Approved: March 5, 2009
Date

MINUTES OF THE HOUSE AGING AND LONG TERM CARE COMMITTEE

The meeting was called to order by Chairman Bob Bethell at 3:30 p.m. on February 17, 2009, in Room 711 of the Docking State Office Building.

All members were present.

Committee staff present:
Norm Furse, Office of the Revisor of Statutes
Doug Taylor, Office of the Revisor of Statutes
Kelly Navinsky-Wenzl, Kansas Legislative Research Department
Terri Weber, Kansas Legislative Research Department
Judith Holliday, Committee Assistant

Conferees appearing before the committee:
Representative Tom Sloan
Gilbert Cruz, State Ombudsman
Wayne Bollig, Director Veterans Services, Kansas Commission on Veterans Affairs
Martin Kennedy, Deputy Secretary, Kansas Department on Aging
Mitzi McFatrich, Executive Director, Kansas Advocates for Better Care
Ami Hyten, Assistant Executive Director, Topeka Independent Living
Rocky Nichols, Executive Director, Disability Rights Center of Kansas
Dodie Wellshear, On behalf of Kansas Academy of Family Physicians
Kathy Damron, On behalf of University of Kansas Medical Center
Bob Williams, Executive Director, Kansas Association of Osteopathic Medicine
Courtney Huhn, Medical Student, University of Kansas Medical Center

Written testimony only:
Ernie Kutzley, American Association of Retired Persons
Debra Zehr, President, Kansas Association of Homes and Services for the Aging
Tom Laing, Executive Director, InterHab

Others attending:
See attached list.

Chairman Bethell brought the minutes of the February 10 and February 12 Committee meetings before the Committee for approval. Representative Carlin made the motion to approve the minutes, seconded by Representative Phelps. The motion carried.

Hearing on HB 2242 - State long-term care ombudsman; expanding the authority of the state long-term care ombudsman to advocate for otherwise qualified individuals not in long-term care facilities.

Chairman Bethell opened the hearing on **HB 2242**.

Representative Tom Sloan brought before the Committee **HB 2242**, which originated with the Douglas County legislators and interested individuals. (Attachment 1) Representative Sloan told the Committee that the Long-Term Care Ombudsman serves as an advocate for residents in facilities, and **HB 2242** extends that authority to persons who would otherwise qualify to reside in facilities, but do not. He expressed belief that the Legislature should extend the Ombudsman authority to pursue complaints on behalf of persons not in facilities, and could investigate complaints on behalf of non-facility-based residents as funds permit.

Gilbert Cruz, State Ombudsman, testified in support of **HB 2242**. (Attachment 2) Mr. Cruz stated the Ombudsman program currently covers most residential facilities, except for nursing facilities for the mental health or the mentally retarded, private homes or other non-licensed settings. He stated that **HB 2242** in its present form, 1) does not contain the necessary legal protections and jurisdictions for the Ombudsman program to enter a non-licensed facility; and 2) would require adding ten more ombudsmen. In addition, the present funding for the Ombudsman program prevents using the grants to develop ombudsman services for the home.

Minutes of the House Aging And Long Term Care Committee at 3:30 p.m. on February 17, 2009, in Room 711 of the Docking State Office Building.

Mr. Cruz suggested amending the language in **HB 2242** to allow a pilot project in Wichita; amending language to include legal protections and jurisdictions to enter non-licensed facilities in the pilot area, and have the language include former residents in a facility; include the Kansas Soldiers Home and Kansas Veterans Home within the definition of facility; and convene a meeting of stakeholders to explore options within the home utilizing results of the pilot project.

Wayne Bollig, Director, Veterans Services, Kansas Commission on Veterans Affairs, testified in support of **HB 2242**. (Attachment 3) Mr. Bollig told the Committee that the State's Long-Term Care Ombudsman continues to work with the Kansas Commission on Veterans' Affairs as it transitions into a Medicare facility, and adding the two veterans' homes in the bill will provide another layer of representation for the veterans.

Martin Kennedy, Deputy Secretary, Kansas Department on Aging (KDOA), testified in support of **HB 2242** as amended. (Attachment 4) Mr. Kennedy stated that as community support is expanded more seniors and people with disabilities will be leaving nursing homes and going home. He encouraged the State Long-Term Care Ombudsman to work closely with the Area Agencies on Aging and the Centers for Independent Living to ensure that people leaving a nursing home can receive the services necessary to remain at home.

Mitzi McFatrich, Executive Director, Kansas Advocates for Better Care, expressed strong support for **HB 2242.** (Attachment 5) Ms. McFatrich believes this bill offers Kansas recipients of long-term care an independent, objective authority who can intervene on their behalf whether in a nursing home or in their own home. KDOA investigates complaints of abuse, neglect and exploitation in nursing facilities. The State Long-Term Care Ombudsman advocates on behalf of facility residents at their request. SRS Adult Protective Services investigates complaints of abuse in the homes, but there is no comparative consumer advocacy in the home setting.

Establishing an ombudsman for the home-based care program will: provide the same level of advocacy for long-term care individuals whether in their homes on in a nursing home; build consumer confidence about the safety and health oversight for home-based services; provide protection when incidents occur; and provide a safety net for the minimally regulated services for home-based care.

Ami Hyten, Assistant Executive Director, Topeka Independent Living Resource Center (TILRC), testified as neutral on **HB 2242**. (Attachment 6) Ms. Hyten submitted her agency's perspective on various issues for people living in long-term facilities, and people living at home and receiving home and community based services. Ms. Hyten stated that extensive training will be needed to become acquainted with community resources and applicable laws, rules and regulations. The State will need to identify overlap of services with adult protective services, case management agencies, and other community partners.

Rocky Nichols, Executive Director., Disability Rights Center of Kansas (DRC), testified as neutral on **HB 2297**. (Attachment 7) Mr. Nichols stated that the DRC is a private, nonprofit corporation that advocates for the legal and civil rights of persons with disabilities. He stated his agency's respect for the Long Term Care Ombudsman office and the services they provide. However, he expressed his agency's concern that advocacy services being proposed as an extension of the Ombudsman program are already being provided by the DRC for Kansans with disabilities regardless of age, in any setting, and its authority is not limited. Mr. Nichols stated the DRC would not need a new law passed to help them do all that is proposed in this bill or the pilot in the balloon amendment.

Written testimony in support of **HB 2242** was submitted by the following:
Tom Laing, Executive Director, InterHab (Attachment 8)
Ernie Kutzley, American Association of Retired Persons (AARP) (Attachment 9); and
Debra Zehr, President, Kansas Association of Homes and Services for the Aging (Attachment 10).

Chairman Bethell closed the hearing on **HB 2242**.

Hearing on HB 2297 - Geriatric medicine; approved postgraduate training program for KU medical school and doctor of osteopathy loan programs.

Minutes of the House Aging And Long Term Care Committee at 3:30 p.m. on February 17, 2009, in Room 711 of the Docking State Office Building.

Chairman Bethell opened the hearing on **HB 2297**.

Dodie Wellshear testified on behalf of the Kansas Academy of Family Physicians (KAFP) in support of **HB 2297**. (Attachment 11) Ms. Wellshear stated that the KAFP has no objections to adding geriatrics and geriatric psychiatry fellowships to the list of approved postgraduate residency training programs for the medical student loan programs. The KAFP advocates amending **HB 2297** to allow a fourth year of training for family medicine residency. This extra year would allow a resident planning to practice in an underserved area to gain extra expertise in geriatrics, emergency medicine, obstetrics or some other specialty before having to fulfill the requirement to pay back their loan obligation.

Ms. Wellshear explained that the intent of the loan programs is to put more primary care physicians into underserved areas. There is no primary care pathway to a fellowship in geriatric psychiatry, but instead is through a psychiatry residency, which is not one of the approved programs for the loan recipients. The KAFP believes that specialty should not be included in the loan programs.

Kathy Damron presented testimony on behalf of the University of Kansas Medical Center in support of **HB 2297**. (Attachment 12) Ms. Damron stated the bill does not have a fiscal impact, but it merely allows the residents taking the extra year of specialized study in their residency to defer paying back their student loan. Chairman Bethell asked Ms. Damron to address the issue of slots, and she responded that if the bill was passed and the number of slots would need to be expanded, that this would need to be addressed at a later date.

Bob Williams, Executive Director, Kansas Association of Osteopathic Medicine, testified in support of **HB 2297**. (Attachment 13) Mr. Williams stated his agency's position that geriatric medicine is a part of primary care, and by including fellowship training in geriatric medicine for osteopathic medical service scholarships, the medical community will be better prepared to address the needs of a growing aging population in the state.

Courtney Huhn, a second year medical student at the University of Kansas Medical Center, presented testimony in support of **HB 2297**. (Attachment 14) Ms. Huhn told the Committee that the geriatric population is growing, especially in rural areas of Kansas. Currently, the Kansas Medical Student Loan (KMSL) recipients must repay their loans through service in rural parts of Kansas, which would lead to better care for the growing geriatric population. With passage of **HB 2297**, the repayment of the service would be postponed by one year while the student completes the fellowship.

Ms. Huhn addressed the issue of filling the slots, stating that this would not be a problem since there are 120 slots to be filled, 30 for each residency year.

Ms. Huhn introduced several colleagues from across the state who are also KMSL recipients interested in geriatrics: Melissa Garber, 4th year medical student, Hutchinson; Tessa Rohrberg, 1st year medical student, Sharon Springs; Tricia Barker, 1st year medical student, Minneapolis; and Amanda Baxa, 1st year student, Tampa.

Written testimony in support of **HB 2297** was submitted by Martin Kennedy, Deputy Secretary, Kansas Department on Aging. (Attachment 15)

There was a question raised regarding the inclusion of geriatric psychiatry in the language in this bill. Chairman Bethell called on Michelle Niedens, Alzheimer's Association, to address the issue. Ms. Niedens told the Committee the shortage of geriatricians in the state, particularly in geriatric psychiatry, makes this germane to the bill. In many areas, Alzheimer's or dementia patients are treated in primary medicine facilities and admitted to hospitals, often with less than desirable results. That makes this a primary medicine issue. She referenced a report her agency recently completed that will be forwarded to the Chairman's office with information on this issue.

Chairman Bethell closed the hearing on **HB 2297** and stated he would like to work the bill today if the Committee was willing. There was a consensus of the Committee to work the bill at this meeting.

Minutes of the House Aging And Long Term Care Committee at 3:30 p.m. on February 17, 2009, in Room 711 of the Docking State Office Building.

Representative Schwab made a motion to pass **HB 2297** out favorably, seconded by Representative Horst. The motion carried.

Representative Hill offered a substitute motion to **HB 2297** by deleting the words "or geriatric psychiatry" from the language wherever found in the bill. Representative Schwab seconded the motion. The motion carried.

There was discussion of adding a fourth year to the three-year family medicine residency program. There was a question if this language is actually needed, or if this is a University decision on a curriculum issue. Representative Flaharty offered a conceptual amendment to authorize the Revisor to write the appropriate language adding the fourth year of family practice to the bill. Representative Williams seconded the motion. The motion carried.

Representative Schwab moved to pass out **HB 2297** favorably as amended, seconded by Rep. Horst. Motion carried.

There was discussion that the Committee pursue the issue of geriatric psychiatry through drafting of a new bill to be introduced through another committee and then brought back to the Aging and Long Term Care Committee at a later date. There were no objections.

The meeting was adjourned at 5:00 p.m.

The next meeting is scheduled for February 26.

HOUSE AGING AND LONG TERM CARE COMMITTEE

DATE: 2/17/09

NAME	REPRESENTING
Mitzi McFatrich	Kansas Advocates for Better Care
Jennifer Newlin	" " " "
Mary Beth Tund	Washburn nursing graduate student
Courtney Hohn	self, medical student KUSOM
Amanda Baxa	self, medical student KUSOM
Tessa Rohrberg	self, medical student KU-SOM
Patricia Bakr	self, medical student KU-SOM
Heather VanBeveren	self - medical student
Melissa Garber	self, (medical student KUMC)
Jacqueline Kitchen	self (medical student KUMC)
Allison Proctor	Washburn School of Nursing
Joe Ewert	KAHSA
Debra Zehr	KATSA
Ami Hyten	Topeka Independent Living Resource Center, Inc.
Rocky Nichols	DRC
Chris Gigstad	Federico Consulting
B. Muriani	SRS
Deb Merrill	KAPA
Marty Kennedy	KDOA

PLEASE USE BLACK INK

HOUSE AGING AND LONG TERM CARE COMMITTEE

DATE: 2/17/09

NAME	REPRESENTING
Wayne Dollig	KCVA
Dodie Wellshear	KAFP
Gilbert CRUZ	KLTCO
Shelley King	Dept. of Admin., Ofc. of Chief Counsel

PLEASE USE BLACK INK

TOM SLOAN
REPRESENTATIVE, 45TH DISTRICT
DOUGLAS COUNTY

STATE CAPITOL
300 SW 10TH AVENUE
TOPEKA, KANSAS 66612
(785) 296-7654
1-800-432-3924

772 HWY 40
LAWRENCE, KANSAS 66049-4174
(785) 841-1526
tom.sloan@house.ks.gov

STATE OF KANSAS

TOPEKA

HOUSE OF

REPRESENTATIVES

COMMITTEE ASSIGNMENTS
CHAIRMAN: VISION 2020

MEMBER: ENERGY AND UTILITIES
GOVERNMENT EFFICIENCY
AND FISCAL OVERSIGHT
JOINT COMMITTEE ON ENERGY
AND ENVIRONMENT

Testimony on HB 2242 - Concerning the Long-Term Ombudsman

Committee on Aging and Long Term Care
February 17, 2009

Mr. Chairman, Members of the Committee: HB 2242 involves few words, but has the potential to profoundly impact the lives of a few people who otherwise would be at great risk. Currently the Long-Term Care Ombudsman serves as an advocate for residents in facilities - HB 2242 extends that authority to persons who otherwise would qualify to reside in facilities, but do not.

This bill originated from the annual meeting of Douglas County legislators with community organization officers and individual citizens expressing their concerns. One of the suggestions was that the Long-Term Care Ombudsman be authorized to investigate complaints of abuse, etc. for persons who are not living in facilities. Our entire delegation expressed support for the recommendation. The late date on which a draft of this bill was completed, due to the workload of the Revisor staff members, necessitated this be introduced as an individual's bill, rather than one listing all of the Douglas County House members.

The delegation members recognize that increasing funding for the Ombudsman to assume a heavier work load will not occur. We also have been informed about the federal constraints on the Ombudsman's spending options.

It is our belief that the Legislature should establish the authority for the Ombudsman to pursue complaints on behalf of persons not in facilities and that IF private or public funds become available he will investigate complaints on behalf of non-facility-based residents as time and opportunity avail. In other words, the Ombudsman will prioritize the complaints and risks to the resident/non-resident and respond accordingly. We do not advocate an increase in funding levels - notwithstanding the fiscal note developed by the agency and budget staff.

Committee members, HB 2242 is the "right" policy for our state. During these fiscally challenging times it will not be fully implemented, but it remains the "right" course of action and I encourage you to support it.

Thank you for your attention, I will respond to questions at the appropriate time.

HOUSE AGING & LONG TERM CARE
DATE: 2/17/09
ATTACHMENT: 1

KANSAS
OFFICE OF THE STATE
LONG-TERM CARE OMBUDSMAN

Kathleen Sebelius, Governor
Gilbert Cruz, RRT MPA
State Long-Term Care Ombudsman
Gilbert.Cruz@da.ks.gov

Aging and Long-Term Care Committee
Chairman Bob Bethel

Presented by Gilbert Cruz
February 17, 2009

The State Long-Term Care (LTC) Ombudsman Program represents the rights of nearly 28,000 individuals located in adult care homes throughout Kansas. This coverage is comprised of nursing home facilities, assisted living facilities, board and care homes, residential health care facilities, home plus facilities, adult day cares and LTC units (LTCU) in hospitals. The ombudsman program provides FREE advocacy assistance to LTC residents as per the Older Americans Act (OAA) guidelines. Presently, ombudsman services do not include nursing facilities for the mental health or for the mentally retarded, private homes or other non-licensed settings.

The ombudsman program is supportive of the premise of HB 2242 for ombudsman services to cover all individuals in a community needing similar nursing home level type services. There should be no difference in ombudsman services in a nursing facility as opposed to the home. The ombudsman program has always supported the placement of individuals needing LTC in the least restrictive environment possible wherever that setting might be in the continuum of care model. However, in its present form HB 2242 still does not cover the needed legal protections and jurisdictions for the ombudsman program to enter a non-licensed facility. HB2242 will require the addition of ten more ombudsmen, which will require significant funding (see fiscal note).

