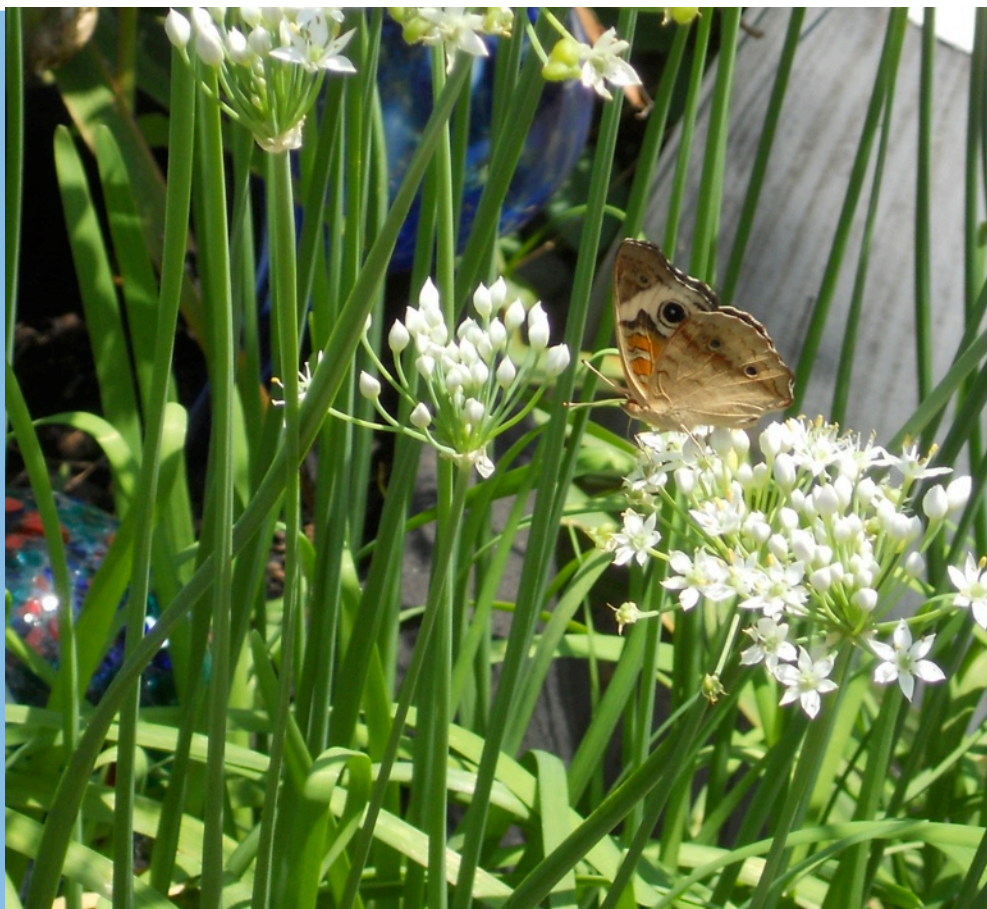


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A place in the sun for everyone

Voices for Quality Care Update 2010

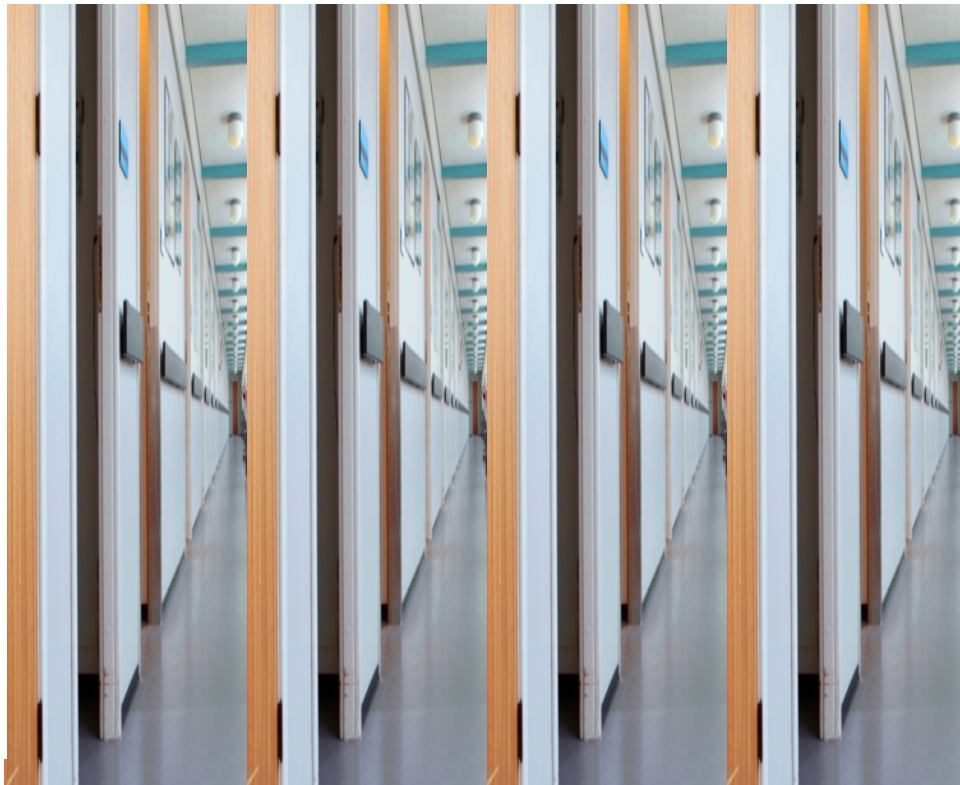
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<http://voicesforqualitycare.org>

