
OFFICE OF THE DISTRICT OF COLUMBIA
LONG-TERM CARE OMBUDSMAN
ANNUAL REPORT

Fiscal Year 2010
(October 1, 2009 to September 30, 2010)



*Advocating for residents, protecting residents' rights, and promoting the best possible
life and quality of care for the District long-term care residents*

*Lynne Person
DC Long-Term Care Ombudsman
Legal Counsel for the Elderly
601 E Street, NW
Washington, DC 20049
(202) 434-2190 Office
(202) 434-6595 Fax*

Legal Counsel For the Elderly

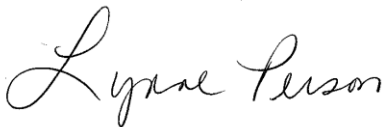
June 2011

We are pleased to present the 2010 Annual Report of the District of Columbia's Long-Term Care Ombudsman Program (DCLTCOP). This report highlights the efforts and accomplishments of the program on behalf of over 5,000 residents receiving long-term care services in District nursing homes, assisted living residences and community residence facilities. These efforts were accomplished by the program staff and 43 certified volunteers.

The DCLTCOP is appreciative of the continued support from District agencies and organizations (government and community-based) that we partner with to satisfy the purpose of this program. Our advocacy includes responding to the needs of District residents facing problems in long-term care facilities.

We hope this Annual Report is informative and helpful to you as you work to improve the quality of life and care for our fellow Washingtonian's with long-term care needs.

Sincerely,



Lynne Person
DC Long-Term Care Ombudsman



TABLE OF CONTENTS

History.....	2
Staffing.....	3
Purpose.....	4
Long-Term Care Services.....	4
FY 2010 Activities.....	6
Significant Achievements.....	13
Recommendations for Legislative Systems and Regulatory Changes.....	16
Volunteers.....	20
Resources for the Ombudsman Program and General Public.....	22

HISTORY

In 1975, the District of Columbia Office on Aging (DCOA) established the Office of the District of Columbia Long-Term Care Ombudsman with grant funds from the Administration on Aging. The 1978 amendments to the federal Older Americans Act, passed in October 1978, considerably strengthened the Ombudsman Program. Title III, Section 307(a)(12) required each state and the District of Columbia (DC) establish a state-level Long-Term Care Ombudsman Program with three responsibilities:

- Investigate and resolve complaints about nursing homes
- Encourage citizens' involvement in nursing homes
- Monitor the development and implementation of regulations, laws, and policies affecting nursing home residents

A 1981 amendment to the Older Americans Act extended the ombudsman program's jurisdiction to board and care homes, called community residence facilities (CRFs), in DC. A 1987 amendment to the Older Americans Act elevated the ombudsman from a program to an office, required that adequate legal counsel be available, and granted immunity to ombudsmen for good faith performance of their duties. A 1992 amendment ensured against conflicts of interest and emphasized the roles of ombudsmen as advocates for change to improve the quality of care and quality of life for residents of long-term care facilities.

The DCOA operated the ombudsman program until 1985, when DC awarded a grant to the Legal Counsel for the Elderly, affiliated with AARP, to operate the Office of the DC Long-Term Care Ombudsman Program (Ombudsman Program). The Ombudsman Program has benefited from placement at Legal Counsel for the Elderly because of the available legal support and access it has to the vast AARP network for recruitment of volunteer resident advocates.

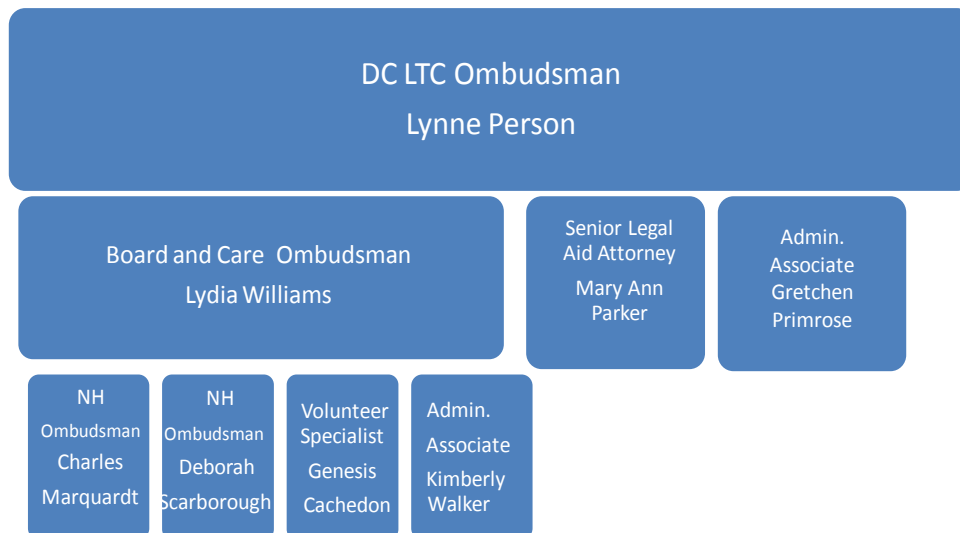
Passage of the Long-Term Care Ombudsman Program Act of 1988, D.C. Law 7-218, D.C. Code Ann. § 7-701.01 *et seq.*, strengthened the program by providing the Ombudsman Program with the tools necessary to carry out the responsibilities mandated by the federal Older Americans Act. The DC law also reinforced the Ombudsman Program's emphasis on advocating for and protecting the rights of residents of nursing facilities, assisted-living residences, and CRFs.