Historically, the position of ombudsman programs across the nation is not to expand beyond the Institute of Medicine's recommendation of one ombudsman for every 2,000 residents. The Kansas Ombudsman Program has one ombudsman for every 3,100 residents. Regardless, twelve states forged ahead to advocate for the resident at the home.*

The funding for these twelve states is State General Fund (SGF), Civil Monetary Penalty fund (CMP), Medicaid Match, Provider Tax, and Money Follows the Person (MFP) grant monies. The remaining funding available to the ombudsman program is the OAA Title VII and III B grant money. According to the Administration on Aging (AoA), the ombudsman program cannot use these grants to develop ombudsman services for the home. Additionally, Medicaid match funding might not be available in Kansas for a community ombudsman program.

Recognizing the State's current fiscal restraints, the ombudsman program suggests the following…

HOUSE AGING & LONG TERM CARE
DATE: 2/17/09
ATTACHMENT: 2

KANSAS
OFFICE OF THE STATE
LONG-TERM CARE OMBUDSMAN

Kathleen Sebelius, Governor
Gilbert Cruz, RRT MPA
State Long-Term Care Ombudsman
Gilbert.Cruz@da.ks.gov

- Scale down the fiscal note of HB2242 to fund a community ombudsman pilot project in Ombudsman Region Four (Wichita) to gather needed information for complete community ombudsman expansion throughout the state. Currently, the Centers for Medicare and Medicaid Services (CMS) Real Choices Grant is in the same community run by the KDOA Aging Disability Resource Center (see attachment) .
  - Annual Cost $83,059 (One FTE)
- Amend the language to include legal protections and jurisdiction for the ombudsman program to enter a non-licensed facility in the pilot project area.
- Amend the language to include individuals who have formally resided in a facility.
- Amend 75-7303 to include Kansas Soldiers Home & Kansas Veterans Home within the definition of facility.
- The ombudsman program recommends the **Aging and Long-Term Care Committee** allow the state ombudsman to convene a meeting with all stakeholders to begin a dialogue on exploring advocacy options within the home utilizing the results of this pilot project. All stakeholders should analyze the following: *current situation, costs, funding options, staffing recommendations, travel, specific HCBS waiver coverage, duplication of services, access to private homes or other non-licensed settings, collection of data, AoA National Ombudsman Reporting System (NORS) requirements, confidentiality, policy and procedure development, scope of responsibilities (quality of care vs. all complaints), new training considerations, conflict of interest and systems advocacy.* After this dialogue occurs, a presentation by the state long-term care ombudsman to the Aging and Long-Term Care Committee on recommendations for further action can be made.

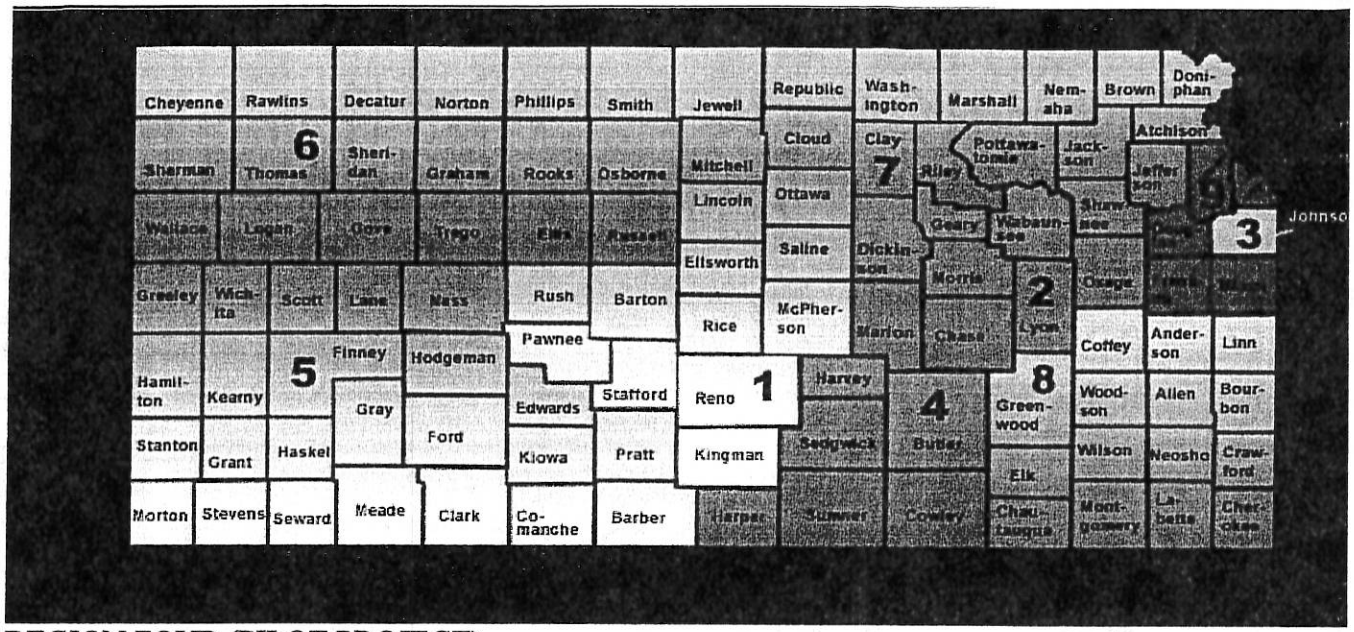
Please contact the ombudsman office if more information or assistance is needed.

References: National Ombudsman Resource Center, Washington D.C.
http://www.ltcombudsman.org/ombpublic/49_151_940.CFM

* Charting the Long-Term Care Ombudsman Programs Role in a Modernized Long-term Care System. National Association of State Units on Aging (NASUA) Study.

KANSAS
OFFICE OF THE STATE
LONG-TERM CARE OMBUDSMAN

Kathleen Sebelius, Governo.
Gilbert Cruz, RRT MPA
State Long-Term Care Ombudsman
Gilbert.Cruz@da.ks.gov



REGION FOUR (PILOT PROJECT)

KDOA receives $1.3 million Real Choices grant

The Kansas Department on Aging has been awarded a $1,272,179 federal grant to help people with chronic illness or disabilities reside in their homes and participate in community life.

Kansas is one of seven states to share in more than $8 million as part of the Real Choice Systems Change grant program through the Centers for Medicare and Medicaid Services, CMS Acting Administrator Kerry Weems announced.

KDOA will use its money to develop a person-centered hospital discharge planning model in the Wichita area. Both Via Christi Health System and Wesley Medical Center will participate in the project.

"Hospital discharge is a critical time for Kansas seniors," KDOA Secretary Kathy Greenlee said. "The purpose of this new grant is to work collaboratively with Wichita hospitals and community organizations to make as many community care options available as possible. Seniors prefer to live at home and age in place. Hospitalization should not deter them from that goal."

The grant will be an enhancement of the Aging and Disability Resource Center project, which is being developed to streamline access to program information, application processes and eligibility determination for all aging and disability services. Pilot sites are in Wichita and Hays.

The hospital discharge planners will use the ADRC to tap into community based resources to use for the discharged patient."I'm delighted for this opportunity to improve our services for seniors," Greenlee said.

Other states receiving grants are Alaska, Idaho, Missouri, Oregon, South Carolina and Wisconsin.

Session of 2009

HOUSE BILL No. 2242

By Representative Sloan

2-4

AN ACT concerning the state long-term care ombudsman; relating to the authority of the state long-term care ombudsman; amending K.S.A. 2008 Supp. 75-7306 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 2008 Supp. 75-7306 is hereby amended to read as follows: 75-7306. The state long-term care ombudsman shall be an advocate of residents in facilities throughout the state, *as well as ~~individuals who would otherwise qualify to reside in a facility but do not~~*. The state long-term care ombudsman shall:

(a) *Prioritize,* investigate and resolve complaints made by or on behalf of the residents relating to action, inaction or decisions of facilities or the representatives of facilities, or both, except that all complaints of abuse, neglect or exploitation of a resident shall be referred to the secretary of aging in accordance with provisions of K.S.A. 39-1401 et seq. and amendments thereto;

(b) develop continuing programs to inform residents, their family members or other persons responsible for residents regarding the rights and responsibilities of residents and such other persons;

(c) provide the legislature and the governor with an annual report containing data, findings and outcomes regarding the types of problems experienced and complaints received by or on behalf of residents and containing policy, regulatory and legislative recommendations to solve such problems, resolve such complaints and improve the quality of care and life in facilities and shall present such report and other appropriate information and recommendations to the senate committee on public health and welfare, the senate committee on ways and means, the house of representatives committee on health and human services and the house of representatives committee on appropriations during each regular session of the legislature;

(d) analyze and monitor the development and implementation of federal, state and local government laws, rules and regulations, resolutions, ordinances and policies with respect to long-term care facilities and services provided in this state, and recommend any changes in such laws, regulations, resolutions, ordinances and policies deemed by the office to

and changing definition of facility as defined in K.S.A. 2008 Supp. 75-7303

individuals who have formally resided in a facility as defined in K.S.A 75-7303.

Section 1. K.S.A. 2008 Supp. 75-7303 (c) is hereby amended to read as follows: "Facility" means an adult care home as such terms is defined in K.S.A.39-923 and amendments thereto, *and further includes Kansas Soldiers Home and Kansas Veterans Home* except that facility does not include any nursing facility for mental health or any intermediate care facility for the mentally retarded, as such terms are defined in K.S.A. 39-923 and amendments thereto.

39-923

Chapter 39--MENTALLY ILL, INCAPACITATED AND DEPENDENT PERSONS; SOCIAL WELFARE
Article 9.--ADULT CARE HOMES

39-923. Definitions. (a) As used in this act:

(1) "Adult care home" means any nursing facility, nursing facility for mental health, intermediate care facility for the mentally retarded, assisted living facility, residential health care facility, home plus, boarding care home, and adult day care facility, all of which classifications of adult care homes are required to be licensed by the secretary of aging.

(2) "Nursing facility" means any place or facility operating 24 hours a day, seven days a week, caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who, due to functional impairments, need skilled nursing care to compensate for activities of daily living limitations.

(3) "Nursing facility for mental health" means any place or facility operating 24 hours a day, seven days a week caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who, due to functional impairments, need skilled nursing care and special mental health services to compensate for activities of daily living limitations.

(4) "Intermediate care facility for the mentally retarded" means any place or facility operating 24 hours a day, seven days a week caring for six or more individuals not related within the third degree of relationship to the administrator or owner by blood or marriage and who, due to functional impairments caused by mental retardation or related conditions need services to compensate for activities of daily living limitations.

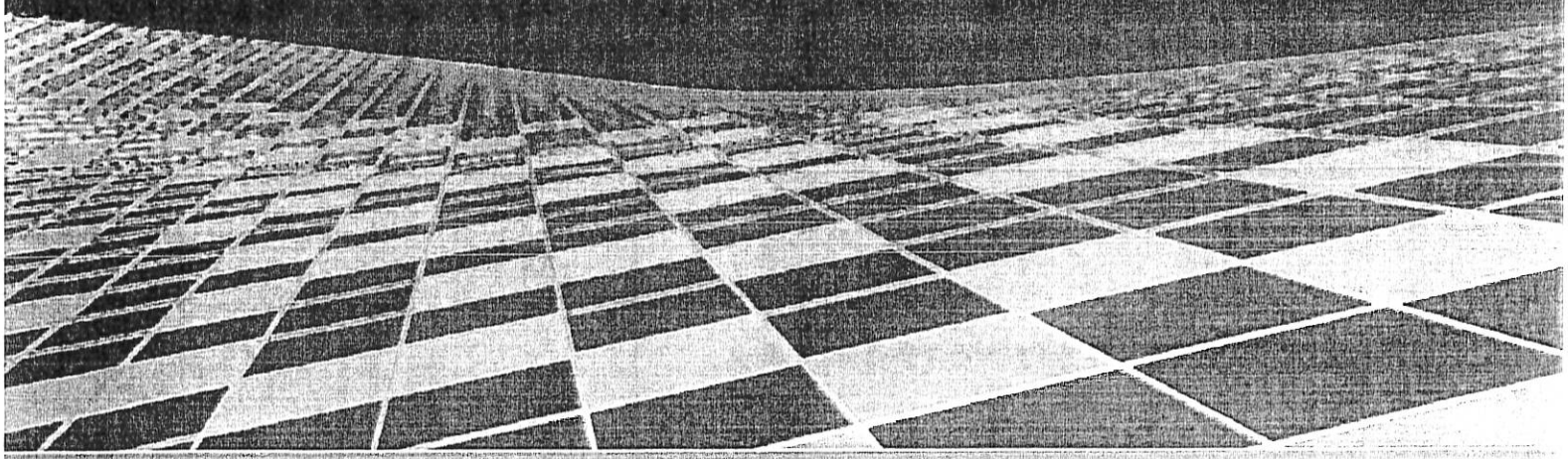
(5) "Assisted living facility" means any place or facility caring for six or more individuals not related within the third degree of relationship to the administrator, operator or owner by blood or marriage and who, by choice or due to functional impairments, may need personal care and may need supervised nursing care to compensate for activities of daily living limitations and in which the place or facility includes apartments for residents and provides or coordinates a range of services including personal care or supervised nursing care available 24 hours a day, seven days a week for the support of resident independence. The provision of skilled nursing procedures to a resident in an assisted living facility is not prohibited by this act. Generally, the skilled services provided in an assisted living facility shall be provided on an intermittent or limited term basis, or if limited in scope, a regular basis.

(6) "Residential health care facility" means any place or facility, or a contiguous portion of a place or facility, caring for six or more individuals not related within the third degree or relationship to the administrator, operator or owner by blood or marriage and who, by choice or due to functional impairments, may need personal care and may need supervised nursing care to compensate for activities of daily living limitations and in which the place or facility includes individual living units and provides or coordinates personal care or supervised nursing care available on a 24 hour, seven day a week basis for the support of resident independence. The provision of skilled nursing procedures to a resident in a residential health care facility is not prohibited by this act. Generally, the skilled services provided in a residential health care facility shall be provided on an intermittent or limited term basis, or if limited in

THE NATIONAL LONG-TERM CARE OMBUDSMAN RESOURCE CENTER

NASUA
National Association of State Units on Aging

Charting the Long-Term Care Ombudsman Program's Role in a Modernized Long-Term Care System



PREPARED BY THE NATIONAL ASSOCIATION OF STATE UNITS ON AGING

2-6

NASUA
National Association of State Units on Aging

Charting the Long-Term Care Ombudsman Program's Role in a Modernized Long-Term Care System

Long-Term Care Ombudsman Program
Strategic Directions Work Group Meeting Report

NCCNHR: The National Consumer Voice for Quality Long-Term Care

1828 L Street, NW, Suite 801
Washington, DC 20036
Phone: 202-332-2275
www.ltcombudsman.org

National Association for State Units on Aging

1201 15th Street, NW, Suite 350
Washington, DC 20005
Phone: 202-898-2578
www.nasua.org

Supported by the U.S. Administration on Aging

2-7

Acknowledgements

A big thank you goes to the following individuals who contributed to this dialogue and report.

WORK GROUP CONVENERS

Mark Miller, former Elder Rights Specialist with the National Association of State Units on Aging (NASUA), National Ombudsman Resource Center (NORC) and **Sue Wheaton,** Ombudsman Specialist, Administration on Aging

WORK GROUP MEMBERS

Wendy Altman, New Hampshire Bureau of Elder & Adult Services; **Heather Bruemmer,** Wisconsin State Long-Term Care Ombudsman (SLTCO); **Hal Freshley,** Minnesota Board on Aging; **Brenda Gallant,** Maine SLTCO; **Maria Greene,** Director, Georgia Division for Aging Services; **Kay Hind,** Executive Director, SOWEGA Council on Aging, Albany, Georgia; **Roland Hornbostel,** Ohio Department of Aging; **Esther Houser,** Oklahoma SLTCO; **Beverley Laubert,** Ohio SLTCO; **Kay Panelli,** Nevada Division for Aging Services; **Sarah Slocum,** Michigan SLTCO; **Lori Smetanka,** Director, NORC, NCCNHR: The National Consumer Voice for Quality Long-Term Care

OTHERS WHO CONTRIBUTED TO THE WORK GROUP DIALOGUE

Martha Roherty, Executive Director, NASUA; **Alice Hedt,** Executive Director, NCCNHR; **Bernice Hutchinson,** Director, Consumer Information Outreach and Assistance, NASUA; **Leslie Swann,** Aging and Disability Resource Centers, Administration on Aging; **Sara S. Hunt,** Consultant, NORC and author of this report.

ABOUT THIS DIALOGUE AND DOCUMENT

This work group dialogue and report was supported, in part, by a grant, No. 90AM2690 from the Administration on Aging, Department of Health and Human Services. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration on Aging policy.

Table of Contents

Charting the Ombudsman Program's Role in a Modernized Long-Term Care System

Long-Term Care Ombudsman Program
Strategic Directions Work Group Meeting Report

Purpose

The overall goal of this report is to help long-term care ombudsmen define their role and develop coordination efforts in a new long-term care system.

