.

Intake Workers must gather, at minimum:

- (1) the date and time of the report;
- (2) the name and contact information of the reporter, unless withheld;
- (3) the name, age, and contact information of the older adult in need of protective services;
- (4) the nature of the incident that precipitated the RON;
- (5) the nature and extent of the need for protective services (particularly if the older adult is in a life threatening situation); and
- (6) the physical and mental status of the older adult in need.

Immediately following receipt of the RON, the intake workers must screen the RON to assign it to one of the referral categories identified in Finding 4 (*i.e.*, Emergency, Priority, etc.).

Protective Services Caseworkers and Supervisors: PDA regulations require Caseworkers (also called investigators) and Supervisors (collectively called protective services staff) to complete (1.) a **Basic Training** that reviews the protective services regulations and fundamental investigative techniques; and (2.) an **annual one-day In-Service (Enhancement) Training**. The OSIG found that the 3½-day Basic Training does not test participants’ knowledge of the regulations. Comparatively, Temple staff told the OSIG that the State of Texas is considered the leading model in protective services training. Temple staff said that the Texas Department of Family and Protective Services requires 160 hours of core training and 18 hours of annual continuing education.

Following the training, participants are asked 25 questions in a “basic knowledge assessment,” and failing investigators are not required to either retake the training, or re-answer the assessment questions. In 2016, Temple increased the number of annual Basic Training sessions that it offered from two to ten, which has resulted in smaller class sizes and higher evaluation scores for trainees.

Temple told the OSIG that by contract, it must offer seven In-Service (Enhancement) Trainings and three Supervisory Trainings annually, but that in Fiscal Year 2017-2018, it will increase the number of Enhancement Training courses from seven to fifteen. Temple staff told the OSIG that the annual Enhancement Training is inadequate to ensure that protective services investigators possess the knowledge to perform at the highest standards.

Temple staff also said that some AAAs have little or no medical support on their cases; do not consult nurses on basic fundamentals; and do not review medical records during their investigations. Temple staff said that Pennsylvania child welfare regulations require child abuse investigators to undergo 120 Basic Training hours and 20 hours of annual continuing education; while Elder Abuse investigators receive a quarter of the education and training.

Temple staff specifically recommended the following training changes to enhance the Pennsylvania protective services program:

- Require a more thorough and expansive knowledge base for investigators within their first 18 months of conducting protective services investigations.
- Use an educational mentoring program for the first 18 months for new investigators.
- Require more than six annual hours of continuing education for Protective Services Investigators.
- Use hybrid training as a format for expanding training opportunities.
- Require certification for Older Adult Protective Services investigators.
- Establish standard guidelines for all protective services investigators to do their jobs.

Finding 4: PDA is not monitoring the AAAs as they categorize and investigate RONS.

PDA does not routinely review RONS. The toll-free Elder Abuse (Telephone) Hotline System identifies where a reporter of elder abuse is located, and routes callers to the nearest AAA for assistance. RONS for adults 60 years of age and older are forwarded to AAAs; referrals for younger adult victims are sent to a DHS contractor for review. Interviewees told the OSIG that PDA has no control over categorization (“Emergency,” “Priority,” “Non-Priority,” “No Need”). A majority of interviewees [including Aging Services Specialists, senior PDA staff, and Temple staff] stated that there is very little consistency among AAAs. For example:

- One interviewee said that:
 - he or she has observed separate AAAs, presented with the same RON, categorize the report differently (in one instance an AAA categorized a set of allegations as “Priority”; while another AAA categorized that same set of allegations as “No Need”); and
 - in another case, one AAA **initiated** an investigation because it found a RON lacked sufficient specificity; while under the same set of circumstances, another AAA **failed to conduct a site visit** because the RON lacked sufficient specificity;
- Another interviewee said, “52 county AAAs [are] doing their own thing”; and
- Still another interviewee said that a set of standard guidelines may minimize the “gray areas” and negate the inconsistencies from one county to another.

Finding 5: PDA is not offering timely guidance to the AAAs on case management.

PDA conducts annual Quality Assurance Monitoring Reviews (QAMRs) at each AAA by reviewing (generally) between 20 and 50 randomly-selected protective services investigations of each AAA. Following the review, PDA conducts an exit interview with the AAA director or protective services supervisors, and issues a post-monitoring letter that (officially since September 2017) issues

a color-based score to the AAA. See Table 3. AAAs submit Corrective Action Plans or Statement of Findings Plans to correct deficiencies. The OSIG found that PDA is not consistently issuing post-monitoring letters to AAAs in a reasonable time after the review. The OSIG found that it took PDA up to more than two months before it issued the letters.

