Annual Report to the Vermont Legislature
January 12, 2024

VERMONT OFFICE OF THE LONG-TERM CARE OMBUDSMAN

Submitted by:
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Reporting Requirement to Vermont Legislature and Governor

The Office of the State Long-Term Care Ombudsman's duties include providing information and recommendations to the General Assembly and state agencies on issues related to long-term care services and supports. The Office reports to the General Assembly and Governor on or before January 15th of each year, as directed by 33 V.S.A. §7503.

We are pleased to present our annual Legislative Report covering federal fiscal year 2023.

A special thank you to our dedicated Volunteer Ombudsmen, Nancee Schaffner and Paula DiCrosta for contributing their time and efforts to advocate for Vermonters in long-term care facilities.

The Vermont Office of the State Long-Term Care Ombudsman

I. Executive Summary

Vermont's Office of the State Long-Term Care Ombudsman, also known as the Vermont Ombudsman Program or the VOP, protects and supports Vermonters who receive long-term care. We serve as watchdogs and advocates. We empower and protect long-term care recipients by providing information on resident rights and facility responsibilities, by bringing individuals and facility staff together to solve problems, and by reporting long-term care regulatory violations. Our work helps to prevent abuse and neglect and to restore dignity for Vermont long-term care recipients.

The VOP in federal FY2023, at-a-glance:

- Our staff consisted of one State Long-Term Care Ombudsman, five local ombudsmen, and two volunteer ombudsmen.
- We investigated and addressed **553** complaints on behalf of Vermont long-term care recipients.
- We resolved over **92%** of complaints to the satisfaction of the care recipient.
- The top complaints received in FY2023 were about care quality **(166)** and involuntary facility discharge **(62)**.
- In addition to our complaint resolution work, we completed:
  - Over **500** visits to long-term care facilities.
  - Over **400** instances of advice and information to individuals.
  - Over **200** instances of training to or consultation with facility staff.

II. How Ombudsmen Solve Vermonters' Long-Term Care Problems

Below are examples of ombudsmen work during FY 2023:

A. Facility Eviction (Involuntary Discharge) Complaints

Ombudsmen commonly address complaints against long-term care facilities that are trying to force residents to move out of the facility against the resident's will. This is called an involuntary discharge. Involuntary discharge cases are generally complicated, and the stakes are high. Long-term care facility residents who are involuntary discharged lose both their home and their care services. Involuntary discharge is much more common when there are staffing shortages which was the case throughout FY2023. Vermonters with significant mental and physical health challenges are among the most likely to be involuntary discharged.

Ombudsmen educate residents and their representatives about their appeal rights, ensure that the facility followed rules regarding adequate notice of the discharge, and investigate the reason for the discharge to determine whether an alternative solution could allow the resident to stay in their home. As a part of this work, an ombudsman might help a resident appeal the involuntary discharge to the state survey and licensing agency. An ombudsman will also work to prevent residents from being discharged into unsafe settings and without adequate care in place. Here are discharge examples from FY2023:

Case #1: A residential care facility issued an involuntary discharge notice to a resident with a severe mental illness. The resident was anxious about being forced into houselessness. The facility director initiated the discharge, because she felt he was doing things that were unsafe, including using the stairs unassisted, he was not bathing regularly, he was asking for too much help, and she believed that his episodes of

incontinence were intentional. The resident reported that he was receiving conflicting information from facility staff about being independent versus asking for help, and one staff member had continuously demeaned him. With the local ombudsman's involvement and over several conversations and meetings, the facility staff realized they needed to change their approach to this resident. All staff were instructed to help the resident to use the elevator with his walker when he requested assistance, and the resident agreed to use a walker on both floors of the house and to alert staff to his use of the stairs. The staff member who was rude was talked to about treating residents with dignity and respect. The facility worked to get the resident disposable briefs that fit him and did not irritate his sensitive skin, and the resident saw a doctor about his incontinence care. The resident shared that he needed assistance to shower and requested a male staff person he felt safe getting assistance from. With these improvements in place, the facility rescinded the involuntary discharge notice.

Case #2: A nursing home resident was told that he would be getting a discharge notice. The discharge was due to the resident shouting and using inappropriate language. With information from the local ombudsman, the family worked with the facility to consider how the facility was approaching the resident's care. Together, they develop a care plan for the resident to address the shouting and inappropriate language. The resident also started working with a therapist. The discharge notice was never issued.

B. Dignity, Respect, and Self Determination

Ombudsmen work to ensure that individuals receiving long-term care retain their dignity, respect, and ability to determine their lives to every extent possible. Here are two case examples:

Case #3: A 78-year-old gentleman who was living independently entered a rehabilitation facility after a fall. The facility would not sign for him to return home due to mild cognitive decline. The man did not want to be trapped in a nursing home for the rest of his life. He reached out to the local

ombudsman for help. He had supportive housing, case management, and family supports already. The nursing home tried to obtain guardianship over the gentleman. The local ombudsman helped with discharge planning, and the family became the man's durable power of attorney. He returned home where he felt happy and safe with services.