STAFFING

The Legal Counsel for the Elderly's Office of the DC Long-Term Care Ombudsman Program staff consists of a full time State Long-Term Care Ombudsman, Board and Care Ombudsman, two full time Nursing Home Ombudsmen, a full time Volunteer Coordinator, a part time Ombudsman Attorney, one full time and one part time administrative support staff, and 43 certified ombudsman volunteers. The Ombudsman Program staff focuses on long-term care complaints, educating the community, monitoring local and federal policy, regulation, and legislation to improve quality of care, and provides legal assistance.

Within the first six months of the fiscal year, the program was without a State Long-Term Care Ombudsman. The Board and Care Ombudsman served as the interim State Ombudsman until the position was filled in August 2010. As a result of this change, duties of the staff shifted in order to maintain the program's monitoring mandates.

Office of the DC Long-Term Care Ombudsman



PURPOSE

The Ombudsman Program is charged by DC statute with the following responsibilities:

- Advocate for the rights of older persons and other persons who are residents of nursing facilities, assisted-living residences, and CRFs
- Investigate and resolve complaints made by or on behalf of an older person or other person who is a resident of a nursing facility, assisted-living facility, or a CRF
- Monitor the quality of care, services provided, and quality of life experienced by older persons and residents in long-term care facilities to ensure that the care and services are in accordance with applicable DC and federal laws
- Establish and conduct a training program for program staff and volunteers
- Establish and maintain procedures to protect the confidentiality of information regarding residents

These responsibilities parallel those in the federal Older Americans Act, which also governs operation of the Ombudsman Program activities.

LONG-TERM CARE SERVICES

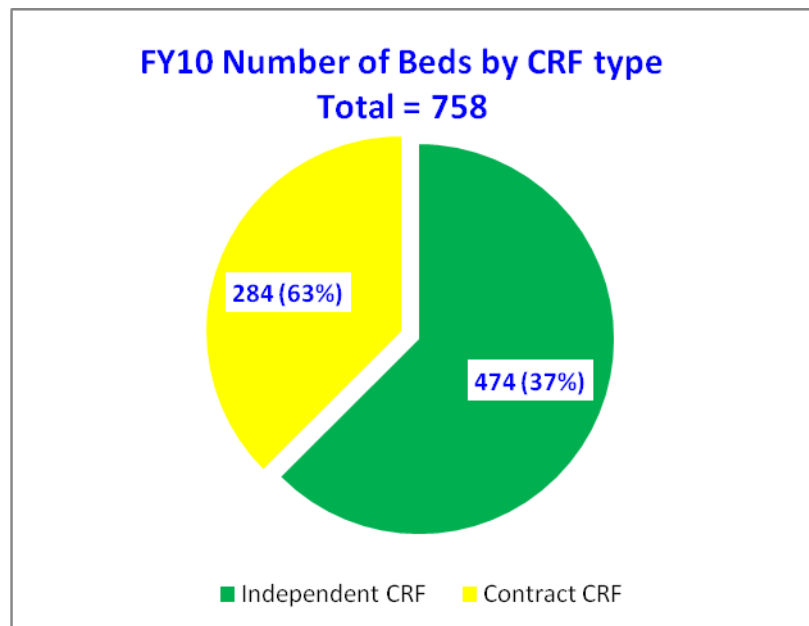
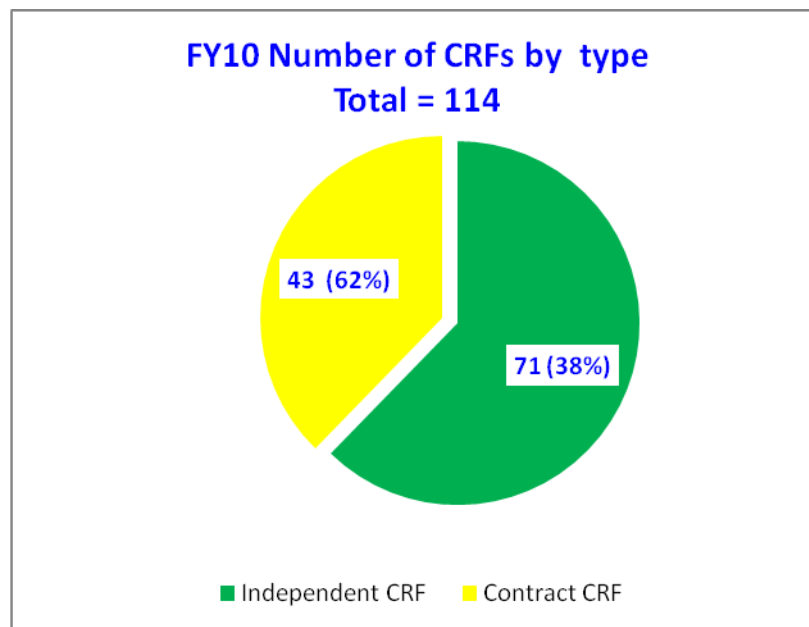
Approximately 5,000 residents live in licensed nursing facilities, assisted-living residences, mental health community residence facilities (MHCRFs), and community residential facilities (CRFs) in the District of Columbia. The 19 nursing facilities licensed by the Department of Health (DOH) have a total capacity of 2,751 beds.¹ The DOH also licenses and monitors 19 assisted-living facilities with approximately 890 units, and 8 CRFs for the elderly with 151 beds.²

It was determined in 2008 that it was no longer necessary for the government to provide mental health services directly through the DC Community Services Agency (CSA) that could otherwise be provided by community providers. The Department of Mental Health's DC CSA transition was completed on March 31, 2010. The plan was implemented in fiscal year 2009. Therefore, and on behalf of the residents living in Mental Health Community Residential Facilities (MHCRFs) the DC Long-Term Care Ombudsman Program staff participated in specific aspects of the transition, educated residents on the process and its implications for them and advocated on behalf of these residents to ensure protection of resident's rights throughout this process.