Table 3. Summary of PDA Rating Scale for AAAs

Red – Significant and/or repetitive quality issues and one or more individuals were left at risk. (PDA staff will monitor again within 90 days of a valid Corrective Action Plan.)

Yellow – Monitoring results reveal significant or repetitive quality issues, but no individuals were left at risk (PDA staff will monitor again in six months.)

Green – Monitoring results that indicate no or minimal quality issues and that no individuals were left at risk (PDA will schedule annual QAMRs.)

A.) Anecdotal Examples of AAA reviews found by the OSIG.

Dauphin County (2016): In March 2016, PDA conducted a review of the Dauphin County AAA, consisting of 60 sample cases. Of the 60 cases reviewed, PDA found that 53 investigations (88.3%) had not been initiated within the required timeframe; 59 cases (98.3%) did not reflect whether a comprehensive investigation had been conducted; 33 cases (55%) had four or fewer journal entries; and in all 60 cases (100%), Investigation Summary and Assessment (ISA) forms were either incomplete or missing. PDA also found that the AAA workers averaged 99 cases, more than three times the maximum allowed by PDA regulations. More than two months after the on-site visit, PDA issued a post-monitoring letter to Dauphin County, and PDA staff started working with Dauphin County to bring it into compliance. By December 1, 2016, Dauphin County had only five areas of noncompliance, and only one of the seven caseworkers at Dauphin County had a caseload higher than 30 cases.

Lawrence County (2017): In April 2017, PDA conducted a review of the Lawrence County AAA, consisting of 55 sample cases. Of the 55 cases reviewed, PDA found that 35 cases (63.6%) had no documented face-to-face visit; and 8 of the older adults in those 35 cases (22.9%) had died while the investigation was open. PDA also found that of the 55 cases, 19 cases (34.5%) were still open with the most recent face-to-face visit conducted in Fiscal Year 2015-2016. None of the 55 cases (0.0%) showed whether a comprehensive investigation had been conducted. In 54 of the 55 cases (98.2%), the investigation summary forms were either incomplete or missing; cases had minimal journal entries and no indication if actions were completed; and none of the reviewed files contained all the required information. Finally, PDA found that two former investigators had a total of 90 cases that had not been reassigned to current employees.

B.) PDA is not Timely Issuing Directives and Bulletins to AAAs.

A PDA senior staff member told the OSIG that PDA has had a problem over the years (to the present) issuing timely directives to AAAs. PDA staff said that proposed internal policies, Aging Technical Assistance Bulletins, and Aging Program Directives remain with PDA Executive Staff (sometimes for years) without being issued. Two PDA employees said that they have recently started revising the PDA process to more timely issue such Bulletins and Directives.

Finding 6: PDA is not adequately staffing its own Protective Services Department.

PDA staff told the OSIG that it is clear that PDA lacks sufficient staff to adequately monitor the AAAs (especially since RONs have increased during the last three years); there is heavy turnover among PDA contract employees; and this turnover affects the consistency of the entire protective services program. PDA records show that 24 of PDA's 25 monitoring reviews (conducted in 2018) were completed after the target dates. One PDA senior staff member said that the true test for the PDA monitoring visits will be PDA's ability to conduct follow-up reviews of AAAs who are rated in the Yellow or Red categories. The senior staff member said that he or she is not certain that PDA can meet those deadlines with its current staff.

THE OSIG'S RECOMMENDATIONS

The OSIG recommended that:

1. PDA review its intake training modules to ensure the content is current and relevant to AAA intake staff;
2. PDA implement and require regular enhancement training for intake staff;
3. PDA and the legislature strengthen and increase the mandatory training requirements for investigative and supervisory staff;
4. PDA consider ways to better educate AAA staff on subject matter topics within a reasonable time after hire;
5. PDA and the legislature consider the viability and advantages of a centralized call center for Older Adult Protective Services;
6. PDA consider developing procedures to more closely monitor the length of time RON investigations remain open to ensure the investigations are completed within the statutorily required timeframe;
7. PDA consider implementing a real-time review component to the QAMRs to allow PDA to monitor the categorization and investigation of RONs as they are received and address problems and incidents of regulatory noncompliance as they arise;
8. PDA timely address indicated incidents of regulatory violations discovered during reviews and provide technical assistance as needed until the AAAs are compliant;
9. PDA revise the cooperative agreements/contracts with the AAAs to afford PDA more authority and control to ensure compliance with Pennsylvania laws and regulations;
10. PDA consider methods, such as increased training and monitoring, to enhance consistency in categorization and investigation of RONs across the individual AAAs;
11. PDA establish best practices in categorization and investigation, and provide guidance to the AAAs to ensure compliance with the identified best practices; and
12. PDA hire additional staff and cross-train existing PDA staff to allow for increased monitoring and technical assistance availability.