1 (888) 600-2375



Meet our new Board Member:

Gerald Kasunic

Gerald "Jerry" Kasunic, is co-owner of Northern Tides, Inc, an art and gift gallery in Lubec, Maine; and manages rental units within Washington County, Maine, year round. Previously, he was the State Ombudsman for the District of Columbia. He was liaison for the National Association of State Long-Term Care Ombudsman Programs and the DC City Council representing both on Capitol Hill.

For more than 19 years, Jerry managed complex health services and advocacy programs serving and protecting DC residents. These duties included dealing with public benefit fraud, health care neglect and abuse, identity theft, illegal discharge practices that potentially caused homelessness, Medicare and Medicaid appeals, contract and arbitration hearings. His work involved all phases of complaint investigation, systemic policy, and legislative advocacy.

In addition to his day-to-day responsibilities as Ombudsman, Jerry was a member of the Olmstead Planning Committee, the Money Follows the Person Initiative Program, an honorary member of the Medical Care Advisory Committee, a member of the National Citizens Coalition for Nursing Home Reform, a member and liaison of the National Association of State Long-Term Care Ombudsman Programs, a member of the Leadership Council of Aging Organizations, a member of the DC Office on Aging's Adult Abuse Prevention Committee, and a mentor for new State Long-Term Care Ombudsman Program Directors.

What have we done this year?

- Conducted 2 Members' Meetings at Holy Trinity Church in Bowie, MD
- Provided Voices representatives to national and state level committee and workgroup meetings
 - Center for Medicare & Medicaid Services Stakeholders' Group
 - Nursing Home & Assisted Living Quality of Care Oversight Committee
 - Ombudsman Program Stakeholders Committee
 - L-PAC Workgroup
 - House Bill 30 work group (Hospice)
 - Money Follows the Person
 - Long-Term Care Workgroup
 - Advancing Excellence Lane
- Responded to 55 helpline and email requests for assistance
- Attended Family Council meetings
- Advocated for Family Councils experiencing difficulties with the regulatory processes
- Attended numerous care conferences
- Provided individual advocacy
- Clarified the purchasing of hearing aids, glasses, dentures, and the like for persons receiving Medicaid funding for long-term care services.
- Continually monitored the state of the Maryland Ombudsman Program
- Sent multiple letters explaining the needs of long-term care residents and their families and friends to
 - Becky Kurtz: National Ombudsman
 - Secretary Kathleen Sebelius, Secretary of the U.S. Department of Health and Human Services
 - Maryland Governor Martin O'Malley
 - Secretary Gloria Lawlah, Maryland Department of Aging

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What have we done this year? (continued from page 2)

- Secretary John Colmers, Maryland Department of Health & Mental Hygiene
- Senior Deputy Director Feseha Woldu, Washington, D.C. Department of Health
- Alice Hedt, Maryland State Ombudsman
- Lynne Person, Washington, D.C. State Ombudsman
- Attorney General Peter Nichols, Attorney General Washington, D.C.
- Attorney General Douglas Gansler, Attorney General Maryland
- Director Nancy Grimm, Maryland Office of Health Care Quality
- U.S. Senator Barbara Mikulski
- U.S. Senator Ben Cardin
- U.S. Representative Steny Hoyer
- Met with
 - Delegates from the Health & Government Operations Committee to explain the needs of people needing long-term care services and their families
- Nancy Grimm and the staff of the Maryland Office of Health Care Quality
- Alice Hedt, Maryland State Ombudsman
- A group of people from organizations interested in the improvement of Maryland's Long-Term Care Ombudsman Program
- Provided information to the Maryland Senate Finance Committee, the House Health & Government Operations Committee, and House and Senate Budget Subcommittees regarding how their decisions would impact people needing long-term care services
- Voices is a member of both state and national level organizations
 - Maryland Association of Non-Profit Organizations
 - Medicaid Matters! Maryland
 - Assisted Living Consumer Alliance
 - The National Consumer Voice for Quality Long-Term Care
 - Coalition for Quality Care