¹ The total number of beds listed in this report combines non-skilled and skilled nursing home beds.

² FY 2010 eleven CRF providers closed their facilities effecting 65 residents to seek alternative housing or programs.

The ombudsman program will continue to monitor all mental health community residential facilities in the District of Columbia. DMH licensed 43 MHCRF providers providing direct mental health services to 284 residents, and 71 independent providers serving 474 residents.



FY 2010 ACTIVITIES

A. Case Resolution and Information Services

Number of LTC information materials provided	825
Number of individuals who filed cases: ³	528
Number of cases closed	516
FY 09 carry-over cases	12
Number of complaints received in FY 10:	1858
Number of complaints handled:	1838
Number of complaints verified:	1821
Number of complaints partially or fully resolved:	1368
Number of complaints not resolved:	37
Number of complaints withdrawn or with no action needed:	16
Number of complaints referred to another agency:	417

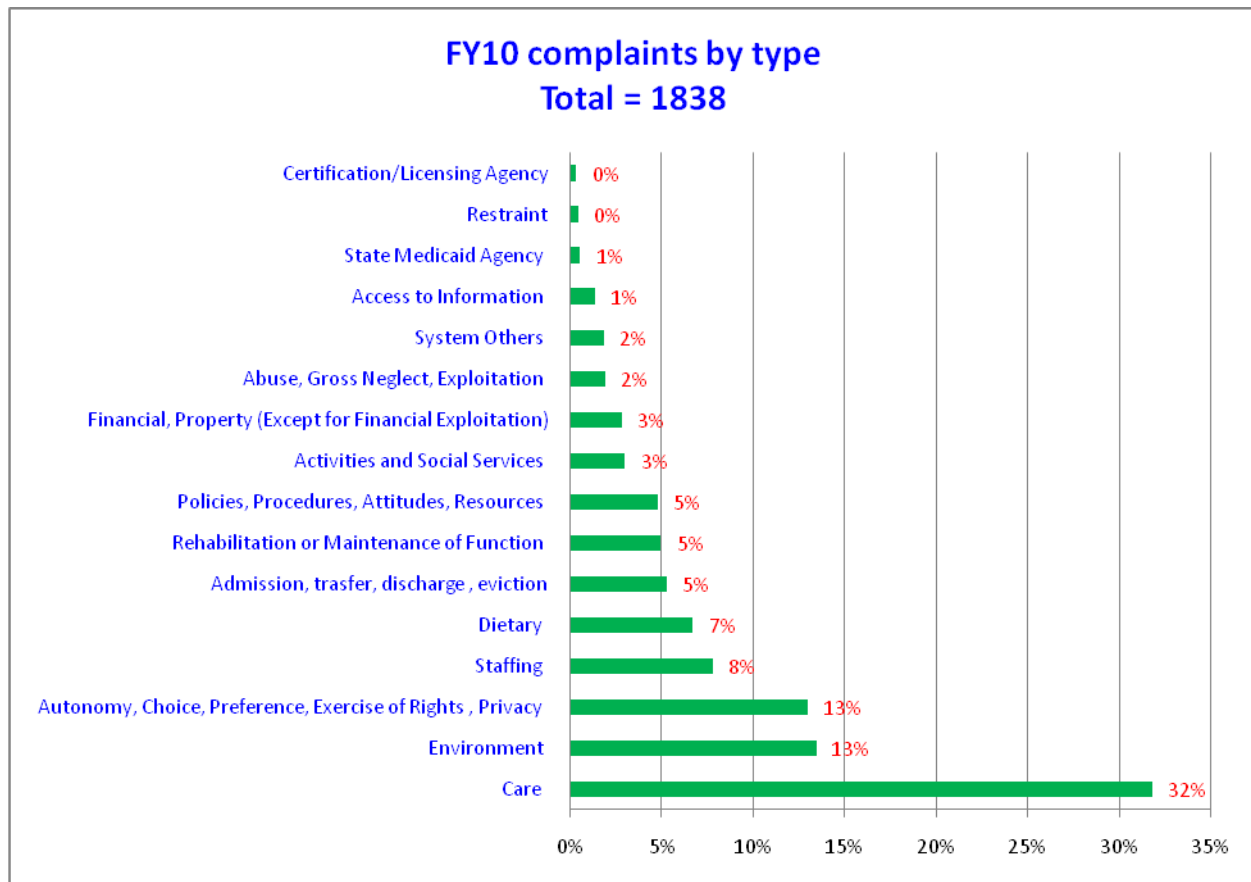
B. Complaint Analysis

Percentage of Overall Complaints Grid⁴

Total number of complaints handled: **1838**

³ A case is defined as any person lodging concerns (complaints) with the Ombudsman Program.

⁴ The categories of complaints listed are the main topic areas that represent 133 sub-complaint categories that DHHS, Administration on Aging, mandated that each ombudsman and volunteer staffer must report during investigations and monitoring visits when complaints are found. A complaint is defined as any problem or issue on which an ombudsman takes action on behalf of a nursing home, assisted-living facility, or CRF resident. The number of complaints is larger than the number of individuals who file complaints because one individual often has several different complaints. For a complete list of codes, please contact the Ombudsman Program at 202-434-2140.