A work group was convened on January 23, 2008 to begin a national dialogue about a strategic role for the Long-Term Care Ombudsman Program in a changing and emerging long-term care system. This report began as a write-up of proceeding from the work group. It was discussed and refined at the 2008 Annual Spring Training Conference for State Long-Term Care Ombudsmen. Prior to the conference, the report was sent to all state ombudsmen and feedback was solicited. The final version of this report reflects revisions based upon the dialogue with state ombudsmen and the Washington State local ombudsmen who attended the conference.

The end result is a set of recommendations to provide essential information to long-term care ombudsman programs as they consider their role in a changing system. The recommendations call for concrete analysis and data to inform LTCOP decision making as programs move forward with efforts to rebalance the long-term care system.

Background

Long-term care services, consumer options, and the health care delivery system are in transition. Several federal and state initiatives are providing the impetus for change. In this time of developing and implementing new opportunities for consumers, questions arise regarding the role of the Long-Term Care Ombudsman Program.

The National Association of State Units on Aging, in collaboration with the National Ombudsman Resource Center and the Administration on Aging, convened a work group as an opportunity to explore and identify opportunities for Ombudsman Program involvement in a modernized long-term care system. The Ombudsman Program roles and advocacy functions were discussed related to nursing home diversion and transition initiatives and quality assurance in the home and community based services arena. Work group participants were state ombuds-

men, state unit on aging directors or their designees, an area agency on aging director, Administration on Aging staff, the National Association of State Units on Aging, NCNCHR, and staff and a consultant from the National Long-Term Care Ombudsman Resource Center.

Overview

Long-term care ombudsmen are important in planning a modernized long-term care system. The individuals ombudsmen serve, residents (or potential residents) of long-term care facilities, are moving into home care settings. The people are the same but the settings are different. The role of the ombudsman has always been to hold systems accountable to fulfill their responsibilities to residents. In thinking about a potential role for ombudsmen in a modernized long-term care system, the role would be the same, making sure that the systems that are in place work for consumers.

There are a number of different issues that surface when thinking about the role of the long-term care ombudsman in a modernized long-term care system. For some consumers, the ombudsman might be the first, or only, point of contact to learn about options in the long-term care system. To focus discussion the work group meeting covered three areas of service options: home and community based care, diversion from nursing homes, and nursing home transition. States are viewing these various initiatives steps in a process of changing the long-term care system that will take years. Six topics were discussed under each of the three areas. This report consists of notes from the dialogue for each of the three topic areas.

Exploring the Long-Term Care Ombudsman Program roles and functions in:

1. Home and community based care,
2. Diversion of people from institutional care,
3. Transition of facility-based residents to less restrictive settings, including transitions resulting from facility closures and emergency relocations.

For each of the three areas listed above, discussion focused on six topics.

Due to time constraints all six topics were not consistently addressed in each area.

1. Systemic advocacy and programmatic roles and functions that ombudsman programs can and/or do play or carry out.
2. Resources that ombudsman programs need to carry out the identified roles and functions.
3. Potential sources of funding and how funding can be obtained from these sources.
4. The interface of the ombudsman program with Aging and Disability Resource Centers and other programs.

5. Potential conflicts of interest for ombudsmen in carrying out each of these roles and related functions.
6. Other challenges to successful ombudsman advocacy in each of these roles.

Regardless of the role of the LTCOP, local ombudsmen need education and information from their state ombudsman about the issues and changes. Local ombudsmen want to have a voice in the decisions that are made about the role of the LTCOP and interactive communication about issues and roles. If the ombudsman role changes, local ombudsmen also need a protocol to follow and resolution, with SLTCOP assistance and support, of any conflict of interest issues of program placement that may arise.[1]

Home and Community Based Care

Long-term care ombudsmen have been discussing the need for advocacy on behalf of individuals receiving home and community based care for more than ten years. There are twelve LTCOPs with responsibility for serving recipients of home and community based care. Of these, nine handle only care complaints, the other three handle all types of issues.[2] Historically, the national position has been for the LTCOP to not expand beyond its current Older Americans Act responsibility to serve residents in long-term care facilities unless there are additional resources and conflict of interest is avoided.[3] The Institute of Medicine study recommended no further expansion of the program until the recommended standard of one full time ombudsman to every 2,000 beds is met.[4]

In recent years growth has accelerated in home and community based services as alternatives to nursing homes. Federal and state initiatives and consumer demand have fueled this growth. Ombudsmen are seeing the individuals they serve move from one setting into another. Individuals with similar needs may live in the community or in other settings such as assisted living or nursing homes. The need for consumer advocacy and the role of the LTCOP continues to be a relevant dialogue.

---

[1] A summary of remarks from local ombudsmen who participated in the session, "Charting The Role of the LTCO in a Modernized Long-Term Care System," during the Annual SLTCO Training Conference, April 14, 2008, Tacoma, WA.

[2] Home Care Ombudsman Programs Status Report: 2007, Mark Miller, NASUA, NORC, *http://www.ltcombudsman.org/uploads/Home_Care_Ombudsman_Programs_Status_Report_2007.pdf*; The Role of the Long-Term Care Ombudsman Program in Home Care Advocacy, June 2001, Bridges, Miller, & Dize, NASUA, NORC, http://www.ltcombudsman.org//uploads/PMhomecareadvocacy.pdf

[3] Future Directions for the Long-Term Care Ombudsman Program, 1993, the National Association of State Long-Term Care Ombudsman Programs. *http://nasop.org/papers/8.pdf*; The Long-Term Care Ombudsman Program: Rethinking and Retooling for the Future, 2003. *http://nasop.org/papers/Bader.pdf*

[4] Real People, Real Problems, an Institute of Medicine study of the Long-Term Care Ombudsman Program, 1995. *http://www.nap.edu/books/NI000028/html/*.

2-12

Home and community based care: Systemic and individual advocacy and programmatic roles and functions that LTCOPs can or do play/carry out.

SYSTEMS ADVOCACY	INDIVIDUAL ADVOCACY
Systems advocacy coalition work: defining quality, advocating for additional funds for services and additional services to meet the needs of individuals receiving in-home care.	Help consumers know what quality care is and what to expect from service providers.
Develop a memorandum of understanding between the LTCOP and the Medicaid Waiver program and any other programs that clarifies roles, complaint intake procedures, and decisions about who responds.	Help consumers clarify issues of concern.
Hold providers accountable for fulfilling their mandated responsibilities.	Be prepared to handle a range of complaint issues in addition to care, such as housing, transportation, frequency of services, caregiver assignments, and workers who do not report to work in a client's home.
Hold state waiver programs and home care programs accountable for fulfilling their responsibilities.	Expand the range of information and assistance content areas and resources utilized by LTCO.
Protect and uphold rights, being sure that protections are in place and requiring providers to inform recipients of their rights.	Empower consumers and provide education about rights, including the consumer's right to choose.
Identify issues patterns in the community, at the individual advocacy level, and then take those issues to the systems level.	Assist consumers in knowing how to talk with care providers, who to involve, offer support and guidance in resolving issues.
	Make referrals to adult protective services and remind providers of their reporting responsibilities.
	Avoid taking on the adult protective services role in the process of handling consumer complaints.

SYSTEMS ADVOCACY	INDIVIDUAL ADVOCACY
Be involved in regulatory and corporate decisions, such as the ability of providers with histories of non-compliance in nursing homes to become providers of home care services. Advocate for adequate nursing home funding for residents who are not in transition. Promote mental health ombudsman program and other ombudsman programs.	Be vigilant regarding financial exploitation or abuse that may involve the service provider as well as the home care client. Relate to area agencies on aging (AAA) in a different way when they are gatekeepers for eligibility and services and sometimes are also responsible for service delivery. In representing clients, the LTCO may be required to take issue with a service provided by a AAA. Be aware of issues of personal safety for individual LTCO who may go into someone's home. This is a different setting than a board and care facility.

Home and community based care: Programs/partners the LTCOP should interface with related to ensuring adequate quality home and community based care.

The LTCOP needs to work with many programs, agencies, and service providers.

- Area Agencies on Aging gatekeeper programs
- Regulatory services for home care providers
- Medicaid agency
- Adult Protective Services
- Aging and Disability Resource Centers (ADRCs)
- Quality Improvement Organizations: The 9th scope of work will have a focus on transitioning people out of hospitals as well as other factors relevant to hospitalization.
- County Department of Social Services
- Mental health organizations

2-14

- Legal counsel with elder and disability expertise
- Provider associations
- Public housing for seniors
- Senior centers
- Citizen advocacy organizations
- Centers for Independent Living
- Disability advocates such as ADAPT and others

Home and community based services: Resources and potential funding sources ombudsman programs need to carry out the identified roles and functions.

The following are some factors that make it difficult to determine the financial and human resources necessary for LTCO to be advocates for clients of home and community based services.

- Within a short time span (days or weeks) home care clients may change where they live or their services. These factors make it difficult to estimate how many LTCO are needed to serve home care clients. Traditionally, LTCO programs have estimated the number of ombudsmen needed based on the number of beds in nursing homes or board and care or assisted living. There is not a fixed number to use as a base in home care.
- LTCOPs that are engaged in home care advocacy can track time per case and obtain an average amount of time; however, this number is not associated with the potential need for ombudsman services.
- The twelve LTCOPs that are in home care have state statutes and non-Older Americans Act funding that enable the expansion of the program. There are some differences in how they operate which also complicates identifying a way to determine resource needs for other states.[5]

Resources and potential funding sources include the following:

- Expansion of Title VII of the Older Americans Act and funds,
- Discreet funding under the Older Americans Act to support home care LTCOPs,
- Money Follows the Person initiatives,
- Quality Improvement Organization funding for Medicare recipients.

---

[5] Home Care Ombudsman Programs Status Report, op. cit.

Home and community services: Possible conflicts of interest for LTCO in carrying out each of the identified roles and related functions.

There was much discussion about conflicts of interest, real and perceived, for LTCOPs that expand into home and community services. (The Older Americans Act conflict of interest provisions for the LTCOP is in the appendix.) There was consensus that the following language from a proposed rule published by the Administration on Aging[6] clearly summarizes the significance for a LTCOP to be without conflict of interest and interference.

> "...as a general principle, that in the conduct of all aspects of the statewide Long-Term Care Ombudsman Program the integrity of the work of the Ombudsman and ombudsman representatives must be maintained; and there must be no inappropriate or improper influence from any individual or entity, regardless of the source, which will in any way compromise, decrease or negatively impact on the objectivity of the investigation or outcome of complaints; the Ombudsman's primary role as advocate for the rights and interests of the resident; the Ombudsman's work to resolve issues related to the rights, quality of care and quality of life of the residents of long-term care facilities; or the Ombudsman's statutory responsibility to provide such information as the Office of the Ombudsman determines to be necessary to public and private agencies, legislators and other persons regarding the problems and concerns of residents and recommendations related to residents' problems and concerns."

Several potential conflicts of interests were identified.

- Placement
  - Within the Administration on Aging a conflict exists if the LTCOP expands into home care and is under the administrative position that also oversees home and community based services.
  - LTCOP placement issues must be re-examined if the scope of the LTCOP expands.
  - State and local agencies responsible for waiver and service programs and/or provider certification have a conflict if they also operate the LTCOP.
  - LTCOP supervisors who also supervise any aspect of home care services, regulatory functions, or licensing of providers.
  - Individuals with conflicts of interest serve on the governing boards of state units on aging and/or area agencies on aging which operate a LTCOP, such as individuals who own or operate home care services. Even if such individuals recuse themselves from voting, their presence can exert an influence.
  - Deterrents to the LTCOP's ability to speak out about issues or to comment on proposed laws, rules, policies or regulations because the program would be criticizing another division within the agency where the LTCOP is located or criticizing another state agency or department.

---

[6] *Federal Register*, November 15, 1994. Excerpts from Preamble, 1327.29(a)Noninterference, contained on a handout for the work group meeting.

- Relationships
  - Agreements between the LTCOP and other agencies or programs must be examined for conflicts of interest if the LTCOP covers home care. An annual review of all such agreements is a recommended practice.
- Funding
  - Specific conflicts of interest in funding sources for LTCOPs in home care need to be identified, such as funding that comes through a provision that also funds home care services. It is essential for the LTCOP to continue to be free of conflict of interest, including funding sources which could be perceived as biasing the ombudsman's work.
- Individual Conflicts
  - The list of what constitutes individual conflicts of interest expands as the scope of the LTCOP expands and includes other employment and roles, financial interests, familial employment, financial interests, and responsibilities, other roles related to home and community based services.

Conflicts of interest for LTCOPs in home care need increased scrutiny beyond the screens that most programs already have in place. While some conflicts of interest must be prohibited, others can be managed. There was consensus that more work needs to be done in this area to delineate possible conflicts at the state level and the local level related to placement, relationships, funding, and individuals.

Home and community services: Other challenges to successful LTCO advocacy in each of these roles.

- Building the case and support for an in-home ombudsman, advocating for the need for this service.
- Adult Protective Services and the LTCOP: role clarification, conflicts of interest due to program location, supervision, or individual roles
- Clients fear loss of services if they complain, which would result in moving into a nursing home.
- LTCOP location at the state and the local level may present new conflict of interest issues if the aging network expands into home and community service assessment of clients, care management and delivery of services.
- Disclosure of conflicts of interests within the LTCOP and for individual LTCO, as well as disclosure of conflicts or of perceived conflicts to clients.
- Determining the resources needed to serve home care clients.
- Securing funding sources to support home care advocacy.
- Involving law enforcement, to add to partners and resources, and bankruptcy monitors is a challenge as well as an opportunity.

Diversion of People from Institutional Care

Diversion: Systemic and individual advocacy and programmatic roles and functions that ombudsman programs can or do play/carry out.

SYSTEMS ADVOCACY	INDIVIDUAL ADVOCACY
Training for Aging and Disability Resource Centers (ADRC) by Long-Term Care Ombudsman Program (LTCOP).	Referral to other options such as to the Gateway Program in Georgia, or to ADRCs.
Providing information to the aging network website.	Long-Term Care Ombudsmen (LTCO) routinely provide information about options other than nursing homes or assisted living.
LTCOPs are involved in speaking up for systems change to address gaps in long-term care (LTC) services or delivery. Examples: In Oklahoma local LTCO are required to participate in meetings about LTC issues/planning or work groups to examine resource development. In Michigan, the State LTCO has been involved in appropriations/budget process to try to increase funding for home and community based services. Michigan also has the policy/provision that if someone gets diverted from nursing home admission or is transitioned out, the funds for this do not come from the regular Medicaid budget. This was done with a work group with support and leadership with the state Medicaid director.	The LTCOP and the aging network do not discriminate against someone who has money. Services are not dependent upon financial eligibility. The network has expertise that is beneficial to everyone. One state is working with the Centers for Medicare and Medicaid Services (CMS) on the Own Your Future initiative. Georgia has lifelong planning to help people with financial planning for long-term care.
Payment issues: paying for care (community or in nursing home) for individuals with serious mental health needs. The source of payment influences where the person goes.	LTCO continually go to health fairs and other similar events to provide public education and give out LTCOP literature.

SUPPORTED BY THE U.S. ADMINISTRATION ON AGING

Diversion: Program or partners, including ADRCs, that the LTCOP should interface with related to nursing home diversion.

The LTCOP routinely works with numerous partners in addressing the needs of older residents in long-term care facilities. As nursing home diversion activities become more widespread, the LTCOP needs to work **more** with:

- Hospital discharge planners,
- The Quality Improvement Organization (QIO): Example: In Michigan the LTCOP has used the QIO process frequently when someone receives a discharge notice from the hospital. Even if the consumer loses the appeal, more often than not, the hospital changes its behavior.
- Adult Protective Services,
- Probate courts that handle guardianship and emergency admissions or commitments,
- Younger adults (with serious mental health illness and physical disabilities): An entire systems change is needed to address their needs with other agencies, such as housing and other services.
- The PASAR process and mental health systems,
- Medicaid agencies,
- Centers for Independent Living,
- Assisted living providers
- Nursing home providers,
- Veterans' programs,
- Waiver programs.

Diversion: Resources LTCOPs need to carry out the identified roles and functions.

- Staffing,
- Training about community resources and options.

When the staffing level for LTCOPs is re-examined, job functions need to be included in the equation. One example is that working with individuals on long-term care options, such as nursing home diversion, takes a lot of time.

Diversion: Potential conflicts of interest for LTCO in carrying out each of the identified roles and related functions.

The following issues of the LTCO role in working with others were identified.

- Conflicts in role, jobs, and turf: Who is doing what?
- Difference in philosophy and in whose interests are being represented: Advocacy for increased options for some consumers may endanger the service needed or choice by the current clientele or for others who may need that service in the future. If a nursing home closes or loses so many occupants that the facility must close, there may be people who need that service and who don't have the option in their area, particularly in rural areas.
- How consumer choice is promoted and implemented: Diversion systems may elevate unrealistic expectations. Examples: Assessing someone for non-nursing home placement, determining that they can stay at home, and then finding that the needed services are not available in their community. The opposite also occurs: an individual is assessed and it is determined that they can stay in the community; yet this individual really wants to go to a nursing home.