Voices Board of Directors

Chair: Kate Ricks
Kate is a retired teacher and advocate for hearing impaired students. She became an advocate for people needing long-term care services and their families when her father entered a nursing home 12 years ago.

Vice-Chair: Bob Bronaugh

Bob is also the President of the Manor Care Chevy Chase Family Council. Both his mother (Advanced Alzheimer's) and his aunt (inoperable brain tumor) died in Montgomery County nursing homes in 2000, 18 days apart. A lifetime resident of Chevy Chase, Bob works full time and specializes in researching the corporate ownership maze of our states' long-term care facilities.

Corporate Treasurer: Clare Whitbeck

Clare is also our Legislative Liaison. Recruited in 2002, she has served as an advocate for residents and families in nursing homes since 2003 along with her corporate duties. When she's not working for Voices, Clare is the grandmother of three four year olds She can even sometimes be found "on the boat."

Board Member: Jacqueline (Jackie) Anderson

Jackie also serves as Co-chair of the Patuxent River Health and Rehabilitation Center Family Council in Laurel. Jackie's advocacy is a result of her mother's nursing home experiences from 2001 to 2009. A native Washingtonian (DC) and a long-time PG County resident, Jackie is passionate about holding long-term care establishments accountable for delivering quality services.

Board Member: Susan Eddy
Susan is co-founder and vice-chair of Heron Point of Chestertown Family Council which has been meeting monthly since 2005.

Our Mission

Voices for Quality Care (LTC), Inc. is a state-wide, all-volunteer, non-profit organization of persons needing long-term care, their friends and families, Resident and Family Councils, advocates, and concerned citizens working together for quality long-term care in Maryland and Washington, D.C. Voices provides information, support, assistance and referrals, encourages the development and continuance of strong resident and family councils, and advocates for responsible public policy.



Legislative Considerations for the Maryland 2011 General Assembly Session

by Clare Whitbeck

Voices has spent the last three years working on improving the Long-term Care Ombudsman Program. With the new Ombudsman Law and the Department of Aging's apparent intent to continue to allow the Maryland State Ombudsman to carry out her duties, we are ready to consider what we believe is the most important goal of all - improving staffing.

Staffing Law

Maryland regulations require only a minimum of 2 hours of direct care per person per day in nursing homes. Studies have shown that it takes a little over 4 hours per nursing home resident per day just to carry out the routine chores such as dressing, bathing, providing food, assisting with mobility, etc. Voices is proposing a law that by May 1, 2013, would require that limit to be raised to 3.67 hours of direct care.

We are considering coming back after the new law is implemented and ask for the final increase. We will need as much support as our members can provide for this effort in the form of your presence at hearings with very little notice, phone calls, e-mails, etc. Everyone working in long-term care agrees that adequate staffing is absolutely necessary for good care. We only have a few homes that are reporting staffing levels below 3.67, so this should be an easy law. However, we have included requirements for posting staffing, visible ID for all staff, etc. that may complicate matters.

Medicaid Application Process

In some meetings with legislators last year and at one hearing, we learned that the Department of Human Resources (DHR), the agency responsible for processing Medicaid applications for nursing home applicants, is functioning poorly. One family provided 5 application forms before DHR could find one to process. It was a year before the nursing home got a Medicaid approval. Meanwhile, the resident was being constantly threatened with involuntary discharge. This year we will go to the Department of Human Resources budget hearing and request that the Department be required to hire a consultant to examine the Medicaid application process and make recommendations for improving the process.

Bills Affecting People in Long-term Care

As usual, Voices will continue to scan bills introduced and look for any that will affect residents of long-term care or in-home care programs in Maryland or in Washington, D.C.

Help Wanted

If any member is particularly interested in working on any or all of these issues, please call and leave a message for me with our answering service at 1 (888) 600-2375. I'll return your call as soon as possible.

Staffing Recommendations

- Minimum staffing levels need to be stated as ratios of staff to residents for each wing, unit, or floor for each shift.
- Staffing ratios need to be stated separately for nurses and nurse's aides.