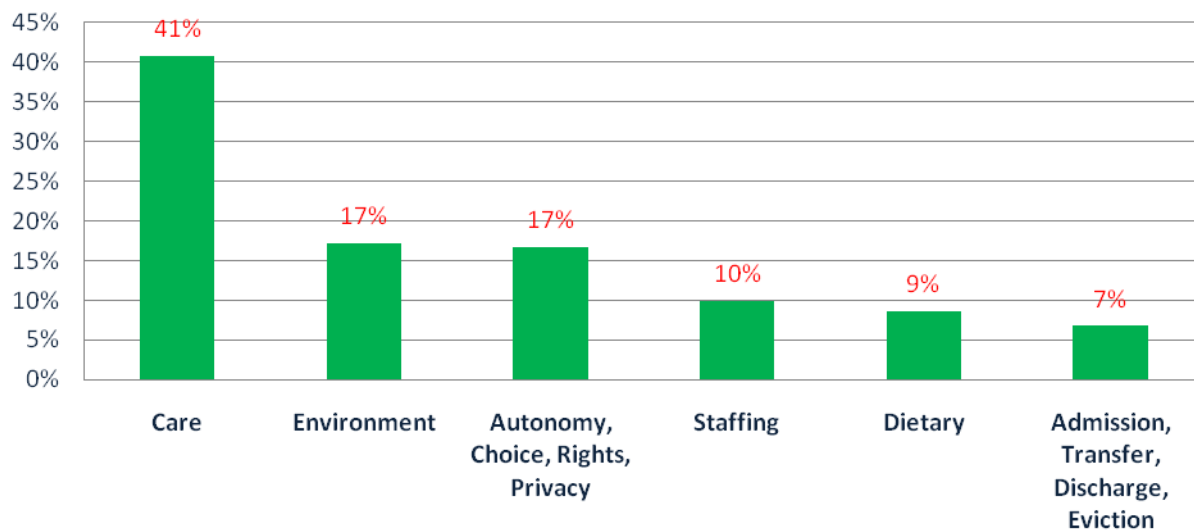
Top Six Complaint Categories and Definitions:

- 1. Care:**
 - a. symptoms unattended
 - b. care plan assessment inadequate
- 2. Environment:**
 - a. odors
 - b. cleanliness
- 3. Autonomy, Choice, Rights, Privacy:**
 - a. dignity and respect
 - b. staff attitudes
- 4. Staffing:**
 - a. unresponsive or unavailable
 - b. lack of supervision
- 5. Dietary:**
 - a. assistance in eating or assistive devices
 - b. food service - quantity, quality, choice, menu
 - c. fluid availability/hydration
 - d. therapeutic diets
- 6. Admission, Transfer, Discharge, Eviction:**
 - a. proper notice, procedures, and planning failures

FY10 Number of top six verified complaints by type

Total = 1838

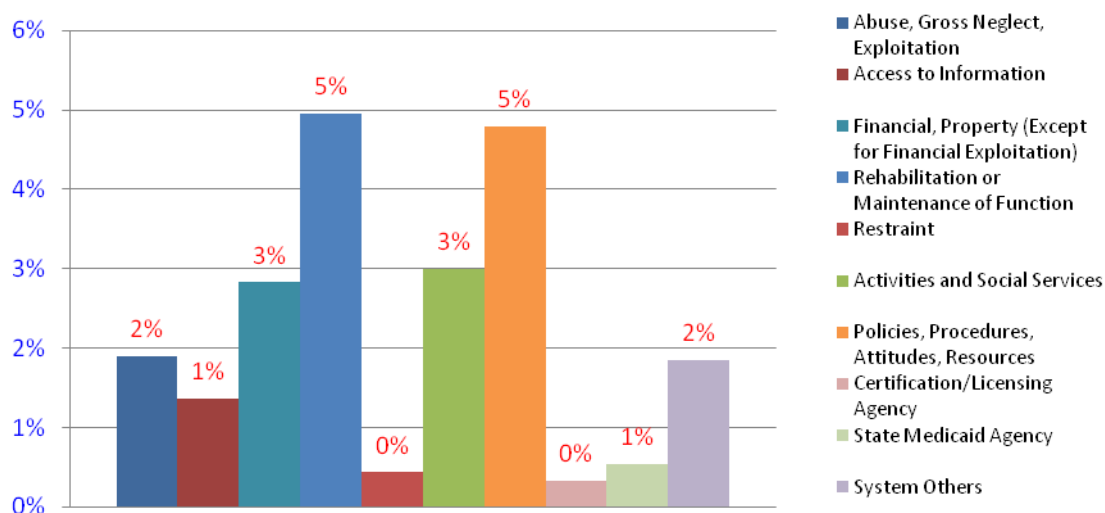
Top Six Total = 1434



Most Frequent Types of Nursing Home Complaints:

FY10 percent of complaints by type

Total= 404

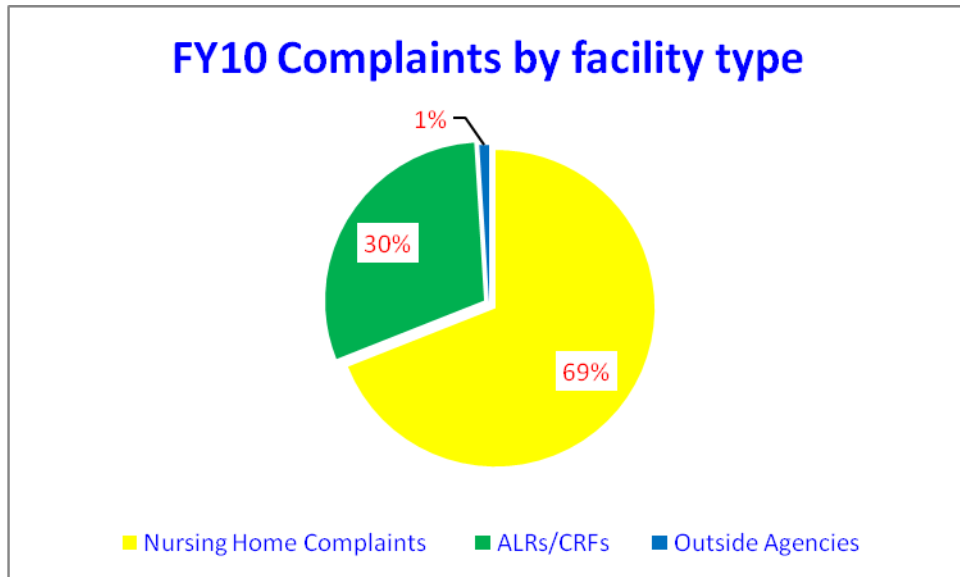


Percentage of complaints by facility type:

Nursing Homes Complaints: **1289 (69%)**

ALRs/CRFs: **549 (30%)**

Outside Agencies: **20 (1%)**



C. Hearings to Challenge Involuntary Moves of Residents

Total number of 6-108 discharge and transfer notices received:	5,046
Notices of involuntary moves challenged:	21
Hearing requests to challenge involuntary moves:	12
Mediations held:	1
Number of discharge and transfer meetings held to prevent issuance of discharge notice:	20
Cases won: (Including status conferences and mediation)	100%

D. Ombudsman Program Presence in Long-Term Care Facilities

Nursing Facilities:

Total number of hours spent by ombudsman staff and volunteers in nursing facilities:	2,959
Total number of volunteers:	43
Number of volunteer ombudsmen visiting long-term care facilities:	8
Number of volunteer ombudsmen participating in program activities, legislation, advocacy, etc.:	35
Total number of volunteer hours: ⁵	1,022
Total number of intern hours:	21
Grand total of volunteer and intern hours:	1,043
Estimated programmatic volunteer and intern savings ⁶	\$34,199.97

Board and Care Visitations:

Number of CRFs and MHCRF visited:	136⁷
Number of ALR visits:	6
Non-licensed CRF or ALR visits:	4⁸
Suspected unlicensed CRFs visited:	3

⁵Volunteer hours consist of: training seminars, information and consultation to individuals, resident visitation (complaint/non-complaint, resident and family council meetings, community education efforts and travel time between events.

⁶Independent Sector. Value of Volunteer Time Report, found at : www.independentsector.org

⁷ For both CRF and assisted-living facilities, the numbers reported reflect repeat staff visits because of repeated visits to same facilities and not necessarily a visit to each facility..

⁸ Non-licensed long-term care facility means hospital, psychiatric hospital, or independent living units.

E. COMMUNITY OUTREACH PROGRAM ACTIVITY REPORT

In FY 10, the DC Long-Term Care Ombudsman Program participated in the following:

- Provided 300 hours of volunteer training sessions accomplished in classroom, field and special training to over 40 trainees.
- Conducted in-service education to facility staff hours in the following top three requested categories:
 - a. Psychosocial issues (behavioral problems) resident issues in long-term care facilities
 - b. Care planning and techniques
 - c. DC Discharge, Transfer, and Relocation Law and planning
- Conducted 188 consultations to facilities or providers for a total of 260 staff and volunteer hours in the following ranked categories:
 - a. Access by or to ombudsman/visitors
 - b. Discharge/eviction, planning
 - c. Room assignment/room change/transfer
 - d. Symptoms unattended, including pain management
- Provided 677 consultations to individuals or the general public for a total of 720 hours in the following ranked categories:
 - a. Medicaid/Medicaid Waivers
 - b. Discharge/eviction, planning
 - c. Legal assistance (discharge/Medicaid appeals, mediations, etc.)
 - d. Information regarding medical condition
 - e. Participation in care planning by resident or designated surrogate
- Provided 205 resident visitations (non-complaint related) including number of visitations to non-licensed long-term care facilities (e.g.: hospitals, psychiatric units, and hospice) for a total of 400.32 hours.
- Participated in 8 of 19 nursing home survey reviews; provided complaint data, trends, and suggestions to improve quality of care and life for residents.

- Attended 112 resident council meetings throughout the fiscal year totaling 123 hours of staff and volunteer time.
- Attended 53 family council meetings for a total of 56 hours of staff and volunteer time to support family councils in such areas as: legal and contractual support, managerial culture change, increasing staff support and resources to improve delivery of care.
- Participated in 64 community educational or community events reaching over 1500 DC residents.
- Conducted 32 individual Medicaid/Medicaid Waiver transitioning meetings with residents, family members, and other advocates to assist nursing home residents' transition to the community.
- Provided 21 training sessions to local and federal government workers pertaining to Ombudsman Program services, ombudsman investigations and legal techniques.
- Conducted 5 media interviews, which includes, but is not limited to, working with: The Washingtonian Magazine, The Washington Post Newspaper and Inside E Street Television Show.
- Participated in 17 city council meetings presenting both oral and written testimony to the Committees on Health, Human Service, Aging and Community Affairs and the Committee of the Whole.
- Spent approximately 145 staff hours during 63 individual sessions to monitor and work on laws, regulations, and policies affecting long-term care residents.