Diversion: Other challenges to successful LTCO advocacy in each of these roles.

Other systemic issues pose challenges to LTCO advocacy related to nursing home diversion.

- The nursing home industry: policy positions, practices, and resistance to change
- Shortage of nurses in home care
- Staffing issues with paraprofessionals in home care
- Establishing Medicaid eligibility.
- Corporate policies in assisted living facilities or home care: Example: One chain does not accept people until after they have been approved for Medicaid.
- Long waiting lists for services: In some states, the waiting list for aging services is very long; in other states, the waiting list for disability services is long. In both situations, an individual's ability to live in the community can change while the person is on the waiting list.
- The capacity or development of the ADRC to provide a full range of counseling and information: Some states are making referrals and the ADRC is not able to provide timely information about the full range of services and resources. The intake process is very important. Once intake is completed, the next steps are based upon the intake information.
- Vouchers for respite services and other support for family caregivers are insufficient to support diversions.

2-20

Nursing Home Transition

Working with individual residents who want to move out of a facility is not new to LTCO. Until recently there was not a specific focus or identified funding and services to assist residents in moving out of a facility. In April 2007, the National Long-Term Care Ombudsman Resource Center, NASUA, hosted a conference call on the role of the LTCOP in working with other agencies and some of the challenges encountered in nursing facility closures and relocation. Information was collected on the federally funded long-term care system rebalancing programs, Money Follows the Person, Nursing Home Diversion, Aging and Disability Resource Centers, and the role of the LTCOP. Prior to this NORC hosted a national dialogue call on the involvement of LTCOPs in nursing home transition activities.[7] Mark Miller, NASUA, NORC, who conducted the work on the LTCOP in transitions and in home care, identified a key dilemma that surfaced through the dialogue.

> **Dilemma:** Is the ombudsman role proactive or reactive in talking with residents about the possibility of moving out of nursing home? Do ombudsmen provide information about transition options to all residents, or to residents who seem like they might be able to move out, or to residents who say they want to leave the facility? Defining the role creates even more uncertainty when the LTCO knows that it is highly unlikely that services are available to make it possible for a particular resident to leave. Ombudsmen want to avoid creating false expectations.

Points of consensus from discussing the role of the ombudsman:

- It is not the role of the LTCO to judge the soundness of a resident's plan.
- Individuals are free to leave a facility unless a guardian has the authority to determine their living arrangements or a court ordered the placement. The LTCO can give information about who to call and contact information, and leave it up to the resident to make the call.

A few states shared their experience with individuals who transition. Sarah Slocum, Michigan State LTCO, shared how the LTCOP has defined its role in working with residents. Local LTCO are taught to be alert for individuals who might be appropriate for living in another setting and to make referrals to the assessment organization, with the resident's permission, if the resident wants to pursue this option. The LTCO does not make any judgment about whether a person will qualify. The SLTCOP is finding that when a facility closes, only about five percent of residents can go anywhere except into another nursing home; this includes those who

---

[7] Strategy Brief: Ombudsman Involvement in Nursing Home Transition Activities, December 2004, Mark Miller, NASUA, NORC. *http://www.ltcombudsman.org/uploads/OmbInNursingHomeTrans.pdf*

go into assisted living. The Money Follows the Person (MFP) individuals are likely to have higher needs for supportive care than individuals who move out under the nursing home transition. Esther Houser, Oklahoma State LTCO, agreed that the individuals who are transitioning out under MFP are more vulnerable than the individuals with whom the LTCOP has experience in assisting in moving. In Georgia, they are finding that facilities want their older residents to remain in the nursing home, preferring that younger residents access transition options.

When an individual is engaged in the transition process, what is the obligation of the LTCOP to monitor the process once plans are in place? Three states indicated that the LTCO follows the person transitioning out of the nursing home. In one state, the LTCO starts by working with the nursing home social worker and the discharge planning process from the facility. A first clue about how things might go is whether the assessment group keeps their appointment with a resident to conduct the assessment. In another state the LTCO follows the person only if the individual is moving into an assisted living facility or into a board and care facility. A third state is proposing that the LTCO will follow the resident who transitions out for a period of one year.

Transition: Systemic advocacy and programmatic roles and functions that LTCOPs can or do play/carry out.

- Participate in transition work groups, advisory groups or other planning and monitoring activities at the state level.
- Advocate for a policy that allows people to use their Medicaid patient pay amount for the first six months for housing. Medicaid pays the difference to the facility.
- Advocate for a policy to exempt people who transition out on a Medicaid waiver from the Medicare co-pay.
- Advocate for accessible housing options.
- Divert individuals to other options if possible before they enter a nursing home.
- Assist individuals to connect with transition options early in their nursing home stay.
- Clarify the role of the LTCO in following residents who transition out of a nursing home.

Transition: Programs/partners the ombudsman program should interface with related to nursing home transition.

- Medicaid
- Resident assessment organizations
- Hospital and nursing home discharge planners
- Aging network, particularly home and community based services
- Home health agencies

- Mental health system
- Disability network
- Aging and Disability Resource Centers
- Senior housing authorities
- Transportation providers
- Department of Energy and other energy assistance programs
- Housing assistance
- Veterans Administration
- Social Security Administration
- Provider organizations: nursing homes, hospitals, medical society and others

Transition: Resources LTCOPs need to carry out the identified roles and functions.

- Funding to reach the Institute of Medicine recommended LTCO staff to bed ratio and to support routine visits to residents. The local LTCO participating in the 2008 spring training conference asked, "How far can you stretch an ombudsman?"
- Resources to increase the LTCOP staff at the state and the local level to engage in transition activities and also fulfill the other responsibilities of the program.
- Enough LTCO staff to have different ombudsmen assigned to facilities for complaint work and regular visits and other ombudsmen who serve as transition coordinator for residents in the facility. If LTCO are not transition coordinators, more staff in the LTCOP are needed for routine visits, advocacy and time to deal with consumer education and outreach related to transition options and accessing the assessment or point of entry.
- Training for ombudsmen on a range of topics, applicable to the LTCO role, such as: housing options, using housing experts; Social Security, helping residents get their full Supplemental Security Income restored; Medicare Part D, working out co-payment if a person moves into community from facility; ADRCs resources including databases; using online resources such as Benefits Checkup to see what assistance may benefit a resident.
- Coordination with the Senior Health Insurance Programs (SHIPs) on providing education, information, and resources.
- Coordination with the Veterans Administration.
- Affordable housing for individuals who could transition into the community and other systems in place to make transition a reality.

Transition: Potential sources of funding and resources and how they can be obtained from these sources.

- Older Americans Act programs including caregivers support funding
- Civil Monetary Penalty funding
- State-funded financial streams or programs
- Medicaid funding: administrative and service dollars

Transition: Possible conflicts of interest for LTCO in carrying out each of the identified roles and related functions.

- Potential for providers and consumers to be confused about the role of the LTCO: Is the LTCO a resident advocate in resolving complaints or an outreach and referral person who seeks to help identify people to move out of the facility? Does the LTCO come in to make visits and resolve complaints or to try to help people leave?
- Does working on the transition initiative divert the LTCO from other responsibilities to residents?
- Does the LTCOP stand to gain financially by taking on a specific role in transitioning residents? Does the conflict of interest provision in Section 712(a)(5)(C)(ii) of the Older Americans Act apply only to individual representatives of the program or to local/regional programs (entities) as well? Do consumers, providers, or anyone else perceive any payments to the LTCOP for transition work as a conflict of interest?

Transition: Other challenges to successful LTCO advocacy in each of these roles

- Transition emphasis is on younger residents in some states while the LTCOP's federal mandate is to serve seniors.
- Perspective of the licensing and certification agency staff: Some surveyors want to protect the resident and are certain that harm will follow them if the resident goes home. There is a need for information, education, and collaboration.
- Before new roles are taken on, the basic LTCOP infrastructure must be in place for fulfilling the OAA functions: state enabling statutes that comply with the federal law, consistent training, policies and procedures or regulations, clarity about conflict of interest, clarity about the role of the LTCO, effectiveness in data management, ability to designate or withdraw designation of individuals or programs, and the ability to engage in systems advocacy.

Summary and Recommendations

Long-Term Care Ombudsman Programs have a history of working with individuals who are making decisions about long-term care options, who live in facilities and want to move back home, and who go from one care setting to another. The current federal and state long-term care initiatives are making more community options available for more consumers. Long-term care ombudsmen have a knowledge base and skill set that can be helpful to consumers in resolving issues for individuals and in representing consumers in shaping policies. As Alice Hedt, Executive Director of NCCNHR pointed out, the issues and value perspective remain the same for LTCO: taking direction from the resident, being the voice for residents, respecting and advocating for resident choices, working for quality care for individuals.[8] When considering the role of the LTCO in a modernized long-term care system, the core issues and values are unchanging.

The federal Older Americans Act directs the Long-Term Care Ombudsman Program to serve seniors who are residents of long-term care facilities. There are strict conflict of interest safeguards for individual ombudsmen and for the state and local ombudsman programs. Confidentiality provisions make it clear that the ombudsman serves the resident. Federal funds through the OAA may be used to support only the responsibilities listed in the act. State long-term care ombudsman programs are continually working to improve their accessibility to residents and consistency in training, service delivery, and reporting.

Two key questions arise when considering the role of the long-term care ombudsman program in a modernized long-term care system.

1. What can the long-term care ombudsman program do within its current federal responsibilities relevant to home and community based services, nursing home diversions, and nursing home transitions?

2. If the long-term care ombudsman program responsibilities are expanded to more direct work with individuals who are transitioning or who need an independent (outside the service determination and delivery systems), what changes are necessary, e.g. staffing, funding, protections against conflict of interest?

The National Association of State Long-Term Care Ombudsman Programs adopted a paper that lists salient questions that a LTCOP needs to consider before the program expands or changes its role. The paper, "Guidance to Long-Term Care Ombudsman Program Participation in Developing Consumer Advocacy Programs", distinguishes baseline issues that must be addressed from other issues important for decision-making. The content delineates

[8] Comments during the 2008 Spring Training Conference for SLTCO session on the role of the LTCO in a modernized long-term care system, April 14.

many of the topics discussed during this work group meeting and the 2008 Spring Training Conference for SLTCO regarding the role of the LTCOP in a modernized long-term care system. The paper is included in the appendix of this report.

Recommendations

The work group recommended the following areas for action in order to assist in further clarifying the role of the long-term care ombudsman program in a changing long-term care system.

- Study the need for a home care consumer advocate ombudsman program. Can a compelling case be made? What data or evidence supports the need for such a program? Is there a demand or a perceived need that will support the creation of a home care ombudsman program or the expansion of the LTCOP, including establishing a mandate and providing resources?
- Analyze the LTCOP's conflict of interest provisions in federal and state LTCOP laws and regulations (or policies). Identify the types of conflicts of interest that need to be addressed if a program expands beyond the current federal mandate. Include program placement conflicts as well as individual conflicts.
- Study the staffing needs if a long-term care ombudsman program expands its services and make recommendations about essential staffing in order to expand.
- Study the financial resources needed to support an expanded long-term care ombudsman program and make recommendations about essential funding and potential sources of such funds.

APPENDIX

Older Americans Act Language

Title 42—The Health and Welfare
Chapter 35—Programs for Older Americans
Subchapter XI—Allotments for Vulnerable Elder Rights Protection Activities
Part A—State Provisions
Subpart ii—ombudsman programs
Section 3058g State Long-Term Care Ombudsman Program

Older Americans Act, Section 712

(a)(4)(A) In general.—Except as provided in subparagraph (B), the state agency may establish and operate the Office, and carry out the program, directly, or by contract or other arrangement with any public agency or nonprofit private organization.

(B) Licensing and certification organizations; associations.—The State agency may not enter into the contract or other arrangement described in subparagraph (A) with—

(i) an agency or organization that is responsible for licensing or certifying long-term care services in the State; or

(ii) an association (or an affiliate of such an association) of long-term care facilities, or of any other residential facilities for older individuals.

Conflict-of-Interest

(a)(5)(C)—Entities eligible to be designated as local Ombudsman entities, and individuals eligible to be designated as representatives of such entities, shall

(ii) be free of conflicts of interest and not stand to gain financially through an action or potential action brought on behalf of individuals the Ombudsman serves;

(f) Conflict of Interest.—The State agency shall—

(1) ensure that no individual, or member of the immediate family of an individual, involved in the designation of the Ombudsman (whether by appointment or otherwise) or the designation of an entity designated under subsection (a)(5), is subject to a conflict of interest;

2-27

(2) ensure that no officer or employee of the Office, representative of a local Ombudsman entity, or member of the immediate family of the officer, employee, or representative, is subject to a conflict of interest;

(3) ensure that the Ombudsman—

(A) does not have a direct involvement in the licensing or certification of a long-term care facility or of a provider of a long-term care service;

(B) does not have an ownership or investment interest (represented by equity, debt, or other financial relationship) in a long-term care facility or a long-term care service;

(C) is not employed by, or participating in the management of, a long-term care facility; and

(D) does not receive, or have the right to receive, directly or indirectly, remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility; and

(4) establish, and specify in writing, mechanisms to identify and remove conflicts of interest referred to in paragraphs (1) and (2), and to identify and eliminate the relationships described in subparagraphs (A) through (D) of paragraph (3), including such mechanisms as—

(A) the methods by which the State agency will examine individuals, and immediate family members, to identify the conflicts; and

(B) the actions that the State agency will require the individuals and such family members to take to remove such conflicts.

Annual State Long-Term Care Ombudsman Training Conference

CHARTING THE OMBUDSMAN ROLE IN A MODERNIZED LTC SYSTEM

APRIL 14, 2008

Long-Term Care Ombudsman Programs can play an important role in states' efforts to rebalance their long-term care systems and ensure quality care across settings. This session will share the draft report of the workgroup convened by the Ombudsman Resource Center. The report identifies options, opportunities, and challenges for ombudsman program involvement in individual and systems advocacy in a changing long term care system. Attendee comments and feedback will be encouraged to help further refine the report and its recommendations.

Questions for Discussion and Dialogue

1. How do you decide when to take on new programs and responsibilities?
2. What should the role of the LTCO be as states take on new initiatives for "changing" or "modernizing" the long-term care systems?
3. What should the nature of the communication be between the state and local ombudsmen that is both timely and productive?
4. What do local ombudsmen need from their state ombudsman to help them understand and participate in the changing system?

National Association of State Long Term Care Ombudsman Programs

Guidance for Long Term Care Ombudsman Program Participation in Developing Consumer Advocacy Programs

PAPER ADOPTED: OCTOBER 2000

The National Association of State Long Term Care Ombudsman Programs recognizes that the frail elderly have a great need for advocacy services and quality assurance, regardless of where they are living. Individuals living in the community move from one setting to another: apartment, assisted living, hospital, nursing home. Following a stay in a nursing home, they may return to their home or to an assisted living facility. Advocacy during these transitions is especially critical to support elders' rights to self determination and maintain continuity of care.

State Long Term Care Ombudsman Programs have struggled for many years to meet the requirements of the Older Americans Act to investigate complaints about nursing homes and board and care homes. Because of a lack of funding, many state programs have not fulfilled the current requirements under federal law.[9] This is particularly true in the area of advocacy for residents of board and care homes. The problem has been further exacerbated by the rapid growth in "assisted living type" facilities in most states.

During the past few years, the health care system has been constantly changing. Home and community based services have expanded while the nursing home census has declined. There has been much discussion about consumer protections, appeals, and advocacy. Proposals for developing an advocacy system for health care consumers have been contained in various pieces of legislation. The term "ombudsman" has been widely used with various meanings.

Several states have created ombudsman programs for various constituencies such as children, mental health clients or residents in assisted living facilities. In almost half the states the role of the Long Term Care Ombudsman Program (LTCOP) has been expanded to serve other arenas such as: managed care, acute care, or home and community based services.[10] States with expanded responsibilities for the LTCOP have laws authorizing the expansion and have grant funding or additional state or federal funding to support these activities. Discussions regarding consumer protections and the role of the Long Term Care Ombudsman Program will be ongoing as the health care system evolves.

---

[9] *Long Term Care Ombudsman Program: Overall Capacity.* Department of Health and Human Services. Office of Inspector General. OEI-O2-98-00351; *Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act,* Institute of Medicine.1995.

[10] From *Results of a Survey of State Long Term Care Ombudsman Programs, April 1998 – March 1999.* National Long Term Care Ombudsman Resource Center. Prepared by the National Association of State Units on Aging. 1225 I Street, N.W., Ste 725, Washington, DC 20005. (202)898-2578.