**Health Care Reform:
Beginning in 2011–
Nursing home staffing levels
will be calculated directly
from payroll data rather than
self-reported by the nursing
homes with no outside
verification.**

ADVOCATE – ADVOCATOR – ADVOCATING – ADVOCACY

by Jaqueline Anderson

NO, the above is not a riddle nor a tongue twister; IT is an introduction to one of the most important words in the dictionary, tied to what might prove to be one of the greatest responsibilities of your life!!

Webster defines advocate as one who speaks in favor of (recommend), or one who supports or defends a cause, or one who pleads in another's behalf. **And, Webster defines advocacy** as (an) active support, as of a cause.

At one time, I thought advocates were only associated with wrong doings or deceitful deeds because of these (following) two overused words, "devil's advocate." However, years of maturity, coupled with the appropriate knowledge, has provided me with a better understanding of advocates and the process in reaching one's main objective. Advocating for a worthy cause is rewarding, especially when the cause emerges from one's experience with today's traditional nursing home.

OH, DON'T be fooled!! There is no definitive way by which one becomes an advocate—the process is an art! And, generally, one's role is manifested out of some forced learning experience; e.g., those experiences developed through concerns over deficiencies or inadequacies associated with the quality of care for a loved one, who might be an occupant of a nursing home, assisted living facility, group home, etc. And, such as life, one day you will find yourself pushed into an advocate's role, i.e., ensuring that your loved one receives the quality of care to which they are entitled, care that is government regulated, care that is a basic human right and the responsibility of the facility in which your loved one is housed and *should be serviced*.

Nevertheless, in the green sidebar you will see some basic steps to use until you have developed your own advocacy style.

1. Educate yourself as to family/resident rights and the responsibility of the facility to adhere to those rights;
2. Participate in your loved one's medical management by attending Care Plan Conferences with follow-ups as to those agreed upon care directives;
3. Immediately address medical care issues; particularly, if they present immediate danger or harm to your loved one;
4. Be visible, visit often and introduce yourself to your loved one's direct caregivers;
5. Seek out that facility's support group- the Family Council –for guidance, information and social support. And, finally.....
6. Keep abreast of changing nursing home laws, reforms and regulations by visiting Voices for Quality Care's website. Become a Voices' member so that you can become a more powerful advocate for your loved one. Remember, a single voice only produces a whisper, but several **Voices** will surely produce a **ROAR!!**

Highlights from "Health Care Reform"

by Gerald Kasunic

It has just been over 7 months since the new health care reform bill was signed into law. The Patient Protection & Affordable Care Act (PPACA) and its companion law are intended to reform private health insurance markets, insure approximately 32 million Americans, end lifetime caps on health insurance coverage, and outlaw using pre-existing conditions as a reason for denying health insurance coverage. This ends some

of the most objectionable insurance company practices and protects consumer rights.

PPACA has some benefits for people needing long-term care services and family members planning for long-term care. Over the course of the next ten years and through the PPACA, Medicare will save approximately \$500 Billion by restructuring payments to the Medicare Advantage Program and

by attacking fraud, waste, and abuse of Medicare Programs and reinvesting the savings. In addition, premiums will increase for higher income seniors. These are expected to add 12 years of fiscal stability to Medicare. It will also begin closing the donut hole (Medicare Part D, out-of-pocket pharmaceutical expenses) over the next couple of years.

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Highlights from "Health Care Reform" (continued from page 5)

The PPACA suggests several changes over the next few years. State officials and health care professionals are working on state specific plans on how to implement these changes.

Medicare benefits will not be cut under the PPACA. This new law improves Medicare benefits by increasing its protections and guaranteeing those benefits. The Law improves and expands coverage by adding free Medicare-covered preventive care benefits, increasing access to primary care services, and stressing incentives for quality care received by beneficiaries. In fact, the PPACA financially rewards primary care doctors who treat people on Medicare, gives extra payments to health care providers in areas of the country with shortages of medical care providers, and will financially help to educate our future doctors and nurses.

Additional benefits and program reforms are also occurring in the areas of expanded choice and

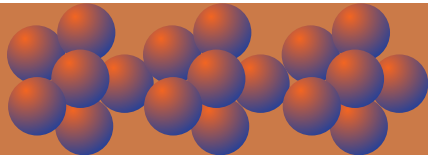
consumer protections. The federal and state government health care agencies are focusing on enhancing the Money Follows the Person Program (MFP).

MFP is a program created to rebalance state Medicaid dollars in order to increase the opportunities for home health care for Americans who wish to receive long-term care services at home rather than being admitted into a nursing home. Under the MFP and the health care reform laws, home and community based Medicaid waiver programs, (HCBW) will provide benefit options and individual rights protections to stay at home. MFP and HCBW waiver programs will pay for, or supplement, the services received at home. Check with your state Medicaid Office for eligibility requirements.