FY 10 Residents' Rights Luncheon at Ingleside Presbyterian Retirement Community

SIGNIFICANT ACHIEVEMENTS

***2,974 People Served
5,000 LTC Population⁹***

In FY 10, the DC Long-Term Care Ombudsman Program achieved the following:

- The Ombudsman Program was an integral part of the Department of Mental Health's closure of eleven MHCRFs. This included six independent facilities with thirty-four residents and five contracted facilities with thirty-one residents, a total of 65 residents. The Ombudsman Program collaborated with DMH to recognize needed closures and sanctions for providers with repeated and egregious violations that adversely affected the lives – quality of care and life of the residents. Subsequently, the Ombudsman Program played a significant role in the transitioning of these residents to alternative residences.
- For the first time, and in addition to the long standing Memorandum of Agreement (MOA) with the Department of Mental Health, the Ombudsman Program was successful in securing MOAs with Adult Protective Services, Department of Health and the Department of Health Care Finance.
- In November 2009, DCLTCOP intervened in a case which was referred from a social worker with University Legal Services. The case concerned a resident who had allegedly assaulted a staff person at a MHCRF and was subsequently hospitalized. After the resident was found to be stabilized, the provider was refusing readmission without following any of the required discharge procedures. The Board and Care Ombudsman investigated the case and learned that the intensive services which were supposed to be provided to resident by the MHCRF (contracted) and case management team had not been provided. A complaint was filed with DMH. Also, both the Ombudsman Attorney and Board and Care Ombudsman provided information to the provider about the discharge process and requirement of a 21 day notice, except for emergency. After a meeting with the case management team and hospital team, provider accepted resident back into facility with appropriate supports.
- In January 2010, DCLTCOP was notified that a nursing home was planning to implement a facility-wide policy, stating any resident who leaves the facility AMA (against medical advice) would be subject to having his/her belongings searched upon return to the facility. The DCLTCOP attorney researched both federal and local laws and provided a legal response to the facility why this policy should not be initiated. In addition, a nursing home ombudsman intervened on behalf of residents who were told they would be subjected to this new policy. The administrator agreed with DCLTOP's analysis and the new policy was rescinded.
- In February 2010, DCLTCOP challenged a proposed parking space policy of a long-term

⁹ According to the reported DC LTC facility's capacity, the number exceeds 5,000

care facility with both nursing home and assisted living residents. We wrote to the administrator stating the proposed new parking space lease was inappropriate for long-term care residents and recommended rescinding policy until feedback from the residents could be obtained. On February 17, 2010, the Board and Care Ombudsman and Ombudsman Attorney met with the administrator and their legal counsel to discuss these changes. It was agreed that the facility would postpone implementation of the new parking lease policy and that DCLTCOP would submit comments and suggestions that would be reviewed by their counsel. A new policy was formed based on this additional input.

- In March 2010, DCLTCOP attorney received a notice from Office of Administrative Hearings that a guardian had filed an appeal on behalf of a nursing home resident, who had been transferred to a hospital. There was a disagreement regarding her readmission based on medical advice being provided by the hospital. The assigned Nursing Home Ombudsman, initiated discussion with the guardian to determine conflict. Apparently, there was concern whether the resident could swallow, and thus the nursing home staff was unsure how to provide nutrition and hydration upon readmission. While the resident had a tube inserted in her nose for nutrition, hydration and medication, the hospital stated it was only temporary and that she needed a more permanent “G-Tube” for nutrition, hydration and medication. The guardian questioned the adequacy of the information received to make this decision; therefore the Ombudsman attorney participated in a hearing before an administrative law judge. A continuance was requested for more time to determine resident’s condition, medical needs and directions for readmission. The judge granted more time, but requested that a formal motion be filed if both parties reached an agreement. The ombudsman interviewed the resident, reviewed medical records, and assisted the guardian in getting a second opinion. The guardian agreed to the “G-Tube” and the facility agreed to readmit the resident. The attorney filed a Motion of Continuance which outlined the agreement and the next steps to be taken. The motion was granted by the judge and the case was closed.
- In April 2010 the DCLTCOP Volunteer Coordinator initiated a first ever webinar on Advance Directives in recognition of National Healthcare Decisions Day 2010. Panelists included the DCLTCOP Ombudsman Attorney and an attorney from Legal Counsel for the Elderly.
- In May of 2010, DCLTOCP participated in a case in which a resident was being forced to vacate his bed. The facility alleged he had reached a plateau and no longer needed long-term care services. The daughter had concerns that he still required skilled nursing care. She also had concerns regarding the proposed relocations offered for her father. She wanted him to remain in DC. There were issues surrounding his eligibility for DC Medicaid because he was in a Maryland Nursing Home facility and received Medicaid via the state of Maryland. The Ombudsman Attorney coordinated conference calls and negotiated an agreement between the parties in which the resident would remain in the facility while an appropriate placement was obtained. In conclusion, the resident was discharged to a nursing home of the family member and residents’ choice.
- In May of 2010 the Board and Care Manager coordinated a “*look back*” session for the Department of Health Officials and Assisted Living Residences Administrators for a review of the ALR regulations and survey process since recent implementation.

- In August of 2010, DCLTCOP Attorney and Ombudsman provided legal assistance on behalf of a MHCRF resident who was threatened with discharge from the agency where she received community support services. The agency stated the reason for the discharge was because the daughter was not happy with services provided to her mother. The family member was advised that the agency could not summarily discharge the resident per DC law. The Division of Licensure for DMH agreed and rescinded the discharge of the resident.
- Throughout the year, the Ombudsman Program:
 - Facilitated re-activation of three nursing home family councils (Thomas Circle, Rock Creek Manor, Knollwood); conducted staff training and family education on regulations and guidelines.
 - Facilitated resolution of systemic complaints of lost/missing resident clothing, dirty and broken wheelchairs, and wheelchairs not being returned to appropriate residents.



Ombudsman staff and volunteers in long-term care issues discussion

RECOMMENDATIONS FOR LEGISLATIVE SYSTEMS AND REGULATORY CHANGES

Inadequate Staffing

PROBLEM: Staffing shortages continued to be a major issue in DC nursing facilities, in part because of poor benefits and wages of certified nursing assistants, especially now that this staffing shortage is the third most commonly reported complaint in FY 07. The high maintenance needs of residents and low retention rate for nursing staff are the most serious areas of concern for nursing home administrators.