2-30

The National Association of State Long Term Care Ombudsman Programs offers the guidance in this paper to assist states as well as the national organization in participating in discussions about consumer protections and ombudsman services. Critical factors to consider in making decisions about appropriate roles for the LTCOP are listed under six major topics:[11] (1) Structure of the Office of State Long Term Care Ombudsman and Elements of the Host(s) Agency for State and Local Entities; (2) Qualifications of Representatives; (3) Legal Authority; (4) Resources; (5) Individual Client Advocacy Services; (6) Systemic Advocacy Work. **Under each topic, questions that are followed by an * are baseline issues.** If these questions cannot be affirmatively answered, these issues can seriously undermine the operation of the LTCOP embodied in the Older Americans Act. Unless the factors that prevent an affirmative answer are changed, the LTCOP should not expand its role. A related paper, *The Long Term Care Ombudsman Program and Managed Care: A Working Paper,* Ideas Gleaned from Conversations with LTC Ombudsmen & Others, 1997, contains supplemental information regarding ways the LTCOP can more fully serve managed care consumers within its Older Americans Act (OAA) mandates.

1. Structure of the Office of State Long Term Care Ombudsman and Elements of the Host(s) Agency for State and Local Entities

- ☐ Will client interests and a client driven philosophy continue to be the primary focus of the LTCOP?*
- ☐ Will program representatives continue to serve as *client* representatives—as advocates, not as extensions of another entity's responsibilities such as: regulatory agencies, adult protective services, guardianship?[12]*
- ☐ Is the LTCOP structure independent from the management, regulation, payment, provision of, or eligibility determination for services covered by an expanded ombudsman role?*
- ☐ Is the LTCOP structured in a way that provides independence from conflicts of interest and provides access to directors of the management, regulatory, payment, eligibility functions of covered services?[13]*

---

[11] These topics are those used in Table 5.2 of *Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act,* Institute of Medicine.1995, pp. 162-183.

[12] For more information about role distinctions, refer to the following papers adopted by NASOP: *Licensing & Certification For Nursing Facilities And The Long Term Care Ombudsman Program,* October 1996; Adult Protective Services and the Long Term Care Ombudsman Program, November 1994.

[13] In this paper, *covered services* means those services included in the expanded role of the LTCOP.

- ☐ Will the structure of local entities of the LTCOP need to change to avoid conflicts of interests? An expanded role for the LTCOP could present conflict of interest issues with the aging network and other entities directly or indirectly providing: housing with supportive services; case management; home and community based services; guardianship; adult protective services; assessment, screening, or eligibility determinations prior to nursing home or community placement; or licensing or monitoring of housing or services.

☐ If the current structure of the LTCOP must change, what will be the new structure?

- ☐ How can this be created?
- ☐ Is there an existing host agency that can house the expanded program?
- ☐ How will the structure accommodate client access to the program=s services and a timely response?

☐ Will the expanded role cover the entire state?

☐ Who will be responsible for the expanded role of the program since the OAA requires a full time State LTCO?

☐ Will all representatives and services be part of the LTCOP?

- ☐ Will representatives working in the area of expanded responsibilities be identified by a distinct title, e.g. community services ombudsmen, hospital ombudsmen?
- ☐ Will representatives be generalists, able to handle all complaints or specialists who deal with certain types of issues or services?

☐ Will the LTCOP have responsibility for managing the budget for the expanded role?

- ☐ Are there negotiated agreements regarding the funding flow that will avoid having ombudsman programs, or an ombudsman program serving more than one client group, from competing for fiscal resources?
- ☐ Is there a unified budget for the LTCOP and the expanded ombudsman services?

2. Qualifications of Representatives

- ☐ Will program representatives continue to be free from conflicts of interest?*
  - ☐ Will the conflict of interest criteria or screens need to be revised?
  - ☐ Will changes be necessary to avoid the *perception* of conflict of interest, e.g. prior or current employment of representatives?
- ☐ What skills and knowledge will be necessary to handle the expanded role?
- ☐ Will program representatives have necessary skills to perform new tasks?
- ☐ What initial and on going training will be needed?
  - ☐ Is there money to provide training?
  - ☐ How will this be developed?
  - ☐ How will this be provided?
  - ☐ What "start up" time will be needed before representatives can provide services?
- ☐ Will the current designation procedures for representatives of the LTCOP work or will modifications be needed?

3. Legal Authority

- ☐ Will the immunity protections for representatives of the LTCOP cover this new area of work?*
- ☐ Are there state laws that would restrict the authority of the office from performing comprehensive ombudsman services (complaint investigation and resolution, representation of clients, education and systemic advocacy) to this new clientele?*
- ☐ Is the legal framework for the expansion compatible with that of the OAA for the LTCOP, i.e. the functions and responsibilities do not conflict?*
- ☐ Are the confidentiality provisions regarding access to program records and information consistent with those of the LTCOP under the OAA?*
- ☐ What authorizes the expansion of the program, e.g. state law? regulation? contract?
- ☐ What is the legal basis and support for the program=s expansion?
- ☐ What is necessary to assure access to clients and records to perform the job?

4. Resources

- ☐ Are there sufficient resources to assure that federal funds remain dedicated to long term care residents at the level stipulated by the OAA?*
- ☐ Is there assurance that federal funds committed to the LTCOP, will not be used to support expanded role?*
- ☐ What fiscal resources are necessary to develop and sustain an expanded role?
- ☐ How will the resources be acquired?
- ☐ Will the fiscal resources for expansion be on-going or will they be short term and necessitate continual fund-raising or applications?
- ☐ What type of data and information management systems are needed to handle the expanded functions?
- ☐ What human resources are necessary to expand the role?
  - ☐ What resources will be needed to maintain the current LTCOP during the transition to, or development of, an expanded role?
  - ☐ What staffing standard will be used for the expanded service?
  - ☐ What will be needed for planning?
  - ☐ What will be needed to provide the services?
  - ☐ What will be needed for management?
  - ☐ What will be needed to generate visibility and credibility for the expanded role with other agencies, clients, and the public?
- ☐ If volunteers will be used in the expanded role, will recruitment efforts compete with those of the existing LTCOP?
- ☐ Will legal resources be adequate to support the expanded role?

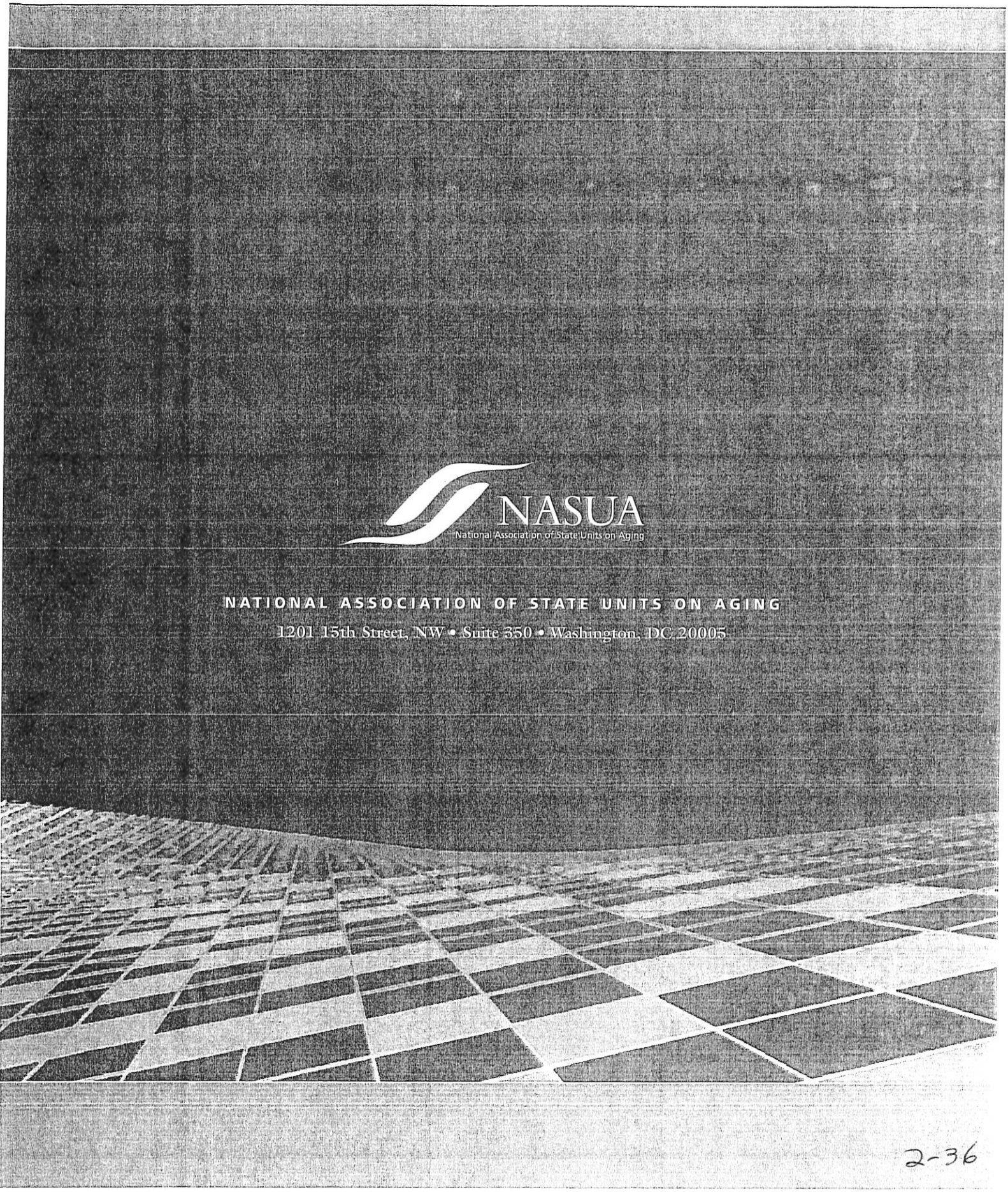
5. Individual Client Advocacy Services

- ☐ Will an emphasis continue to be placed on empowering the client and working with citizen organizations?*
- ☐ Will the expansion decrease the availability and accessibility of client services under the existing LTCOP? *
- ☐ How will the program reach out and become visible to new clients?
- ☐ Will volunteers be an appropriate resource for advocacy for this new clientele?

- ☐ Will the complaint handling and advocacy strategies be compatible with the current program?
- ☐ What new relationships are needed with regulatory, provider and payer groups?
- ☐ How will outcomes and client satisfaction be determined?
- ☐ What types of educational resources and training will be needed for new clientele?

6. Systemic Advocacy

- ☐ Will the program be a public voice to make the needs of clients known to agencies and public officials?*
- ☐ Will the program be free to issue public reports regarding client issues and recommending changes?*
- ☐ What are the current systemic issues for this new population?
  - ☐ Is there a potential conflict between advocating for systemic changes for the new clientele and changes on behalf of long term care residents currently served?
  - ☐ If so, how will these conflicts be addressed?
- ☐ Who is currently working on these issues in your state?
- ☐ What new relationships or coalition partners will you need to work with to resolve these issues?
- ☐ Are these issues and stakeholders compatible with the issues and stakeholders working on long term care resident issues or will they create potential conflicts for the program down the road?



NATIONAL ASSOCIATION OF STATE UNITS ON AGING

1201 15th Street, NW • Suite 350 • Washington, DC 20005

KANSAS COMMISSION ON VETERANS' AFFAIRS

Jayhawk Towers, 700 SW Jackson, Suite 701
Topeka, KS 66603-3758

(785) 296 3976
(785) 296-1462 (Fax)

Testimony

Wayne Bollig

Director of Veteran Services

House Committee: Aging and Long-Term Care Committee
Chairman Bob Bethel
February 17, 2009

RE: HB 2242

Introduction:

I would like to thank the Committee for allowing us to speak in support of HB 2242. The changes recommended in this bill include a proposed change to the definition of a facility to include the Kansas Soldiers Home and Kansas Veterans Home allowing the state long-term care ombudsman to represent veterans residing in these facilities. The Kansas Commission on Veterans' Affairs supports this change. The KCVA feels that by including the two veterans' homes in this bill we can provide for an additional layer of representation for our veterans increasing the opportunity for the ombudsman program to provide support to residents of our homes when needed.

Over the past year as part of the Governor's task force, Mr. Cruz, the states long-term care ombudsman has been instrumental in assisting changes needed at the Kansas Soldiers Home. He continues to work with the agency in its transition to a Medicare facility. We appreciate the efforts of the ombudsman and support his efforts in this area.

HOUSE AGING & LONG TERM CARE
DATE: 2/17/09
ATTACHMENT: 3

KANSAS
DEPARTMENT ON AGING

Kathleen Sebelius, Governor
Kathy Greenlee, Secretary
www.agingkansas.org

House Committee on Aging and Long Term Care
Feb. 17, 2009

HB 2242/Expanding the authority of the Long Term Care Ombudsman
Martin Kennedy, Deputy Secretary

I appear today to testify in support of HS 2242 in its proposed amended form. As many of you know, Secretary Kathy Greenlee served as the State Long Term Care Ombudsman immediately prior to being named to her current position. She believes her advocacy on behalf of nursing home residents helped inform her work as Secretary of Aging.

The Department on Aging strives to develop an array of services to assist seniors as they age. Seniors and their families consistently express a desire to remain living in their own homes and communities as long as possible. For many seniors, however, nursing home placement may be their ultimate choice. We work closely with nursing home providers to support new models of nursing home care. We are deeply committed to culture change in long term care and recognize the many outstanding Kansas providers.

We support the concept of giving the state Long Term Care Ombudsman jurisdiction to serve former nursing home residents, as suggested in the amendment offered by Gilbert Cruz. As we expand community support, more seniors and people with disabilities will be leaving the nursing home and going home. Ombudsmen are familiar with the unique perspective of nursing home residents. We believe this limited expansion of the law would be compatible with the mission of the state long term care ombudsman.

To provide comprehensive services in each community across the state, local organizations must work together. We encourage the state Long Term Care Ombudsman to work closely with the Area Agencies on Aging and the Centers for Independent Living. These two groups of organizations have a wealth of knowledge about the types of services available to assist a resident who leaves the nursing home with the hope of continuing to remain at home.

New England Building, 503 S. Kansas Avenue, Topeka, KS 66603-3404
Voice: (785) 296-4986 • Toll-Free: (800) 432-3535 • Fax: (785)
TTY (Hearing Impaired): (785) 291-3167 • E-Mail: wwwmail@ag

Kansas Advocates
for
Better Care

"Advocating for Quality Long-Term Care" since 1975

Aging and Long-Term Care Committee
Chairman Bob Bethell
Testimony presented by Mitzi E. McFatrich, Executive Director
February 17, 2009

Since 1975 Kansas Advocates for Better Care (KABC) has given voice to long-term care consumer concerns. Over three decades, long-term care options have grown – from nursing homes, to assisted living, to continuing care retirement communities, and now, increasingly toward home and community based care – allowing elders and persons with disabilities to age in the place of their choosing.

Kansas Advocates for Better Care appreciates Representative Tom Sloan's leadership in introducing legislation that would move Kansas in a direction which would better protect the health and safety of persons receiving long-term care at home.

Kansas Advocates for Better Care strongly supports HB2242 and its extension of ombudsman services to persons receiving long-term care but residing outside a licensed facility. We believe the bill that you are considering is the correct direction for Kansas to move. It would offer Kansas recipients of long-term care an independent, objective authority, able to intervene on their behalf whether they were in a nursing home or in their own homes. The Ombudsman is uniquely positioned to understand and address the needs of long-term care recipients.

Under the existing oversight structure in nursing homes Kansas Department on Aging investigates complaints of abuse, neglect and exploitation in nursing facilities. The State Long-Term Care Ombudsman advocates on behalf of facility residents at their request. In home settings, SRS Adult Protective Services investigates complaints of abuse, neglect and exploitation. But there is no parallel component (like the ombudsman) for consumer advocacy in the home setting.

State legislatures in twelve other states have recognized the need and passed enabling legislation for long-term care ombudsmen to advocate, mediate and negotiate on behalf of elders and others who receive community based, long-term care services in their homes. Two other states, Georgia and New Mexico have passed legislation to extend the long-term care ombudsman's authority to serve persons transitioning from nursing homes to the community as part of their Money Follows the Person program. Three states passed legislation mandating

913 Tennessee Suite 2 Lawrence, K
phone: 785.842.3088 fax: 785.749.0029 toll-free: 800.525.1782

community long-term care ombudsman services in the years just prior to the passage of OBRA Nursing Home Reform in 1987.

Establishing an ombudsman for the home-based care program does the following important things. It:

- fills the gap in the existing system to provide the same level of advocacy for persons receiving long-term care whether in their homes or in a nursing home,
- builds public confidence about the safety and health oversight for home-based services,
- provides some level of protection when the inevitable occasionally occurs, and
- provides a safety net for the minimally regulated services of home-based care.

We do not wish to see the responsibility of the Ombudsman extended beyond the program's ability to provide adequate service to those in licensed care facilities. Such a move would undermine the efficacy of the Ombudsman's office and in essence remove the health and safety protection currently in place for those in licensed long-term care facilities. The Institute of Medicine has recommended a ratio of one ombudsman to every 2,000 residents of long-term care facilities. In Kansas we are currently short of that recommendation by at least two ombudsmen.