An additional program being created is entitled Community First Choice Option (CFC). CFC is focused on providing community benefits to people with disabilities. These include rental subsidies,

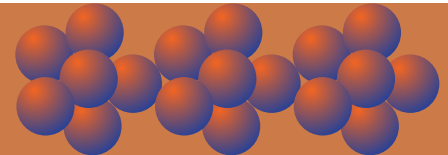
household and furniture assistance, Americans with Disabilities Act compliance support, and other funding incentives to transition into the community or remain within their homes with community support.

Through these reforms, more and more Americans will be able to stay home and avoid institutionalization, save out-of-pocket monies, and know that their rights will be protected. Furthermore, we must keep in mind that this law, like many reform laws prior to it, is a blossoming document that will need constant reviewing and strengthening over time. Our legislatures and government administrators must be kept informed when our rights, tax dollars, or personal out-of-pocket funds become subject to exploitation and profiteering. And, we as advocates, family members, and long-term care residents, should ensure our Voices are always at the table to defend our health care rights and to be heard.



Considering the Future

by Susan Eddy



We are on the threshold of an increasingly older society. Yet we are no way prepared for years of "protracted debility, dementia, and dependence" of the elderly, according to a Presidential Council on Bioethics. The Council calls this a "looming crisis" in its 2005 report Taking Care: Ethical Caregiving in Our Aging Society.

A married couple with four living parents is facing a 52 percent chance that two out of the four parents will live 5 to 10 years unable to care for themselves. This same couple faces a 87

percent chance that one of the four will die after a period of prolonged frailty.

Fast forward 40 years and close to half those caregiving children will need long-term care themselves. In 2050, the US population will have 18 million people over 85, a quadrupling of that age group in 50 years.

Yet as the population becomes increasingly older, the number of those in the caregiving age group is decreasing. Soon both paid and unpaid caregivers will be in short supply.

The Council recommends research and planning to avoid what could become a destructive conflict between generations and neglect and abandonment of the frail elderly. Specifically, the council points to the importance of fostering cooperation among families, professional caregivers, and caregiving institutions.

There are many challenges ahead: ethical, social, economic, and medical. The council report reminds us, however, that old age and dying are not problems to be solved but "human experiences that must be faced".

The senses: Often Forgotten Bits of Long-Term Care

The long-term care community tends to focus primarily on quality of care issues giving far less attention to quality of life issues. Even so, there are some issues affecting not only quality of life, but also and equally quality of care, that are only rarely sufficiently addressed. "Can you see this?" "Can you hear that?" Negative answers to these questions do not tend to generate fast remedial responses. Consider for a moment how many of those "behaviors" we attribute to a decline in mental status might, in reality, be simply responses to diminished sensory clues.

Sunlight and Interior Lighting

It is well documented that daily exposure to direct sunlight impacts both physical and mental well-being. Exposure to sunlight affects the circadian rhythms, the natural 24-hour cycles of physiological and behavioral processes that include the sleep-wake cycles, body temperature, blood pressure, and the release of hormones. Direct sunlight is important in the synthesis of vitamin D which influences the body's ability to absorb the calcium so important in the prevention of osteoporosis and bone loss.

Eunice Noell-Waggoner of the Illuminating Engineering Society of North America states, "Typical interior lighting does not contain the spectrum to treat vitamin D deficiency or the spectrum to which the circadian system is most sensitive."¹ We've learned to create light but we still can't match the sun. It has been shown that even as little as 15 minutes of direct sunlight per day on hands and face can have a major impact on reducing hip fractures.

This is something to consider when speaking of the "sundowner" traits of some persons with dementia and other nursing home and assisted living residents with disrupted sleep patterns. Is the interior lighting and the exposure to direct sunlight a contributing factor? How many of our nursing homes particularly have some means of regular exposure to direct sunlight through enclosed courtyards or atriums? How many of our dementia units are tucked away in locked wards where residents have little or no exposure to direct sunlight year after year?

Area Minimum Lighting

For assisted living facilities in Maryland, for both nursing homes and assisted living facilities in Washington, D.C., and in the federal regulations the only requirement for lighting is that there should be "adequate" light.