Case #4: A nursing home resident was asked to move rooms and roommates four times in two months. The local ombudsman supported the resident in filing an appeal. The resident was allowed to stay in her room with her "view of her world" through her bay window.

C. Collaboration with other VLA Projects:

The VOP is a project of Vermont Legal Aid. There are times when ombudsmen team with other Vermont Legal Aid projects or outside agencies to solve a resident's problem. Here is an example:

Case #5: A resident with mild cognitive impairment had hired an agency to help manage her finances. She reached out to the local ombudsman and complained of the agency's problematic behavior. The employees were overly controlling and disrespectful. They did not involve her in decision making about her finances or share the status of her resources. She described feeling fearful of them. They insisted on attending medical visits with her, which she described as unnecessary and humiliating. They referred to themselves as her "guardian" to other providers.

The local ombudsman referred this client to Vermont Legal Aid's Elder Law Project (ELP). An ELP attorney obtained and reviewed documents from the agency. It was confirmed that they did not have guardianship over the client, only power of attorney. With the client's direction, the ELP attorney helped the client dissolve this agency's power of attorney relationship with her. In addition, the ELP attorney and the local ombudsman are collaborating to secure an alternative power of attorney or representative payee for the client, assist the client to obtain all of the client's records held

by the former power of attorney, and inform the administrator of the client's facility about the problems with the agency. The client is relieved to have regained control over her life, and the administrator was grateful to be informed that this agency was not a good referral for others.

III. Long-term Care Complaint Data

Across FY 2023 (2022), the VOP worked on **331 cases** and **553 complaints.** Over ninety-two percent **(92.6%)** of the complaints closed in FY2023 were fully or partially resolved to the satisfaction of the resident, participant, or complainant. Below, we break down these numbers by setting and complaint topic.

A. Number of cases and complaints by long-term care setting

In FY 2023 (2022), the number of cases and complaints by setting was as follows:

- Nursing home cases and complaints: 172/316
- Residential care home and assisted living residence cases and complaints: 94/160
- Home and community-based cases and complaints: 65/77

B. Major complaint categories for all settings

Every year, ombudsmen work on a range of complaints. The top three primary complaint categories for FY 2023 are (1) Care; (2) Admission, Transfer, Discharge, Eviction; and (3) Autonomy, Choice, Rights. Together, the three categories make up 62% of the complaints the VOP received.

Each major category can be broken down into several subcategories. By far, the top complaint subcategory for FY2023 concerned involuntary discharge (63), which was 11% of complaints to the VOP in 2023.

The following table shows major complaint categories in all settings for all cases opened or closed in FY2023.

Major Complaint Category	Number of complaints	Percent (%)
Abuse, Gross Neglect, Exploitation	25	4.52%
Access to Information	26	4.70%
Admission, Transfer, Discharge, Eviction	88	15.91%
Autonomy, Choice, Rights	88	15.91%
Financial, Property	27	4.88%
Care	166	30.02%
Activities, Community Integration, and Social Services	18	3.25%
Dietary	33	5.97%
Environment	17	3.07%
Facility Policies, Procedures, and Practices	25	4.52%
Complaints about an Outside Agency	16	2.89%
System - Others (non-facility)	24	4.34%
Total	553	100%

Facility Resident Complaints to VOP by County	
Counties	**Complaint Number**
Addison county	5
Bennington county	37
Caledonia county	26
Chittenden county	122
Franklin county	31
Lamoille county	1
Orange county	4
Orleans county	7
Rutland county	83
Washington county	76
Windham county	24
Windsor county	68
Total	**438**

C. Major complaint categories for each setting

1. Nursing Homes

In FY 2023, most complaints to the VOP involved nursing home residents. Complaints about quality care made up 40% of nursing home complaints for FY2023.

The table below shows the distribution of complaints to the VOP regarding nursing homes by complaint category.

Nursing Home: Major Complaint Category	Number of complaints	Percent (%)
Abuse, Gross Neglect, Exploitation	12	3.80%
Access to Information	10	3.16%
Admission, Transfer, Discharge, Eviction	30	9.49%
Autonomy, Choice, Rights	60	18.99%
Financial, Property	14	4.43%
Care	127	40.19%
Activities, Community Integration, and Social Services	11	3.48%
Dietary	25	7.91%
Environment	13	4.11%
Facility Policies, Procedures, and Practices	12	3.80%
Complaints about an Outside Agency	0	0.00%
System - Others (non-facility)	2	0.63%
Total	316	100%

2. Residential Care Homes & Assisted Living Residences

In FY 2023, almost a quarter of complaints to the VOP for residential care home and assisted living facility residents were Admission, Transfer, Discharge, Eviction.

The table below shows the total distribution of complaints to the VOP regarding residential care homes and assisted living facilities by complaint category for FY2023.