**PENNSYLVANIA DEPARTMENT OF AGING
RESPONSE TO OSIG EXECUTIVE SUMMARY**

Department of Aging Response

The Department is committed to upholding both the provisions of the federal Older Americans Act, which provides Title VII funding to support programs and services to protect elders from abuse and to provide public education, training, and information regarding abuse prevention, and Act 79 of 1987, which is state legislation that requires the department to establish and maintain a statewide system of protective services for older adults found to be in need of them. Protective Services are those activities, resources and supports provided to older adults to detect, prevent, reduce, or eliminate abuse, neglect, exploitation, and abandonment. These services are to be available and accessible through protective services agencies, which are the 52 local area agencies on aging (AAAs), that cover the 67 counties of the commonwealth.

The Department appreciates the time, effort, and courtesy that the Office of State Inspector General (OSIG) put into conducting its investigation of the Department's Protective Services Office. The OSIG's findings and recommendations, many of which have already been or are in the process of being implemented, will ensure that the Department continues to improve in its capacity to provide protective services to older adults who need them. Moreover, the Department welcomes the opportunity to provide the following responses to the OSIG findings.

Finding 1: In 20.4% of the 18,275 cases (3,724), the AAAs failed to conduct a face-to-face interview of the alleged neglected or abused older adult within the required 72 hours.

In response:

- Act 79 of 1987, known as the Older Adults Protective Services Act, requires the Department to monitor the AAA for compliance with the Act and the approved AAA protective services plan.
- Regular quality monitoring visits are conducted by staff from the Department's Protective Services Office review a random sample of each AAAs Protective Services (PS) cases. When non-compliance is discovered, such as the AAA not conducting a face-to-face visit within the standards of the Act, the finding is noted and a corrective action plan is issued by the Department's Protective Services Office.
- The AAA is required to respond to the corrective action plan describing how the AAA will ensure compliance for delivering protective services in their planning and service area that must include how the AAA will meet the required standards for initiating the face-to-face visit with the older adult in accordance with Regulation §15.42 (a).
- The Department has and will continue to issue findings and corrective action plans to the AAAs when these standards are not met.
- With regard to the AAAs entering insufficient or incorrect data into the PDA database, SAMS, it's recognized that the continued increase in the number and complexity of the abuse reports received places added pressure on the ability of the AAAs to meet this requirement. Notwithstanding, the benefit of each AAA properly, accurately, timely, and objectively documenting the receipt of the report, and all investigation and assessment activities is critical. The Department will continue to advocate for additional resources, and the Protective Services Aging Specialists will continue to provide technical assistance and training in SAMS proficiency.

Finding 2: In 43% of the 18,275 cases (7,859), the AAAs did not determine whether the allegation of abuse was substantiated within the legally-required 20 days.

In response:

- Please note that Regulation §15.42 (d) requires the AAA to make all reasonable efforts to complete an investigation of a report of need for protective services as soon as possible and, in cases of abuse and neglect, at least within 20 days of the receipt of the report. The investigation of the report is complete only when the report has been determined to be substantiated or unsubstantiated, and if substantiated, only after necessary steps have been taken to reduce an imminent risk to the older adult's person or property.
- Generally, in abuse and neglect cases, 20 days is enough time to determine and document the need for protective services, or lack thereof. While extending the investigation beyond 20 days can needlessly prolong potential risk to the older adult reported to be in need of protective services, it is recognized that circumstances may arise that necessitates that more time is needed to conduct a thorough investigation.
- The regulations do not impose a 20-day time limit for investigating cases of financial exploitation, as it's recognized that obtaining needed records/documents might take some time for the AAA to properly gather and review as part of the investigation.
- The AAA is required to make every reasonable effort to complete all investigations as soon as possible with expediency and efficiency.
- The Department is required to monitor the AAA for compliance with Act 79 and approved AAA protective services plans.
- All AAAs are monitored annually. Regular quality monitoring visits are conducted by staff from the Department's Protective Services Office reviewing a random sample of each AAAs Protective Services (PS) cases. When non-compliance is discovered, such as the AAA not completing an investigation of a report of need in accordance with the standards of the Act, the finding is noted and a corrective action plan is issued by the Department's Protective Services Office.
- The AAA is required to respond to the corrective action plan describing how the AAA will ensure compliance for delivering protective services in their planning and service area that must include how the AAA will meet the required standards for completing investigations in accordance with Regulation §15.42 (d).
- To further enhance quality assurance measures already in place, in September 2017, PDA issued an Aging Program Directive whereby the AAAs were informed of scenarios that may trigger additional quality assurance monitoring of protective services including, but not limited to, an annual (scheduled) monitoring visit, legislative inquiry, complaint being received, appeal being filed, etc. In any of these situations, the Department's Protective Services Specialists will pull a random sampling of PS cases for review. These cases will include substantiated, unsubstantiated and no-need cases. Said review could result in the issuance of a corrective action plan.
- The above referenced Aging Program Directive also informed the AAAs that their performance level would be designated, whereby if a monitoring result indicated no or minimal quality issues and no individuals were left at risk, the AAA monitoring performance level result would be designated green; if the monitoring result revealed significant or repetitive quality issues, and no individuals were left at risk, the AAA monitoring performance level result would be yellow; and if the monitoring results revealed significant and/or repetitive quality issues and one or more individuals were left at risk, the AAA monitoring performance level result would be red.

- If the steps outlined in the Aging Program Directive for each performance level are not met and if persistent serious quality issues continue, the Department will pursue all available options including alternative entities to provide protective services in accordance with the Act and its regulations.

Finding 3: PDA is neither requiring nor offering sufficient training to adequately prepare AAA staff to properly categorize and investigate RONS.

In response:

- The Department recognizes the significance of Regulation §15.121 that addresses staff training and experience standards, and respects the OSIG finding as a way to improve accountability, management oversight, preparedness, effectiveness, and the overall delivery of protective services for the older adults in need of them.
- The OSIG finding from those who help to develop and conduct the training is valuable as such feedback and insight will allow the Department to better tailor and improve training sessions, and overall provide greater protection to older adults who are vulnerable and at risk of abuse, neglect, exploitation, and abandonment.
- Portions, however, of the OSIG finding do necessitate Department clarification including:
 - The Department does require protective services training in accordance with the regulations, and prior to the initiation of the OSIG inquiry, and its subsequent findings, and recommendations, the Department was already in conversation with its training contactor, Temple Institute on Protective Services, to review the trainings currently provided and to enhance the timely access to trainings, the overall content of the training material, and the learning experience of the AAA staff in need of this specialized training. The need for improved access was identified by the Department for its training contractor's implementation. AAA staff who participate in these trainings complete evaluations that are promptly reviewed by the Department so that recommendations offered are considered as improvements, and areas of concern with either the trainer or the content, are immediately addressed. These conversations continue and additional training improvements will be implemented.
 - The current basic protective services intake training is maintained by the PA Association of Area Agencies on Aging (P4A) Long Term Living Training Institute (LTLTI).
 - The training is conducted by current and past Department Protective Services Office staff, along with the current Director of the Temple Institute on Protective Services, who presents a portion of the training.
 - The case studies, while relevant, will be updated as the training was developed nine years ago.
 - Content pertaining to the Adult Protective Services law, which addresses the handling of reports of abuse for adults ages 18 – 59 that are received by the AAAs, will also be updated.
 - The Department recently was permitted to fill a vacant position that will work with the Protective Services Office to ensure that a timely review of all training materials is conducted, including training modules that are housed on the LTLTI portal, and updates are made in a timely fashion.
 - The Temple Institute on Protective Services comments regarding inadequate training content as reported to the OSIG are appreciated and are being further investigated by the Department so that any perceived or real training inadequacies are addressed.