We do not want the legislature to create a hollow promise to persons receiving long-term care at home by extending the Ombudsman's mandate to serve without the resources necessary to serve. A few states have taken this approach and left their citizens without access to advocacy and left the ombudsman program without a way to offer the protections it was intended to provide.

Consumers of long-term care are woefully aware of Kansas' current economic plight. Given the current realities of the state finances, KABC would recommend the following to the Aging and Long-Term Care Committee:

1. Create and fund a pilot program which would provide access to the ombudsman program for persons receiving long-term care services in their home setting and launch the pilot in a limited geographic area.
2. Charge the pilot program with the responsibility of determining the scope of need for advocacy services; to configure and test the limits of a workable community ombudsman model; and to gather and analyze data that would inform an expansion of the ombudsman program or an acceptable alternative that would address long-term care in home settings statewide.
3. Direct the State Long-Term Care Ombudsman to convene stakeholders for the purpose of
    - identifying critical components for home based long-term care advocacy,
    - analyzing existing models and funding options,
    - making recommendations for adequate staff to recipient ratio
    - determining covered population,
    - collecting relevant data,
    - developing policies for maintaining confidentiality,
    - defining the scope of response ability, and training for staff

4. Direct the State Long-Term Care Ombudsman to report stakeholder findings and recommendations to the Aging and Long-Term Care Committee for further action.
5. Provide for language in HB 2242 that
    - affords legal jurisdiction and authority for the Ombudsman to enter private homes within the pilot's scope.
    - limits the Ombudsman's responsibility for the pilot to persons who have previously received long-term care within a facility.
    - allows the Ombudsman to offer services to residents of the Kansas Soldiers Home and the Kansas Veterans Home.
    - amends or revises the definition of "resident" and "facility" under KS 75-7303 to allow prior residents of facilities to be served in their homes within the scope of the pilot.

This is good legislation that addresses a critical need for consumers of long-term care. The Members and Board of Kansas Advocates for Better Care urges this Committee to advance HB 2242.

Thank you for the opportunity to express our position.

Sincerely,

Mitzi E. McFatrich
Executive Director
Kansas Advocates for Better Care
A 501 (c) 3 designated non-profit membership organization

Topeka Independent Living Resource Center

785-233-4572 V/TTY • FAX 785-233-1561 • TOLL FREE 1-800-443-2207
501 SW Jackson Street • Suite 100 • Topeka, KS 66603-3300

Testimony before the House Long Term Care and Aging Committee
Presented by: Ami Hyten, Assistant Executive Director
February 17, 2009

Chairman Bethell and Honorable Members of the House Long Term Care and Aging Committee;

The Topeka Independent Living Resource Center (TILRC) is a civil and human rights organization. Our mission is to advocate for justice, equality and essential services for a fully integrated and accessible society for all people with disabilities. TILRC has been providing cross-age, cross-disability advocacy and services for over 25 years to people across the state of Kansas. Our agency has been particularly interested in and committed to assuring people who require long term care services have access to information, services and supports that offer choices; choices that promote freedom, independent lifestyles and dignity, including the dignity of risk.

We appreciate the opportunity to appear before you today to present our perspective on the office of the Long Term Care Ombudsman and prospective expansion of the jurisdiction for this office. In considering expansion for this office, we would encourage the committee to review the attached amendment language our agency has generated to address current limitations on the jurisdiction of the office for existing care facilities.

In its current form, the mission of the long term care ombudsman is *to advocate for the well-being, safety, and rights of residents of Kansas long-term care facilities by assisting them in attaining the highest possible quality of life.* This mission does not draw distinctions between the types of long-term care facilities or the nature or severity of the disabilities the residents in these facilities experience. Current state law, however, excludes nursing facilities for mental health and intermediate care facilities as defined under K.S.A. 39-923. Given these statutory restrictions, the mission of the long term care ombudsman office may be more appropriately re-written: *to advocate for the well-being, safety, and rights of* ***physically disabled and elderly*** *residents of Kansas long-term care facilities by assisting them in attaining the highest possible quality of life.*

We support the current iteration of the long term care ombudsman mission. Eliminating statutory restrictions for the people who can seek assistance from this office will promote access to a system specially designed with people specifically trained to address the issues people who live in long term care facilities may encounter.

Current systems in the Home and Community Based Services area offer people receiving long term services and supports in their homes with mechanisms to address health, well-being, and safety issues. Adult Protective Services, an entity within the Department of Social and Rehabilitation Services, offers intervention on behalf of adults in need of protective services to help with service coordination, advocacy, or other supportive services.

Topeka Independent Living Resource Center

785-233-4572 V/TTY • FAX 785-233-1561 • TOLL FREE 1-800-443-2207
501 SW Jackson Street • Suite 100 • Topeka, KS 66603-3300

The service providers and professionals who are mandatory reporters under the state's adult protective services system are myriad and multiple. The experience and resources adult protective service workers bring to bear in helping resolve health, safety and well-being issues is often critical in helping people organize services and supports to remain in their homes and communities.

As advocates who have provided resources and community-based services and supports for people with disabilities for over 28 years, it is our experience that the types of issues people face in the community are dramatically different from the types of issues people face when living in long term care facilities. Extensive training will be necessary for the ombudsman staff to become acquainted with community resources and applicable laws, rules and regulations. The state will need to identify how the activities of the long term care ombudsman will overlap and intersect with the activities of adult protective services, case management agencies, and other community partners. Addressing all of these issues will be critical in the design of a long term care system that supports individual choice, freedom and quality services.

Thank you for the opportunity to present this proposed amendment and offer our perspective on ensuring and promoting quality long term services, supports, and choice for all Kansans.

75-7303

Chapter 75.--STATE DEPARTMENTS; PUBLIC OFFICERS AND EMPLOYEES
Article 73.--STATE LONG-TERM CARE OMBUDSMAN

75-7303. Definitions. As used in the long-term care ombudsman act:

(a) "Ombudsman" means the state long-term care ombudsman, any regional long-term care ombudsman or any individual designated as an ombudsman under subsection (h) of K.S.A. 2005 Supp. 75-7306 and amendments thereto who has received the training required under subsection (f) of K.S.A. 2005 Supp. 75-7306 and amendments thereto and who has been designated by the state long-term care ombudsman to carry out the powers, duties and functions of the office of the state long-term care ombudsman.

(b) "Volunteer ombudsman" means an individual who has satisfactorily completed the training prescribed by the state long-term care ombudsman under subsection (f) of K.S.A. 2005 Supp. 75-7306 and amendments thereto, who is a volunteer assisting in providing ombudsman services and who receives no payment for such service other than reimbursement for expenses incurred in accordance with guidelines adopted therefor by the state long-term care ombudsman.

(c) "Facility" means an adult care home as such term is defined in K.S.A. 39-923 and amendments thereto~~, except that facility does not include any nursing facility for mental health or any intermediate care facility for the mentally retarded, as such terms are defined in K.S.A. 39-923 and amendments thereto~~.

(d) "Resident" means a resident as such term is defined in K.S.A. 39-923 and amendments thereto.

(e) "State long-term care ombudsman" means the individual appointed by the governor to administer the office of the state long-term care ombudsman.

(f) "Regional long-term care ombudsman" means an individual appointed by the state long-term care ombudsman under K.S.A. 2005 Supp. 75-7304 and amendments thereto.

(g) "Office" means the office of the state long-term care ombudsman.

(h) "Conflict of interest" means (1) having a pecuniary or other interest in a facility, but not including interests that result only from having a relative who is a resident or from being the guardian of a resident, (2) being actively employed or otherwise having active involvement in representation of or advocacy for any facility or group of facilities, whether or not such representation or advocacy is individual or through an association or other entity, but not including any such active involvement that results only from having a relative who is a resident or from being the guardian of a resident, or (3) being employed by or having an active association with any entity that represents any resident or group of residents, including any area agency on aging, but not including any such active association that results only from having a relative who is a resident or from being the guardian of a resident.

DISABILITY RIGHTS CENTER of KANSAS
EQUALITY • LAW • JUSTICE

Disability Rights Center of Kansas
Rocky Nichols, Executive Director
635 SW Harrison, Ste 100 • Topeka, KS 66603
785.273.9661 • 877.776.1541 (Voice)
877.335.3725 (TDD) • 785.273.9414 FAX
rocky@drckansas.org • *Telephone Ext. #106*

Informational Testimony on HB 2242
Rocky Nichols, Executive Director, DRC Kansas

Chairman Bethel and members of the Aging and Long-Term Care Committee, my name is Rocky Nichols. I am the Executive Director of the Disability Rights Center of Kansas (DRC). DRC is a public-interest advocacy agency, part of a national network of federally mandated and funded organizations legally empowered to advocate for Kansans with disabilities. DRC is the officially designated protection and advocacy system for Kansans with disabilities. DRC is a private, 501(c)(3) nonprofit corporation, organizationally independent of both state government and disability service providers. DRC advocates for the legal and civil rights of persons with disabilities.

I want to preface my remarks by stating that DRC respects the Long Term Care Ombudsman (LTCO) office and the services they provide. They are a partner agency of DRC. We are here to explain what DRC does, how it is different than what the LTCO does, and to ask legitimate questions about the goals of this bill how it interfaces with the existing advocacy capacity in Kansas.

HB 2242 -- as well as the balloon amendment being offered by the LTCO -- creates new authority for the LTCO to engage in community settings. This bill and the corresponding program would:

1. Amend Kansas law to add the new ability for LTCO to provide advocacy services in the community [the bill expands advocacy to all individuals who would qualify for institutional care; the balloon version would expand it to those who formerly resided in a facility]
2. Amend Kansas law to add new corresponding access authority for LTCO to access places in the community [currently, LTCO only has access to certain facilities]
3. Not provide LTCO advocacy services to Kansans with developmental disabilities or mental illness, which is appropriate because the LTCO's federal authority does not apply to DD institutions (ICFMRs) or nursing facilities for mental health (NFMHs).

DRC Kansas already possesses every authority and every program being proposed to be granted to the LTCO in HB 2242 … and much more:

- DRC Kansas, as the protection and advocacy system for Kansas, already has the authority to provide advocacy for Kansans with disabilities regardless of age – in ANY setting (institutional, residential, community, wherever).
- DRC Kansas has the corresponding access authority to investigate and gain entrance to any place where a person with a disability receives services. As it was proven in the Kaufman House case, DRC's access authority is far superior to SRS Adult Protective Services, LTCO, or other similar access authorities. Unlike other entities, DRC's federal authority grants it "reasonable unaccompanied" access to anywhere the person receives services.
- DRC Kansas has authority in DD institutions and nursing facilities for mental health. DRC can provide advocacy for all Kansans with disabilities. Unlike the LTCO, our authority is not limited. Our only limit is funding and resources.

(OVER)

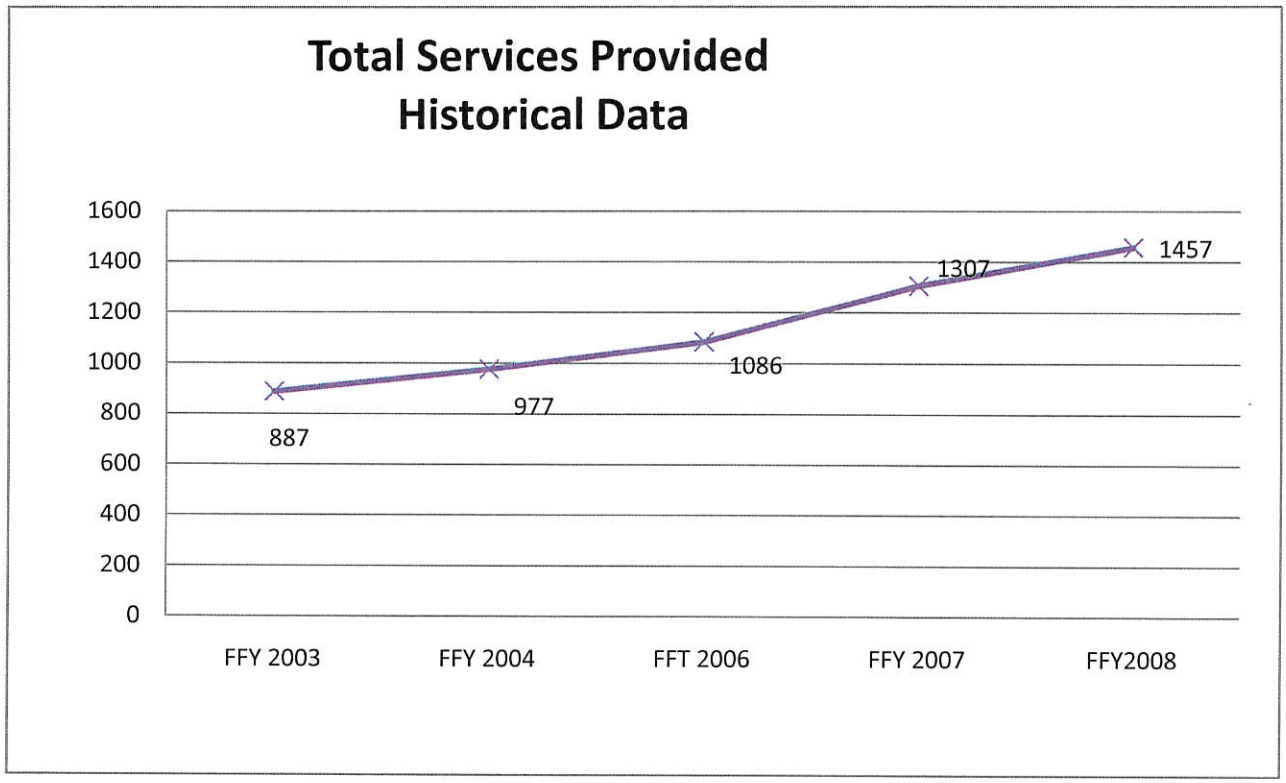
Given this information, one question that DRC Kansas would pose is why should the Legislature change state law to expand the authority of the LTCO into new areas and provide corresponding access authority and potentially new funding, when Kansas' protection and advocacy system (DRC Kansas) already has these authorities and abilities without any change in state law?

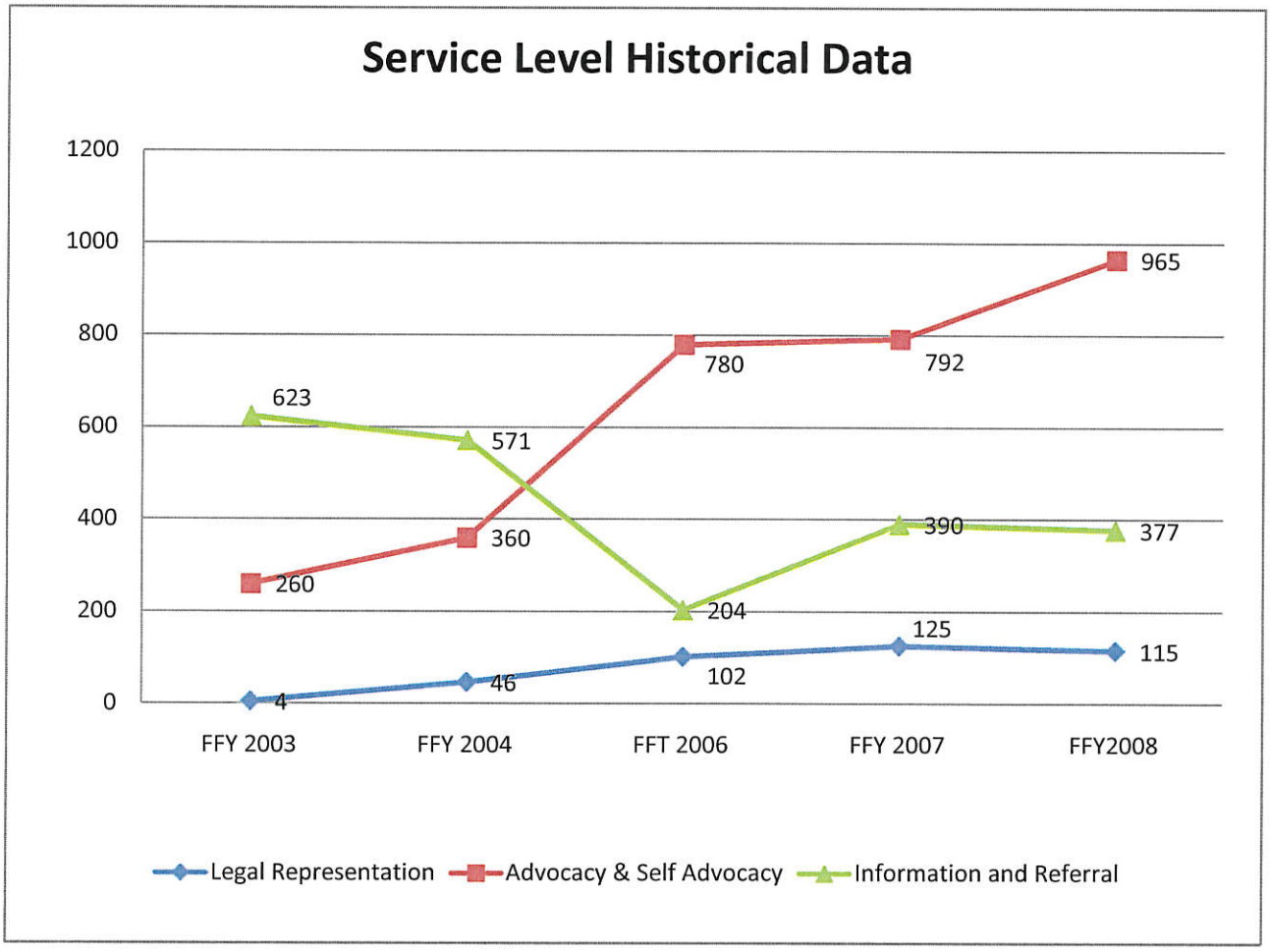
Funding for advocacy in community-based settings is absolutely needed. If you are going to expand advocacy in community-based settings through additional funding or new pilot projects, another question we would ask is why specifically target the LTCO to receive such pilot projects or program expansions? Why not utilize and fund your existing protection and advocacy system that is already engaged in these advocacy areas? Why not use DRC, the agency that has 30 years of experience providing advocacy services in community settings? The majority of states provide funding for their protection and advocacy system to expand the advocacy services available. Kansas does not. DRC would not need a new law passed to help us do everything that is proposed in this bill or the pilot in the balloon amendment. If DRC was to do the work envisioned in the bill, a pilot project could be established as a proviso in an Appropriations bill, or as an administrative initiative without act of law.