Area Minimum Lighting

- ✓ Administrative areas - 30 foot candles
- ✓ Dining areas - 30 foot candles
- ✓ Recreation areas - 100 foot candles
- ✓ Patient's room - 10 foot candles
- ✓ Patient's reading lamps - 30 foot candles
- ✓ Nurses' station - 20 foot candles
- ✓ Medicine storage and preparation area - 100 foot candles
- ✓ Stairways - 20 foot candles
- ✓ Corridors - 20 foot candles

Hearing

Untreated hearing loss can lead to

- Irritability
- Negativism
- Anger
- Fatigue
- Tension
- Stress
- Depression
- Paranoia
- Diminished psychological and overall health

And those don't even begin to include the effects not being able to hear will have on the daily lives of people in long-term care situations. There isn't all that much to do for most of these folks. When you can no longer hear well enough to follow a favorite television program or to hold a conversation or use the telephone, life can become boring and maybe a little more dangerous. If you can't hear a car, cart, or wheelchair coming up behind you, you won't now it's time to move out of the way.

We had a personal experience that demonstrates one consequence very well. A psychiatrist was in to evaluate the medications being given for depression.

From the psychiatrist's view: asked a series of questions, the resident answered only 2 of them correctly. Conclusion? Disoriented as to time and place, dementia onset. Aricept prescribed.

From the resident's view: She didn't have her hearing aids on. She wondered who that lady was. She could barely hear her and couldn't understand anything she was saying.

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Clearly this was a waste of time for both physician and resident. The Aricept prescription was never filled, another physician did the medication review. Fortunately the family and the nursing home staff recognized the problem rather than simply following instructions.

Hearing aids are the primary assistive devices for hearing loss today, but they are very expensive. There are some financial assists for those who do not have the funds to pay for hearing aids, however. In Maryland, Medicaid will pay for hearing aids for people in nursing homes if they have some form of personal income such as a pension or social security. For people unable to find any source of funding, the Starkey Hearing Aid company



runs a program called Hear Now which provides hearing aids at a very low cost for those who qualify.

Vision

Poor vision is equally disruptive in the lives of people needing long-term care services. For people who enjoy reading and television, this can be devastating.

Eyesight does deteriorate as we age as those of us who wear glasses can attest. The amount of light getting to the retina at age 25, for instance, is 100% whereas the amount of light getting to the retina at age 75 is just 25%. And, it takes longer for the eyes to adjust to changes from light to dark and from dark to light as we age. Consider a young nurse or aide in the 25-35 year age range standing with an assisted living facility resident who is 85. From the nurse or aide's perspective, the light in the room is quite sufficient. To the resident, the room looks dark.

This diminishing use of available light makes distinguishing between contrasting colors more difficult. How many of the eating difficulties are actually caused by poor eyesight? White mashed potatoes on a white plate are hard to see.

Coverage of Non-Covered Medical Services for Medicaid Nursing Home Recipients (such as dental services, eyeglasses & hearing aids)

- ✓ The recipient visits a dentist, optometrist; hearing aid specialist, etc. and receives medically necessary services or a signed contract for services.
- ✓ The recipient, recipient's representative, or nursing home social worker submits the bill or signed contract for services to the DSS Long Term Care caseworker.
- ✓ The DSS caseworker contacts the Division of Eligibility Services to "price" the amount of allowable costs that may be deducted from the recipient's available income. The Medicaid fee in effect for the service or the provider's charge is deducted, whichever amount is less. If a Medicaid fee is not established for the service, the provider's reasonable and actual charge is deducted.
- ✓ The caseworker reduces the monthly available income for the cost of care by the allowed amount for as many months as it takes to cover the expense.
- ✓ Medicaid's payment to the nursing home is increased to an amount equal to the amount of the reduction in the patient's available income.

This procedure is only applicable for patients in a nursing home who have available income for their cost of care.

Taste

Poor appetites are a chronic problem in long-term care situations. Changes in the sense of taste and smell probably account for many of these. Taste initially occurs in the taste buds on the tongue. There are four major taste sensations, sweet, salty, sour, and bitter. The refinements in taste beyond that come from the sense of smell working in conjunction with the sense of taste. A decline in the sense of taste is not necessarily an automatic component of aging. However, lifetime habits can contribute to this gradual decline and certain medicines can precipitate a more rapid response.

Some medications affect the sense of taste as can some diseases. Since people who need long-term care often take many medications, the possibility of one or more of them affecting the sense of taste increases.

¹Noell-Waggoner, Eunice, LC, IESNA: Lighting In Nursing Homes—The Unmet Need, <http://www.centerofdesign.org/pdf/LightingNursingHomeUnmetNeed.pdf>

If Medicaid isn't sufficient contact:

Starkey Hearing Foundation Hear Now!

Provides hearing aids for people who have no resources of their own.