Update - Partially Resolved: After working collaboratively with DC Councilmember and Chair of Health Committee, David Catania, the Health Care Facilities Improvement Act of 2010 was passed on March 1, 2010. This law increased minimum staffing requirements from 3.5 to 4.1 hours per resident per day as well increased on-site medical services in order to reduce unnecessary emergency room visits and hospitalizations. The Ombudsman Program has provided input to the Department of Health/Health Regulatory and Licensing Administration (DOH/HRLA) this summer when work began on drafting implementing regulations. With AARP DC, we recommended the regulations follow both the letter and spirit of the law. The Ombudsman Program will continue to monitor the final publishing of the regulations as well as implementation of this law.

Amendments to and Implementation of the DC Assisted-Living Residence Regulations Act of 2000

PROBLEM: Residents in assisted living residences now regulated under the DC Assisted Living Residence Regulation Act of 2000, §44-101 et.seq. continue to receive uneven services and quality of care due because of delays in the enforcement as well as lack of compliance by providers.

The DOH/HRLA appeared to increase its monitoring of providers, but the Ombudsman Program is concerned that sufficient sanctions are not being imposed against providers who are providing inadequate services or operating below minimum standards. Currently, the DOH/HRLA website does not provide notices of infractions levied against assisted living residences so this information is not available to the Ombudsman Program or general public.

DOH/HRLA collaborated with the Ombudsman Program in June 2010 to host a provider forum to review implementation of the law, but providers still do not comply with the law especially in terms of the ISP (Individual Service Plan) for residents and discharge planning. Providers need additional trainings to comply with the licensing standards.

Recommendations for system-wide change:

Advocate for the Department of Health (DOH) to impose higher penalties for civil infractions to licensed (and unlicensed) ALR providers.

Advocate for the DOH, Health Regulation and Licensing Administration, and the Adult Protective Services to assist with inspections of suspected unsafe ALR programs and to introduce new enforcement monitoring schedules to address residents' rights violations.

Register the severity of the issues with policy makers and legislators.

Continue to work with advocates, legislators, regulators, and the community to generate a supply of quality assisted-living residences.

Continue to work closely with the DOH to ensure that workable policies and procedures are established, implemented, and enforced and that DOH develops administrative policies and procedures for its ALR regulatory system.

Insufficient Oversight and Weak Enforcement of Mental Health Case Management Services for DC MHCRF and Supported Independent Living Residents

PROBLEM: Residents in CRFs, MHCRFs, and SILs under 22 DCMR Chapters 34 and 38 continue to endure unprofessionally delivered services and poor quality of care because of untrained community residential providers.

Barriers to resolution: Unmonitored providers are not sanctioned or held to any licensing standard because enforcement teams are not upholding and enforcing the DC Municipal Regulations governing all CRF providers.

DMH SIL providers are not sanctioned or held to the licensing standards due to the definition of their contracted services, even though providers continue to deliver the same mental health community services to residents.

DMH certified community based service providers of case management and representative payee services are not sanctioned for mismanaging community-based services or residents' funds.

Recommendations for system-wide change:

Advocate for both the Department of Health and the DMH to impose higher monetary penalties for civil infractions by unlicensed and licensed CRF providers.

Advocate for the DCRA, University Legal Services, and the Adult Protective Services to assist with inspections of suspected unlicensed, unsafe housing programs and to introduce new enforcement

regulations to address non-licensed housing units.

Register the severity of the issues with policy makers and legislators.

Continue to work with advocates, legislators, regulators, and the community to generate a supply of quality CRFs and assisted-living residences.

Continue to work closely with the DMH to ensure that workable policies and procedures are created, implemented, and enforced and that DOH develop administrative policies and procedures for its CRF regulatory system.

Continue to work closely with DMH and DOH ensuring that the Memorandum of Agreements are upheld by each agency, including sharing information regarding complaints, unusual incidents, annual reports, and quarterly meetings.

Work closely with the DOH and DMH enforcement offices to advocate for managerial oversight of case management and representative payee/ money-management services.

Family and Resident Council Regulation Implementation

PROBLEM: Facilities interfere with both resident and family councils, and the Department of Health states that there are no local regulations to protect resident and family councils. Councils in the nursing home are not protected and are strongly influenced by providers regarding how each council produces grievances, how the city council secures testimony, or how councils can positively impact their own living environments.

Update - Partially Resolved: Through collaborative efforts with DC Council Member and Chair of Health Committee, David Catania, the Health Care Facilities Improvement Act of 2010 was passed on March 1, 2010 and addresses the creation of resident and family council protections with nursing homes. Currently, DOH/HRLA is working on drafting implementing regulations and the Ombudsman Program is advocating that the regulations mirror the law which strengthens family and resident councils.

Barriers to resolution: Because the DCMR Title 22, Chapter 32, does not list either family or resident council protective services, the long-term care providers can interfere with formation and performance of each council without fear of enforcement of sanctions or fines.

Recommendations:

Ensure that the newly accepted regulations are published in the DC Municipal Regulations (DCMR) and enforced by DOH and HRA.

Strengthening DC's Lemon Law

PROBLEM: Both long-term care and home-bound residents receiving defective durable medical equipment do not have current protections under DC Law, Title 50, Subtitle II, Chapter 5, to obtain

replacement equipment.