Who we are; What the Protection and Advocacy System Does – I have attached some information summarizing our authority as well as information on the number of people we serve with advocacy services. A few highlights:

- **1457 advocacy services in FFY 2008** – The vast majority of DRC's services are advocacy, just like is proposed in HB 2242, and not litigation (965 Advocacy or Self Advocacy/Technical Assistance; 377 Information & referral; 115 with legal representation).
- **DRC does both "Ombudsman-type" Advocacy and Intense Services** – DRC provides time and resource intensive advocacy services. DRC provides negotiation, mediation and other "ombudsman-type" services, but we offer the full array of advocacy services -- including information & referral, self advocacy support, advocacy, negotiation, even up to legal representation. Some of our legal and advocacy services cost tens of thousands of dollars and 100s of hours per case.
- **Doing More With Less** – DRC has dramatically increased its services while our resources have been reduced. Since FFY 2006 DRC's has had slightly less funding but increased services to nearly 400 more people (from 1086 to 1457).
- **Community Integration** – (from institution to community … the goal of pilot project as proposed) – DRC already provides advocacy to typically more than 200 cases for individuals residing in institutions who want to receive community based services in the most integrated setting.
    - FFY 05 = 281; FFY 06 = 206; FFY 07 = 216; FFY 08 = 190
- **Full Array & Person Controlled Advocacy** – Unlike other state agencies engaged in investigation or these issues (SRS/APS, LTCO, KDOA, etc.) DRC is the only entity with the investigative authority AND the corresponding ability to provide the full array of legally-based advocacy (negotiation, advocacy, litigation) AND where the advocacy is controlled by the person with a disability.
- **$1.3 million budget and 15 staff** – 6 practicing attorneys, 4 non-attorney advocates, 5 staff specializing in public outreach, education and administration.

We appreciate you allowing DRC Kansas to provide you this information. We would love the opportunity to continue to engage the Committee on the topic of expanding advocacy for Kansans. We would ask that if you create any new pilot projects, funding or services, that you not limit the program to one advocacy agency, and that you consider supporting your existing protection and advocacy system.


Total Services Provided
Historical Data
1600
1400
1200
1000
800
600
400
200
0
887
977
1086
1307
1457
FFY 2003
FFY 2004
FFT 2006
FFY 2007
FFY2008


Service Level Historical Data
1200
1000
800
600
400
200
0
623
571
204
390
377
260
360
780
792
965
4
46
102
125
115
FFY 2003
FFY 2004
FFT 2006
FFY 2007
FFY2008
Legal Representation
Advocacy & Self Advocacy
Information and Referral

DISABILITY RIGHTS CENTER of KANSAS
EQUALITY • LAW • JUSTICE

Disability Rights Center of Kansas
Rocky Nichols, Executive Director
635 SW Harrison, Ste 100 • Topeka, KS 66603
785.273.9661 • 877.776.1541 (Voice)
877.335.3725 (TDD) • 785.273.9414 FAX
rocky@drckansas.org • *Telephone Ext. #106*

Disability Rights Center of Kansas, Inc. (DRC)
Designated Protection and Advocacy System (P&A) for Kansas
Rocky Nichols, Executive Director

- **DRC – State P&A, 501(c)(3), governance is separate from government, no direct control from government or outside interests, focus on the interests of persons with disabilities. Every state & territory has a P&A, created and empowered by federal law.**

- **Advocacy Services – Advocacy for the human, civil and legal rights of Kansans with disabilities (right to not be abuse or neglected, rights under ADA, IDEA, Rehab Act, Fair Housing Act, etc.).**

- **DRC's direct services to people with disabilities include legal representation, advocacy, and technical assistance/self advocacy support. DRC also provides information and referral, public policy advocacy/educating policymakers, and conducting trainings/outreach.**

- **Do Much More than ANE – 12 Priority Areas where DRC provide services 1) ANE, 2) Guardianship elimination & alternatives, 3) Healthcare rights, 4) Community Integration, 5) Accessibility, 6) Employment, 7) Fair Housing, 8) Assistive Technology, 9) Special Education, 10) Rehabilitation Act, 11) Voting and 12) Preventing the Criminalization of Disability.**

- **Approximately $1.3 million budget – serve all 12 priorities (not just ANE) – though ANE is greatest focus/cost**

- **DRC's Role in State ANE investigation system is different – particularly the actions DRC takes and the fact that the victims control those actions and the justice they receive.**

- **State Agency's investigations (Aging, SRS, KDHE) primarily depend on**

(OVER)

- **where the person resides (ICFMR, IMD, DD Group Home, etc.). State Agencies (like APS/SRS) have the burden of investigating *every* appropriate allegation within a certain period of time (ex: 30 days).**

- **DRC's Investigations – does not matter where person resides (any setting). DRC does *not* have to investigate every allegation.**

- **State Agency's actions (Aging, SRS, KDHE), based on the result of the investigation, *primarily* focus on administrative sanctions, enforcing licensure, potentially pulling licenses, etc. State Agencies serve the interest of the State, and judge what is in the "best interest" of the person with a disability. Input from victim, but actions, steps and remedies are controlled by the State.**

- **Law Enforcement, Attorney General, Local County and District Attorneys – Prosecution of perpetrators. Prosecutors represent the State in the criminal prosecution, but interact directly with the victim and obtain important input and feedback from the victim. The prosecutor controls the legal actions, not the victim.**

- **DRC's legal actions are victim controlled. After the investigation is conducted by DRC and if the case is accepted for legal representation, the victim/client works with the DRC attorney and the victim controls the legal decisions. DRC not only represents the "best interest" of the victim of ANE; DRC represents and abides by the decisions of victim. Victim controls the actions, steps and remedies.**

- **DRC is the only entity in the investigative system that can both conduct investigations <u>and</u> represent the victim in legal proceedings to obtain justice (victim-controlled). DRC's actions are not administrative sanctions or licensure issues, they are tenacious and active legal services and advocacy to obtain justice for the victim.**

- **DRC's Federal Access Authority – Different Access, Fills Gaps (See attachment – DRC vs. APS/SRS Access Authority)**

- **DRC – If DRC has a report of ANE *or* probable cause of ANE, it triggers DRC's federal access authority. DRC then has "reasonable unaccompanied access" to the person, to their records and reports (including staff records and notes, etc.) and to the place where services are being received (even a private residence).**

Comparison of DRC and APS/SRS Access Authority to Investigate Complaints of Abuse or Neglect

Problem: Hostile, Uncooperative, or Abusive Guardian. Guardian may be the one perpetrating or assisting (ether actively or tacitly) the abuse, neglect or exploitation. For example, at the Kaufman House Mr. Kaufman was the alleged abuser of his ward, and the other guardians uncooperative or were AWOL.

Situation	*Access Sought*	*DRC Authority*	*APS/SRS Authority*
Individual has a guardian, ***guardian refuses consent***	**Individual**	Yes. Reasonable Unaccompanied Access, but must terminate interview at individual's request.	No. Can only do so with a court order. Problem: how can SRS convince the court to do this without this information? Protective services includes evaluating need for services, would have to obtain court order to enjoin guardian from interference under 39-1405 (residents) or 39-1437.
	Facility	Yes. Reasonable Unaccompanied Access to public and private places (including private residences)	No. Can only do so with a court order. Also, the law does not specifically grant access to private residences.
	Records	Yes. DRC makes reasonable effort to contact the guardian. If guardian fails to respond or fails to consent or to act on behalf of the individual, DRC still has access authority. 42 U.S.C. §§ 15043(a)(2)(I)(iii), 10805(a)(4)(C).	No. Can only do so with a court order. Problem: how can SRS convince the court to do this without this information? Protective services includes evaluating need for services, may get court order to enjoin guardian from interference under 39-1405 (residents) or 39-1437.
	Conduct ANE Investigation	Yes. Even without a guardians consent, DRC can fully conduct its ANE investigation under federal law.	No. Can only do so with a court order. Problem: how can SRS convince the court to do this without this information?

Problem: No guardian, person with a disability does not appear to have capacity and person does not provide consent.

Situation (a complaint is received in all)	*Access sought*	*DRC Authority*	*APS/SRS Authority*
Individual does not have a guardian, does not appear to have capacity, and ***person does not consent to investigation.***	**Individual**	Yes. Reasonable Unaccompanied Access.	No. Not unless a court order finds that the person does not have capacity and needs a guardian. May petition for appointment of a guardian. § 39-1437(a). May seek court authorization if regarding a resident of a facility 39-1407, May petition for appointment of a guardian if a resident 39-1408.
	Facility	Yes. Reasonable Unaccompanied Access to public and private places (including private residences)	No. Not unless a court order finds that the person does not have capacity and needs a guardian. Also, the law does not specifically grant access to private residences.
	Records	Yes. Access to all records 42 U.S.C. §§ 15043(a)(2)(I)(ii), 10805(a)(4)(B).	No. Not unless a court order finds that the person does not have capacity and needs a guardian. May petition for appointment of a guardian. § 39-1437(a). May seek court authorization if regarding a resident of a facility 39-1407, May petition for appointment of a guardian if a resident 39-1408.
	Conduct ANE Investigation	Yes. Even without consent of the individual, DRC can conduct its ANE investigation under federal law (person may or may not talk to DRC, but investigation could be conducted).	No. Not unless a court order finds that the person does not have capacity and needs a guardian. May petition for appointment of a guardian. § 39-1437(a). May seek court authorization if regarding a resident of a facility 39-1407, May petition for appointment of a guardian if a resident 39-1408.

Problem: Person with a disability does not have a guardian, has capacity, but does not consent to the investigation (perhaps because they are being threatened or coerced by the perpetrator).

Situation (a complaint is received in all)	*Access sought*	*DRC Authority*	*APS/SRS Authority*
Individual does not have a guardian, has capacity and *does not consent to the investigation.*	**Individual**	Yes. Reasonable Unaccompanied Access, but must terminate interview at individual's request	No. 39-1437, 39-1407 (resident).
	Facility	Yes. Reasonable Unaccompanied Access to public and private places (including private residences)	No. 39-1437, 39-1407 (resident).
	Records	No.	No. 39-1437, 39-1407 (resident).
	Conduct ANE Investigation	Yes. Even without consent of the individual, DRC can conduct its ANE investigation under federal law (person may or may not talk to DRC, but investigation could be conducted).	No. If the person clearly has capacity, SRS cannot conduct the abuse and neglect investigation without the persons consent.

Select Citations regarding DRC and APS authority:

"If the department and such officers determine that no action is necessary to protect the adult but that a criminal prosecution should be considered, the department and such law enforcement officers shall make a report of the case to the appropriate law enforcement agency." § 39-1433(a).

If the complaint is about a resident of an adult care home, medical care facility, or state psychiatric hospital or state institution for the mentally retarded, *"Any . . . agency authorized to carry out the duties enumerated in this act, . . . shall have access to all relevant records." §39-1406*

"The authority of the secretary . . . shall include, but not be limited to, the right to initiate or otherwise take those actions necessary to assure the health, safety or welfare of any resident, subject to any specific requirement for individual consent of the resident." 39-1406 (for IMDs, state ICFMRs, MCFs, & ACHs).

All DRC authority to access facilities and residents comes from: 42 U.S.C. § 15043(a)(2)(H), 45 C.F.R. § 1386.22(f), 42 U.S.C. § 10805(a)(3), and 42 C.F.R. § 51.42(b).

DRC access to facilities for an abuse or neglect investigation does include the opportunity: "to interview any facility service recipient, employee, or other person, including the person thought to be the victim of such abuse, who might be reasonably believed by the system to have knowledge of the incident under investigation . . . ." DD Act regulations, 45 C.F.R. 1386.22(f).

Under the PAIMI regs, reasonable unaccompanied access to facilities and residents includes the opportunity "to interview any facility service recipient, employee, or other persons, including the person thought to be the victim of such abuse, who might be reasonably believed by the system to have knowledge of the incident under investigation." 42 C.F.R. § 51.42(b).

The PAIMI provision regarding access to residents states "Residents include adults or minors who have legal guardians or conservators. P&A activities shall be conducted so as to minimize interference with facility programs, respect residents' privacy interests, and honor a resident's request to terminate an interview." 42 C.F.R. § 51.42(c).

40 YEARS
INTERHAB

WWW.INTERHAB.ORG

February 17, 2009

TO: Representative Bob Bethell, Chair, and

Members, House Committee on Long Term Care

FR: Tom Laing, Executive Director, InterHab

RE: House Bill 2242

Thank you, Mr. Chair, and members of the committee, for today's hearing on this very important bill. The concept of ombudsman services in government is a well-tested and successful model by which citizen concerns are more quickly heard and more expeditiously addressed. We commend the sponsor for rightly noting (and addressing) in his bill that the current law needs to be modernized to reflect the changing service models of long term care, i.e. from facility-based care to home- and community-based care. For that reason, we support House Bill 2242.

Additionally, we recommend the committee make further refinement to the State's ombudsman program, and to these statutes as needed, to broaden the Ombudsman's role within the broader array of long term care – namely, in addition to programs that serve our older citizens, that the Ombudsman's scope of review would also include long term care settings for persons with developmental disabilities.

The current law correctly identifies the federally funded protection and advocacy offices of the Disability Rights Center (DRC) in reference to services for persons with developmental disabilities. However, the reference to DRC only points to a need for coordination between the DRC and the Ombudsman's office. DRC plays a different role than an Ombudsman's office would play, and therefore, the need exists for the coverage of the Ombudsman's office to include persons with developmental disabilities.

The Ombudsman's office could serve a vital role within the DD community, not only in providing another source for review of DD issues, but also in providing a starting point in information referral for Kansas families who have questions about the DD service system. The Ombudsman could serve as a vital 'clearinghouse' for information on how to access services, availability of services and how funding is determined. For those who are new to the state, or the DD system, the Ombudsman's office could play a very helpful role.

We recommend these proposed enhancements with an awareness of the State's fiscal note for the bill as written. We understand that any expansion will cost money, but we believe the fiscal note fails to

HOUSE AGING & LONG TERM CARE
DATE: 2/17/09
ATTACHMENT: 8

700 SW Jackson Suite 803 Topeka, Kansas 66603-3737 [p]785.235.5103 [f]785.235.0020

take into account the statutory capacity of the Ombudsman's office to certify and utilize volunteers in the Ombudsman program. Certainly in the DD community network (and I assume the case is the same in the community of care for older Kansans) there are numerous persons who would be willing to become trained as active volunteers for Ombudsman assignments.

We support the intended goals of HB 2242, and ask that its expansion of the role of the Ombudsman be further amended to direct that Ombudsman activities be extended to receive and respond to issues arising in the DD community service network as well.

Thank you for receiving this testimony. We respectfully request your thoughtful consideration of our recommendations and urge the adoption of House Bill 2422.

AARP Kansas
555 S. Kansas Avenue
Suite 201
Topeka, KS 66603

T 1-866-448-3619
F 785-232-8259
TTY 1-877-434-7598
www.aarp.org/ks

February 17, 2009

The Honorable Bob Bethel, Chairman
Aging and Long-Term Care Committee

Reference - HB 2242

Good afternoon Chairman Bethel and Members of the House Aging and Long-Term Care Committee. My name is Ernest Kutzley and I am the Advocacy Director for AARP Kansas. AARP represents the views of our over 376,000 members in the state of Kansas. Thank you for allowing us to present our comments in support of HB 2242 that would allow the Ombudsman program to advocate for those who qualify for institutional care settings but are receiving home- and community-based services (HCBS).