<http://www.starkeyhearingfoundation.org/hear-now.php>



The Importance of Staff Training

by Bob Bronaugh

An important element in improving the quality of care and reducing the number of deficiencies and complaints in our nursing homes is adequate staff training. This applies to staff at all levels, but particularly to LPN Charge Nurses and GNAs (Geriatric Nursing Assistants).

This past summer, Kate, Clare and I visited a male resident. While waiting for him to yield in a bed pan, we witnessed a female resident sitting in the hall on the edge of her wheelchair. When it came time to return this resident to her room, a GNA began rolling her down the hall, without first repositioning her in her wheelchair. The resident fell out of her wheelchair, face first on the floor, right in front of the nursing station in full view of several staff members. Fortunately, she did not suffer any injuries, but she easily could have.

When we did enter the resident's room, whom we were there to visit, I put out my hand to shake hands with him. He promptly pulled his hand back, refusing to shake hands with me, and explained that he had urine on his hands from bed pan usage. This is both a sanitary and dignity issue.

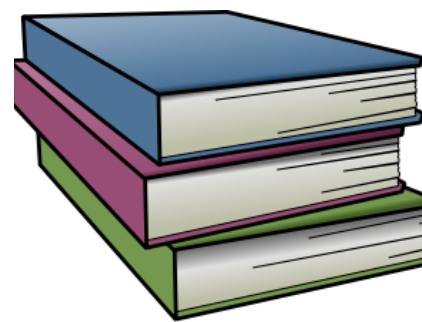
During the past three years two nursing homes that I am aware of have been cited with deficiencies for infection control, because the nursing assistants did not know that they were supposed to change their latex gloves after caring for one resident, and before caring for the next resident. These very simple instances could have easily been eliminated with proper training.

Three years ago, after a resident died, the state surveyors entered a nursing home at 4 AM to perform an Immediate Jeopardy Survey. The purpose was to determine facility and staff competency to

perform CPR on a resident with a tracheotomy. The surveyors found that one third of the nursing staff on the 11p.m.-7a.m. shift was unable to demonstrate competency in this task. They even asked the Director of Nursing to demonstrate the proper technique, and the DON failed.

Two years ago, a nursing home was cited with multiple deficiencies when its Social Worker did not take a male resident seriously when he said to his roommate "I'm going to kill you." Two weeks later, before 6 AM and during the annual survey, this resident got out of bed, walked over to his roommate who was sleeping, and proceeded to give him a severe beating. The beating was so bad that the nursing home was cited with an environmental deficiency for failing to clean up the blood spillage. What makes this situation even worse is that the staff did not know that this resident was known by others to have mental health problems.

Most nursing home Social Workers hold at least a Bachelors degree and many hold Masters degrees. Registered Nurses require two years of nursing education, LPNs require one year of nursing education, and Geriatric Nursing Assistants in Maryland require a minimum of 75 hours of training with 37.5 hours of classroom instruction and not less than 37.5 hours of supervised clinical experience in long term care. Nurses receive their training at the college level. Geriatric Nursing Assistants can receive their training at community colleges, high schools, technical schools, or in some cases directly from nursing homes that are licensed to run nursing aide training programs. 16 of the 28 Genesis Healthcare facilities offer this training, and all 9 CommuniCare nursing homes



feature these training programs. Those individuals who decide to take their training directly through these nursing home programs must agree to work for the nursing home for one year after they are licensed, or reimburse the nursing home if they decide to leave before their year ends. Most nursing homes employ an RN Staff Development Director, whose function is to provide further, or advanced, training to nursing staff.

As a result of the cost to health insurance companies, more and more patients are being discharged too soon from our hospitals and put into our nursing homes. The residents in our nursing homes are sicker than ever before, and the staffs at these nursing homes may not be adequately trained to care for them. In years past, most of these people remained in the hospital. Today, we find them in our nursing homes.

If nursing homes are to improve, we must place a higher priority on staff training.

There are no required training courses or workshops for Directors of Nursing, yet the job requires knowledge and skills not taught in most RN education programs

New State Ombudsmen!

2010 has turned out to be a year of many changes. Among the changes are the new State Ombudsmen in both Washington, D.C. and in Maryland. We welcome them both.

Meet Washington, D.C. Long-Term Care State Ombudsman

Lynne Person

Before accepting the position as the DC Long-Term Care Ombudsman effective August 9, 2010, Lynne was employed with the D.C. Department of Mental Health (DMH) from March 2002 to July 2010. She served as the Director for the Division of Licensure in the Office of Accountability from 2002-2005, where she received the Director's Award for her contributions specific to Mental Health Community Residential Facilities (MHCRFs) for District of Columbia adults with mental illness. Following an eight month period where she served as the interim Deputy Director for the Office of

Accountability, in April 2005 she assumed the role of Administrator for the Residential Treatment Center Re-Investment Program and Youth Forensics Assessment Center in the Office of Programs and Policy, Child and Youth Services Division.