- Although the Temple Institute on Protective Services does not provide quality monitoring services for the Department, their comments regarding AAAs not consulting nurses and not having medical support on their cases is being further investigated by the Department.
 - Regulation §15.12 (b) requires the AAAs to submit to the Department a protective services plan. Among the requirements of the protective services plan, the AAAs are required to provide an explanation of the organizational structure and staffing of the AAAs protective services functions, including provisions for purchasing these services if applicable. For the purpose of advising the AAA on medically related issues encountered during the assessment and the development of a service plan, the AAA organizational structure must include the consultation services of a registered nurse or physician licensed to practice in the Commonwealth. When the Department Protective Services Office conducts its quality monitoring, if non-compliance with the Act or the approved AAA protective service plan is identified, the finding will be noted and a corrective action plan issued.

Finding 4: PDA is not monitoring the AAAs as they categorize and investigate RONS.

In Response:

- The Department recognizes the significance of Regulation §15.26 that addresses the screening and referral of reports received, and respects the OSIG finding as a way to improve accountability, management oversight, preparedness, effectiveness, and the overall delivery of protective services for the older adults in need of them.
- Portions, however, of the OSIG finding do necessitate Department clarification including:
 - The toll-free Elder Abuse Hotline System routes callers to the appropriate local AAA, where the older adult reported to be in need of protective services is located, for receipt, screening, and referral.
 - Reports of Need (RONS) for adults 60 years of age and older are routed to the local AAA; and RONS for younger adult victims (18 to 59 years of age) are routed to the Department of Human Services' (DHS) contractor for review as DHS is responsible under the Adult Protective Services Act for these investigations.
 - The Department's Protective Services Office does monitor the AAA for compliance with the Act and its approved AAA protective service plan.
 - Regulation §15.12 (b) (3) addresses that portion of the AAA protective services plan that must contain a description of the local process for delivery protective services to older adults who need them, including the 24-hour capacity to receive reports, the investigation of reports, and the necessary actions arising from investigations. The description is to focus on the specific local methodology to be implemented in activities for which the Act and its regulations allows for local differences and flexibility.
 - Regarding the issue of the categorization of RONS, it is worth noting that Department program and executive staff also individually reviewed a summary of several RONS and assigned a categorization. Upon comparison, the results yielded a variance in the RON categorizations. For example, one reviewer categorized a RON as a Priority, while another categorized the same RON as Non-Priority. Despite the difference in categorization both RONS yielded a timeline for when the investigation needed to be initiated.
 - The Intake process for RONS is 24-hours a day, and an effective and thorough Intake process is intended to elicit from the caller as much descriptive detail of

the situation as possible so that a category is chosen and response time for the investigation to commence is determined.

- The Department Protective Services Office does review RONS during its monitoring visits, and as described earlier, the Department did inform the AAAs via an Aging Program Directive issued in September 2017, that an additional monitoring review could take place based on a trigger, such as a complaint that an AAA is categorizing all RONS as No Need for Protective Services.
- Due to concerns with the number of RONS being categorized by the AAAs as No Need for Protective Services, which means that no investigation will be conducted but depending on the circumstances of the information gathered, the case may have been referred to other more appropriate resources, such as regular case management or to a community-based social service agency, effective January 2, 2019, Department Protective Services Specialists will review all Reports of Need that have been categorized as No Need. The Department then has the authority to re-categorize a Report of Need and require the AAA to conduct an investigation in accordance with Act 79 standards. The Department review of No Need RONS will be daily and will continue for as long as the Department deems necessary.

Finding 5: PDA is not offering timely guidance to the AAAs on case management.

In Response:

- The Department issues guidance to the AAAs on post quality assurance monitoring visits and after review of an AAA protective services plan.
- While the exit interview with the AAA provides for a verbal discussion of the initial findings and sets an expectation of any corrective action plan that will be contained in the post-monitoring letter, the Department recognizes the need to ensure that letters are drafted, reviewed, and issued in a more-timely fashion. A rather lengthy internal Department review process yielded a consistent letter format that is now used in the creation of all post-monitoring letters that are issued to the AAAs with the expectation that the letter is issued within 30 days of the monitoring visit.
- The Department recognized that communication between program staff, executive staff and legal counsel was quite often ineffective and inconsistent, resulting in unrealistic expectations and misunderstandings about the appropriateness of how and when to issue Aging Program Directives and/or Aging Technical Assistance Bulletins. The Department appreciates OSIGs candor in providing this information as a way to enhance program operations.

Finding 6: PDA is not adequately staffing its own Protective Services Department.

In Response:

- The Department has and will continue to advocate for additional resources to ensure compliance with the OAA, Act 79 and its regulations.