The Long-Term Care Ombudsman Program, authorized by the Older Americans Act, provides an additional mechanism for ensuring quality and protecting residents' rights. The ombudsmen advocate for residents in nursing homes and supportive housing and investigate and respond to complaints for residents in every state.

However, people of all ages now prefer to receive long-term care services and supports (LTSS) in their own homes whenever possible. Under the "Money Follows the Person Grant", received by Kansas in 2007, many individuals placed in nursing or intermediate care facilities can be served in their homes and communities. Home- and community-based services help to preserve individuals' independence and ties to family and friends at a cost less than that of institutional care.

The individuals ombudsmen have traditionally served - residents of long-term care facilities – are now moving into home care settings. Twelve states currently have Long-Term Care Ombudsmen with HCBS responsibility. The people being served remain the same, but the settings are different. The role of the ombudsman has always been to hold systems accountable to fulfill their responsibilities to residents. In thinking about a potential role for ombudsmen in a long-term care community setting, the role would be the same – to ensure that the systems that are in place adequately provide for consumers.

AARP believes that states should:

- Carefully evaluate the need for all of the range of LTSS and design their budgets and policies to eliminate institutional bias, expand access to HCBS, and allow consumers to choose the setting in which they receive services;
- Extend the scope of the ombudsman program to include HCBS and ensure that ombudsmen have adequate funding to monitor such services.

Therefore, we support HB 2242 which will provide for expansion of the long-term care ombudsman program to include (HCBS) services. We appreciate the opportunity to provide these comments and respectfully request our support of HB 2242.

Thank you.
Ernest Kutzley

HOUSE AGING & LONG TERM CARE
DATE: 2/17/09
ATTACHMENT: 9

KAHSA

creating the future of aging services

To: Representative Bob Bethell, Chair, and Members,
House Aging and Long Term Care Committee
From: Debra Harmon Zehr, President
Date: February 17, 2009
Re: House Bill 2242

Thank you Chairman Bethell, and Members of the Committee, for this opportunity to provide comment on House Bill 2242.

The Kansas Association of Homes and Services for the Aging represents 160 not-for-profit long term care provider organizations through out the state. Over 20,000 older Kansans are served by our members, which include retirement communities, nursing homes, hospital long-term care units, assisted living facilities, senior housing and community-based service providers. Nearly half of our members are Medicaid HCBS/FE providers.

We support the need for ombudsman services for persons receiving long-term care in community-based settings. Much work has been done over the past 15 years to rebalance the long-term care system in Kansas and to give citizens more choice in long term supports and services. Today Kansas ranks among the top five states in the country for number of persons receiving services through the Medicaid HCBS program.

Kansans who need long term supports and services deserve high quality care delivered by competent caregivers, whether services are received in facility-based or community-based settings. Much work remains to establish parameters for "quality" in community-based services and little research has been done to assess quality outcomes. In Kansas there are no uniform training standards or requirements for personal care attendants, the primary paid hands-on caregivers for self-directed individuals residing in the community.

House Bill 2242 should be considered as one part of a much needed conversation about quality assessment, assurance and advocacy in community-based services. KAHSA stands ready to assist the Aging and Long-Term Care Committee to craft good public policy in this arena.

Please feel free to contact me at Ph 785-233-7443/dzehr@kahsa.org or Joe Ewert, our Government Affairs Coordinator, at jewert@kahsa.org. KAHSA's Statehouse contacts are John Peterson or Bill Brady with Capitol Strategies.

785.233.7443
kahsainfo@kahsa.org

fax 785.233.9471
217 SE 8th Avenue
Topeka, KS 66603-3906

HOUSE AGING & LONG TERM CARE
DATE: 2/17/09
ATTACHMENT: 10

KANSAS ACADEMY OF FAMILY PHYSICIANS
CARING FOR KANSANS

Testimony: HB 2297

House Committee on Aging and Long Term Care
February 17, 2009
Presented by: Dodie J Wellshear, Government Relations Consultant

Chairman Bethell and Members of the House Committee on Aging and Long Term Care:

Thank you for this opportunity to present testimony on behalf of the Kansas Academy of Family Physicians (KAFP.) My name is Dodie Wellshear, and I am the Government Relations Consultant for the Kansas Academy of Family Physicians. KAFP has more than 1,500 members across the state. The family physicians of the state provide the backbone of primary care in Kansas. The roots of family medicine go back to the historical generalist tradition. The specialty is three dimensional, combining knowledge and skill with a unique process. The patient-physician relationship in the context of the family is central to this process and distinguishes family medicine from other specialties.

House Bill 2297 would add geriatrics and geriatric psychiatry fellowships to the list of approved postgraduate residency training programs for the medical student loan programs. KAFP does not object to the intent of the bill to provide an opportunity for additional training in geriatrics.

In fact, **we would like to see the bill amended to allow a fourth year of training for family medicine residency.** This would allow a resident planning to practice in an underserved area to gain extra expertise in many important issues including, but not limited to, geriatrics, emergency medicine and obstetrics. One of KAFP's officers, Dr. Jennifer Brull, practices in Plainville and was a recipient of the Kansas Medical Student Loan Program. She states:

From the perspective of someone who benefited from KMSL, I would not be opposed to a family medicine resident taking an extra year of training, whether it be a chief resident/ fourth year or a fellowship, AS LONG AS they were still headed out to do family medicine in a rural area. My partner sees a LOT of geriatric patients in his practice (mostly Medicare) but still does full spectrum (including ER, whole family). I can see why someone would want that extra year. I can definitely understand an OB fellowship to get more sections before heading to the boonies. I do not think that folks should be penalized if that is there intent - to gather more skills for their rural practice.

I DO think that if someone does a fellowship and ditches out on their rural commitment to stay in the city and do a limited practice that the wrath of KU and Kansas should rain down upon them and financial penalties should ensue. I believe though, that most students and residents are fairly savvy at getting themselves OUT of the program if they feel their leanings are elsewhere to minimize the financial damage after residency.

www.kafponline.org

7570 W. 21st St. N. Bldg. 1046, Suite C | Wichita, KS 67205 | 316.721.9005 | 1.800.658.1749 | Fax 316.721.9044 | kafp@kafponline.org

HOUSE AGING & LONG TERM CARE
DATE: 2/17/09
ATTACHMENT: 11

KANSAS ACADEMY OF FAMILY PHYSICIANS
CARING FOR KANSANS

The situation with geriatric psychiatry is more problematic.

The basic purpose of the loan programs is to put more primary care physicians into underserved areas, particularly rural areas of the state. Geriatricians would be fine additions to underserved medical communities. But we are concerned that this could start a pattern of authorizing other fellowships that are far afield from primary care. That would dilute the intent of the program. We would also be concerned if this had the effect of diminishing the numbers of students accepted into the Medical Student Loan Program.

Specifically on the issue of geriatric psychiatrists, there is no primary care pathway to a fellowship in that discipline. The pathway is through a psychiatry residency, which is not one of the approved programs for the loan recipients. We do not argue with the need for more geriatric psychiatrists practicing in rural areas, though it is very unlikely that they would, based upon population needs to support such a practice. We simply do not believe that specialty should be included in these loan programs. They were specifically designed, and are working to place more primary care physicians in rural Kansas.

Thank you for your consideration. I would be happy to stand for questions.

KU THE UNIVERSITY OF KANSAS
Medical Center

February 17, 2009

The Honorable Bob Bethell
Chairman
House Aging and Long Term Care Committee
Kansas State Capitol, 161-W
300 SW 10th St.
Topeka, Kansas 66612

Dear Chairman Bethell,

Thank you to the members of the Aging and Long Term Care Committee for allowing the University of Kansas Medical Center to submit a letter regarding the impact of H.B. 2297 on the Kansas Medical Student Loan program. As you know, the program represents a concerted effort by the state of Kansas to draw primary care physicians to underserved areas of our state. The program does so by providing incentives to physicians to complete a primary care residency and then, generally speaking, practice medicine in an underserved area of the state for an extended period of time.

Currently, the Kansas Medical Student Loan program is available for those who complete their residency training in general pediatrics, general internal medicine, family medicine, family practice, or emergency medicine. H.B. 2297 would expand the list of approved residency programs to include "fellowship training in geriatric medicine or geriatric psychiatry."

Our understanding at the University of Kansas Medical Center is that this particular expansion of program eligibility would have no fiscal impact upon the state because it would be administered within the current framework of the program and be paid for within the balances of the fund.

Thank you again for allowing the University of Kansas Medical Center to provide input on H.B. 2297. As always, we appreciate the continued efforts of the Committee and can provide additional information as needed.

Best Regards,

Barbara Atkinson MD

Barbara Atkinson, MD
Executive Vice Chancellor, University of Kansas Medical Center
Executive Dean, University of Kansas School of Medicine

Office of the Executive Vice Chancellor
Mail Stop 2015 | 3901 Rainbow Blvd. | Kansas City, KS 66160 | (913) 588-1440 | Fax (913) 5

HOUSE AGING & LONG TERM CARE
DATE: 2/17/09
ATTACHMENT: 12

K A M

Kansas Association of Osteopathic Medicine
1260 SW Topeka Boulevard
Topeka, Kansas 66612

Call (785) 234 5563
Fax (785) 234 5564
KansasDO@aol.com

TESTIMONY

Aging and Long Term Care Committee
HB 2297

My name is Bob Williams, Executive Director of the Kansas Association of Osteopathic Medicine. Thank you for this opportunity to address the Committee regarding HB 2297.

HB 2297 adds fellowship training in geriatric medicine to the osteopathic medical service scholarship program.

Osteopathic physicians have a high proportion and commitment to primary care/family practice settings and frequently locate in rural Kansas communities. Geriatric medicine is a part of primary care. As the baby boomers age, there is (and will be) an increased need for physicians willing to focus their practice on geriatric medicine. By including fellowship training in geriatric medicine for osteopathic medical service scholarships, the medical community will be better prepared to address the growing needs of an aging Kansas population.

We encourage the Committee to support HB 2297.

Thank you.

House Committee on Aging and Long – Term Care

Tuesday, February 17th, 2009

House Bill 09-2297 : Geriatric Medicine, approved post-graduate training program for KU Medical School and Doctor of Osteopathy Loan Programs

To the Representatives of the House Committee on Aging and Long-Term Care,

I am Courtney Huhn, a second year medical student at the University of Kansas School of Medicine from Lansing, Kansas and a proponent of HB 09-2297. I am the individual who contacted my local representative at the time, Representative Kenny Wilk who I knew from church, about the initiation of HB 09-2297 in October 2007 (last year HB 08-2685). Former Representative Wilk contacted Representative Bob Bethell to start working on this bill. The bill passed the House unanimously last year, was moved on to the Senate where the Legislative session ran out of time prior to the bills completion. I am very grateful for your passing of this bill last year. This year, I again appreciate the opportunity to share some information about why I pursued the creation of this bill and why I am so passionate about the field of geriatrics. I am a Kansas Medical Student Loan (KMSL) recipient who is interested in completing a residency in family medicine and a fellowship in geriatrics. I have a long standing interest in older adults. I want to utilize that interest with my medical education to serve the geriatric population and their unique and special needs that geriatricians are trained to handle. I have always had a love for older adults and I have done many things in my life to fulfill that. I am currently the University of Kansas School of Medicine Geriatric Interest Group President and trying to promote elderly care issues throughout the medical center campus.

This bill originated at the first meeting of the Geriatric Interest Group last academic year (when I was a first year medical student). I asked Dr. Mary McDonald, the group's advisor, if an interested KMSL recipient could complete a geriatric fellowship prior to paying back the KMSL with years of service as a physician to the state of Kansas since geriatrics is a primary care field. I was told that with the current policy a KMSL recipient who is interested in completing a geriatric fellowship has two options. The first option is to complete their three year family medicine residency and then serve four years as a physician prior to receiving the specialized training of a geriatric fellowship and then come back to complete that fellowship. The second option is to pay the KMSL back in monetary form which is about $40,000 with the interest of 15%. This takes the total to nearly $50,000 for one year while completing your geriatric fellowship which is more than the annual salary of that position. As you can see this truly makes it an impossible choice financially. Then one would have to pay back the remaining three years of the KMSL with service as a physician. After hearing this, I decided to see what could be done since geriatrics is considered a primary care field of medicine and a field I am a very interested in pursuing.

Not only is the geriatric population ever growing nationwide but it continues to be underserved. This is also the trend in Kansas. There are about 25 geriatricians serving approximately 400,000 people over the age of 65 in Kansas, according to the US Census Bureau. Most geriatricians are located in urban areas throughout the state. The number of older adults in Kansas is steadily increasing with the baby boomers reaching the age of 65 over the next 20 years. Kansas already has a higher percentage of older adults than the national average. Kansas is at 12.9 percent compared to

12.-. percent for the United States. This percentage increases to about 20-25 percent in the rural Kansas where there are very few geriatricians, if any.

At this time, the state of Kansas has one geriatric fellowship that has the capacity to graduate two geriatricians annually. However, these spots are not being filled and the program is not able to graduate to capacity. With the passage of this bill, KMSL recipients interested in geriatrics can complete the fellowship and serve this population. This will help give rural Kansas more geriatricians, which they desperately need. Since KMSL recipients must repay their loan with service in rural parts of Kansas, there would be more geriatricians in these areas which would lead to better care for the ever growing rural geriatric population.

The medical education system nationwide has recognized this need for physicians with an awareness about geriatric medicine and has altered curriculum accordingly. For example, the University of Kansas School of Medicine now teaches numerous lectures and web modules on geriatric specific issues and awareness. Additionally, the clinical curriculum is undergoing a change starting in June 2009 that adds additional geriatric training, making the clerkship a 4 week geriatric clerkship instead of 2 weeks of geriatrics in a combined clerkship. These are just some examples of the expansion of the medical school curriculum to include better training and awareness in geriatrics.

With the current state of the economy, I understand the hesitation to pass any bill that could potentially increase spending. However, I do not believe that the addition of this fellowship to the KMSL program would increase the cost to the State of Kansas. Of the currently accepted residency programs for the KMSL some already require four years to complete, such as emergency medicine. Therefore, the completion of a three year family medicine or internal medicine residency followed by a one year geriatric fellowship would take the same amount of time as an emergency medicine residency. The years of service (4 for most students, depending on how many years they chose to take) would not be affected with this bill. The repayment of the service would just be postponed by one year while the student completes the fellowship.

I am now available for any questions you may have on why I pursued this bill or about the field of geriatrics itself. I brought along a few of my colleagues today who are also KMSL recipients interested in geriatrics. They are also willing to answer any questions you may have. Melissa Garber is a 4th year medical student from Hutchinson, Kansas; Tessa Rohrberg is a 1st year from Sharon Springs, Kansas; Tricia Barker is a 1st year from Minneapolis, Kansas; and Amanda Baxa is a 1st year from Tampa, Kansas. If we are unable to answer your questions we will find the answers from some of our mentors who are already in the field. Feel free to contact me via e-mail (chuhn@kumc.edu) or phone (913) 306-4383.

Thank you for considering this bill,

Courtney Huhn, MS2

KANSAS
DEPARTMENT ON AGING

Kathleen Sebelius, Governor
Kathy Greenlee, Secretary
www.agingkansas.org

House Committee on Aging and Long Term Care
Feb. 17, 2009

HB 2297/Geriatric medicine,
approved KU postgraduate residency training program
Martin Kennedy, Deputy Secretary

Chairman Bethell and members of the committee, the Kansas Department on Aging appreciates the opportunity to express its written support of HB 2297. This bill would expand the list of approved postgraduate residency training programs to include fellowship training in geriatric medicine or geriatric psychiatry.

The need for doctors trained in geriatric medicine or geriatric mental health grows greater every year. While the U.S. population age 55 is growing rapidly, according to a 2005 census report, the number of medical school graduates going into geriatrics has been slow to keep up.

The focus of geriatric care is somewhat different than that of specialists in other areas of health care. The particular focus of caring for frail elders includes an understanding of how to assess and determine the individual's ability to function which is often as important as understanding their diseases. Geriatric medicine coordinates long-term care for chronic conditions; managing, not curing, a collection of overlapping chronic conditions, and balancing the risks and benefits of multiple medications.

There are 323 licensed nursing facilities in Kansas and each is required to have a medical director on staff. Because of already low numbers of physicians, particularly in rural areas, many find it difficult to fill this position. We believe the passage of HB 2297 would help lessen this problem.

The Kansas Department on Aging supports the passage of HB 2297.

New England Building, 503 S. Kansas Avenue, Topeka, KS 666(HOUSE AGING & LONG TERM CARE
Voice: (785) 296-4986 • Toll-Free: (800) 432-3535 • Fax: (785 DATE: 2/17/09
TTY (Hearing Impaired): (785) 291-3167 • E-Mail: wwwmail@a ATTACHMENT: 15