Update – Resolved: After drafting and supporting expansion of DC’s lemon law to cover durable medical equipment and assistive devices, the DC Long-Term Ombudsman Program is proud to announce the passage of the *Assistive Technological Device Warranty Act of 2009*. Lydia Williams, Interim State Long-Term Care Ombudsman testified before DC Council on June 14, 2010 and the Act became law on October 26, 2010. This law will extend protection that is currently provided to consumers who purchase defective or “lemon” automobiles to consumers who purchase assistive technology devices (devices). In order to ensure that all DC residents are informed of the new law and their rights, the Ombudsman Program is collaborating with AARP DC to host a roundtable for other stakeholders to discuss the law and its implementation.

Ombudsman Program Expansion into Home Health Coverage

PROBLEM: Due to the national and DC trend to transition long-term care and institutionalized residents into the community through a host of federal and local programs, such as: Money Follows the Person, DC Olmstead Plan, and Medicaid Waiver programs; the District of Columbia is not prepared to deliver legal or advocacy services to residents aging in their homes.

Barriers to resolution: The DC Long-Term Care Ombudsman Program local and federal mandates do not address fiscal or programmatic expansion of how the Ombudsman Program can monitor care, advocate on behalf of, or offer and provide legal assistance to residents receiving home health services.

Update: The Ombudsman Program developed strong language to amend its laws and policies to incorporate home health advocacy oversight for residents aging in place. In addition, the Ombudsman Program is hopeful that the bill will be introduced by City Council in FY 11.

Recommendations:

Continue to work closely with the DCOA, LCE, City Councilmember Marion Barry (Chair of the Committee on Aging and Community Affairs), and other stakeholders to strengthen the LTC Ombudsman Program mandates and funding streams.

Develop policies and procedures to address home health ombudsmen function, complaint reporting, ethical issue, and mission.

Continue to partner with the Department of Healthcare Finance and Department of Health to create, comment, and monitor policies, regulations, and legislation that may affect home health programs, transitioning residents from long-term care facilities to the community, and ensure complaint trends are being reported to both agencies for their quality assurance review.

VOLUNTEERS

The Ombudsman Program volunteers continue to strengthen and augment the advocacy efforts for District residents receiving long-term care services in nursing homes, assisted living residences and community residential facilities. The volunteers make it possible for the Ombudsman Program to meet its federal and local mandates. The continued growth in the number of volunteers has resulted in increased community coverage continuing the program's long-term care facility presence. The volunteers provided assistance in the following activities and events:

- Residents' Rights Week Luncheon: Volunteers participated in efforts to bring awareness of and take part in celebrating residents' rights at the annual luncheon hosted by one of the local nursing homes.
- Community Outreach and Education: Volunteers educated the community and residents about the services provided by the ombudsman program to empower them with information for self advocacy.
- Monitoring: Volunteers were assigned to and conducted weekly monitoring in the long-term care facilities throughout the eight wards in the District.
- Complaint Investigation: Seasoned volunteers, under the supervision of designated ombudsman staff, assist and conduct initial complaint investigations.



Left to right; Sheila Wickowski, Genesis Cachedon, Elizabeth Wright

The Office of the DC Long-Term Care Ombudsman wishes to express its appreciation to the volunteers for their unyielding efforts on behalf of District residents in long-term care facilities.



Volunteers in training session

Thank You Ombudsman Volunteers for a great Fiscal Year 2010:

Patricia Acquah, Albertha Alford, Joan Bailey, Shirley Braxton, Stephanie Brown, Alice Burke, Johnnie Cain, Dora Carter, Ramone Dash, Consuella Ellis, Michael Fain, Diane Ford, Carolyn Gilmore, Barbara Hanson, Deborah Harrington, Vera Hayes, Theresa Jenkins, Luzette King, James Kutcher, Ann Lochstampfor, Robert Lubic, Judith Millon, Alberta Murray, Joe-Brenda Musgrave, Thelma Oshin, Claire Riley, Barbara Session, Earnest Stewart, Sally Sullivan, Sheryl Templeman, Katherine Warner, Sheila Wickouski, Joseph Witherspoon, Elizabeth Wright, Camilla Younger

RESOURCES FOR THE OMBUDSMAN PROGRAM AND GENERAL PUBLIC

Additional long-term care information, support, or services can be found at the following websites:

AARP DC	www.aarp.org
Alzheimer's Association	www.alz.org
Bar Association of the District of Columbia	www.badc.org
Catholic University of America, Columbus School of Law	www.law.cua.edu
Center for Medicare Advocacy	www.medicareadvocacy.org
Centers for Medicare and Medicaid Services, Nursing Home Compare	www.medicare.gov
DC Office on Aging	www.dcoa.dc.gov
DC Office on Aging, Aging and Disability Resource Center	www.adrc.dc.gov
District of Columbia Bar	www.dcbbar.org
Legal Counsel for the Elderly	www.aarp.org/lce/
NASOP: National Association of State Long-Term Care Ombudsman Programs	www.nasop.org
National Academy of Elder Law Attorneys	www.naela.org
National Senior Citizens Law Center	www.nslc.org
NCCNHR: The National Consumer Voice for Long-Term Quality Care	www.theconsumervoice.org
NORC: National Ombudsman Resource Center	www.ltombudsman.org
Office of the DC Long-Term Care Ombudsman Program	www.aarp.org/family/caegiving/ articles/lce_longtermcare.html
Parkinson's Association	www.apdaparkinson.org

Office of the DC Long-Term Care Ombudsman

Legal Counsel for the Elderly

601 E Street, NW

Washington, DC 20049

(202) 434-2190 (Office)

(202) 434-6595 (Fax)

www.aarp.org/lce

Legal Counsel for the Elderly is affiliated with AARP and is a part of the Senior Service Network----

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