Prior to DMH, Lynne was employed by Centers for Medicare and Medicaid Services (CMS- formerly HCFA) for almost two years in the Continuing Care Providers Branch, Intermediate Care Facilities for People with Mental Retardation Program as a Health Insurance Specialist. She also worked for a private MRDD

provider for over 8 years years in the capacity of: (1) QMRP/ Program Director in DC for 3.5 years; (2) Quality Insurance Specialist in Dublin, Ohio for 3 years; and (3) State Director in New Jersey for 2 years.

Lynne received B.S. in Psychology from Howard University, an M.S. in Management from Thomas Edison State College and is currently pursuing a Doctorate in Instructional Leadership. She currently serves as the Vice President for the Mental Health Association of Washington DC.

Meet Maryland Long-Term Care State Ombudsman

Alice Hedt

Alice H. Hedt



Ms. Hedt has more than 25 years experience in aging and long term care issues, including starting the first regional ombudsman program to serve the eight county area

around Charlotte, North Carolina, and heading the National Long-Term Care Ombudsman Resource Center funded by the federal Administration on Aging. For five years, she led NCCNHR: The National Citizens' Coalition for Nursing Home Reform in its efforts to provide information and leadership on policy development and strategies for improving care for residents of nursing homes and other long-term care facilities.

Throughout the country, Ms. Hedt has promoted the reduction of pressure sores and restraints through the Advancing Excellence in America's Nursing Homes Campaign and has testified before the U. S. Senate on the importance

of the Nursing Home Reform Law which protects residents in nursing homes receiving Medicare and Medicaid funds. She has developed materials to promote residents' rights, overseen the development of Ombudsman Best Practices, advocated for resident directed care, and worked to make sure that emergency plans are in place for residents in case of natural disasters. She has also developed and administered alternatives to facility based care in Maryland and North Carolina including adult day health, community based respite care, and services for older adults living in public housing.

If our work is valuable to you, please help us make sure it continues.

Voices Volunteers

have brought this organization from its beginnings in the Waldorf Towne Center Food Court in 2002 to the robust organization it is today. But, it's been 8 years now and we are all getting older. If Voices is to continue, we will need more dedicated volunteers and more financial resources. We can no longer handle the volume of work that continues to grow.

The Voices for Quality Care Board has recommitted to continuing this mission.

It is, perhaps, a mark not only of our successes but also of the serious need for the services that we provide that our workload continues to grow. But we cannot do it with the current number of volunteers or our current resources. It has gotten bigger than the volunteer crew can manage.

If we are to continue to provide these services, we must seek additional volunteers, additional funding, and most likely some paid staff time. We have managed to do what we do state wide (and now including the District of Columbia) because of the internet and the advances in computer hardware and software. This equipment allows us to not only communicate across the miles but also to manage the technicalities of an organization of this size without the expense of an

office or paid staff. But, it is not free. There are expenses and these few volunteers cannot fund this organization by themselves. We have bills coming due soon. Among them are the \$1000 for insurance and \$300-\$500 bill to repair our copy machine which would cost at least \$13,000 to replace along with web site fees, answering service fees, meeting supplies, etc.

Membership is Free

We hope to keep it that way. All services our volunteers provide are free. We intend to keep it that way also so that anyone caught in the long-term care merry-go-round will not have to ride alone. We'd like to keep these services available and growing, but we can't do it alone.

How can you help?

We need operating funds:

If every member donated \$20 each year, we would be well on our way to continued solvency. Can't give \$20? \$10 is good. \$5 works.

We need members:

If every member brings one new member to the organization, our membership will double. The more members we have, the louder our voice when we speak for people needing long-term care.

How to contribute \$\$\$

Give on our web site

<http://voicesforqualitycare.org>

Give through United Way at your workplace

We are not listed as a participating organization because we do not have a physical "office". However, you can donate using your United Way donation form by writing in our name and address.

**Voices for Quality Care (LTC), Inc.
P.O. Box 2251
Leonardtown, MD 20650**

Give as a memorial

We are where we are today mainly through two generous gifts in memory of Tonya Gaylor and Linda Moore.

Contribute Time

- coordinate volunteers
- speak to legislators
- call legislators
- write newsletters
- write thank-you letters
- write letters to the editor
- help with research
- work on fund-raising projects