Residential Care Home and Assisted Living Facility: Major Complaint Category	Number of complaints	Percent (%)
Abuse, Gross Neglect, Exploitation	12	7.50%
Access to Information	15	9.38%
Admission, Transfer, Discharge, Eviction	39	24.38%
Autonomy, Choice, Rights	25	15.63%
Financial, Property	11	6.88%
Care	27	16.88%
Activities, Community Integration, and Social Services	4	2.50%
Dietary	7	4.38%
Environment	4	2.50%
Facility Policies, Procedures, and Practices	11	6.88%
Complaints about an Outside Agency	3	1.88%
System - Others (non-facility)	2	1.25%
Total	160	100%

3. Home and Community-Based Cases and Complaints

The VOP advocates for individuals who receive home and community-based services in their homes through the Medicaid Choices for Care Program. In FY 2023, about fifty percent of complaints to the VOP about home and community-based services were related to admissions, transfer, discharge, and eviction and systemic issues.

The table below shows the distribution of complaints to the VOP regarding home-and-community-based services by complaint category for FY2023.

Home Based CFC: Major Complaint Category	Number of complaints	Percent (%)
Abuse, Gross Neglect, Exploitation	1	1.30%
Access to Information	1	1.30%
Admission, Transfer, Discharge, Eviction	19	24.68%
Autonomy, Choice, Rights	3	3.90%
Financial, Property	2	2.60%
Care	12	15.58%
Activities, Community Integration, and Social Services	3	3.90%
Dietary	1	1.30%
Environment	0	0.00%
Facility Policies, Procedures, and Practices	2	2.60%
Complaints about an Outside Agency	13	16.88%
System - Others (non-facility)	20	25.97%
Total	77	100%

A. People Who Submit Concerns to the VOP

The VOP receives concerns about long-term care services from a variety of sources including long-term care recipients, family members of long-term care recipients, and long-term care facility staff. In FY2023,

- 41% of complaints were reported by facility residents or individuals receiving services at home through the Choices for Care program.
- Friends, relatives, and other close contacts of the resident or Choices for Care participant reported just under 30% of complaints.
- The remaining 29% of complaints were submitted by representatives of other agencies, facility staff or administration, or originated with ombudsman staff.

The table below shows who submitted complaints in different settings for cases closed in FY 2023.

Who submitted long-term care complaints in FY2023?						
Person who submitted the Complaint	**Nursing Home**	**Residential Care**	**Assisted Living**	**Community Setting/ Hospital/ Other**	**Total Complaints Opened**	**% Of Total Complaints**
Care Recipient	104	45	7	23	**179**	**41.4%**
Relative/ Friend	76	26	15	11	**128**	**29.6%**
Facility administrator or staff	14	5	1	4	**24**	**5.5%**
Ombudsman	10	14	0	0	**24**	**5.5%**
Representative of other org.	5	2	0	12	**19**	**4.4%**
Unknown	36	10	6	6	**58**	**13.4%**
Total	**254**	**91**	**29**	**56**	**370**	**100%**

IV. Additional Ombudsmen Advocacy Work

Ombudsmen have a number of responsibilities beyond complaint-based casework:

- Perform general visits to observe the conditions and care residents are receiving at long-term care facilities and to ensure that residents are aware of our services.
- Educate residents on their rights.
- Provide residents, Choices for Care participants, and their representatives with guidance and information about how to communicate with providers about their concerns.
- Support resident and family councils in addressing facility issues and concerns.
- Assist residents with advance directives.
- Educate facility and home health staff on resident rights and the role of the VOP.

The table below summarizes some of the duties performed by ombudsmen outside of complaint casework in FY2023.

Other Ombudsmen Work (FY2023)	
Activities	**Number Completed**
Consultations to Individuals	412
Trainings and Consultations to Facilities/Agencies	220
Facility Visits	507
Assist with Advance Directives	23
State Facility Inspection Participation	22
Work with Resident/Family Councils	25

V. VOP Expenditures

The VOP spent $809,567 to provide ombudsman services across Vermont in FY2023. Just over 20% of this money was in carryover funds that resulted from recent one-time Covid funds. In other words, due to increasing costs and need for our work, we spent significantly more than our normal base funding would have allowed. We thank the state legislature for increasing our funding starting in FY2024. This has allowed us to maintain our current staff and replace a sixth ombudsman who retired in 2022.

FY2023 spending included both state and federal monies, as shown below:

- $82,018 Federal OAA Title VII, Chapter II
- $323,302 Federal OAA Title III, State Level
- $73,974 Federal Title VII Ombudsman – CRRSA (Covid Funds)
- $128,648 Federal Medical Assistance Program (Global Commitment)
- $201,625 State General Funds
- $809,567 Total

VI. Systemic Advocacy

Under state and federal law, the VOP is asked to address systemic problems that impact the quality of care and quality of life of individuals receiving long-term care in Vermont.

The VOP guides our systemic advocacy with information we gain during complaint investigations, visits with residents and Choices for Care participants, and collaborations with family members, long-term care staff, and other stakeholders.

Representatives of the VOP have served on numerous workgroups, committees, and task forces related to long-term care services and supports in Vermont. In FY 2023, representatives of the VOP served on the Vermont Vulnerable Adult Fatality Review Team, the Governor's Council on Alzheimer's Disease and Related Diseases, several flood recovery workgroups, a subgroup for the Age Strong Vermont Plan, and regional Choices for Care waiver teams.

In addition, we have tracked and commented on several proposed federal and state regulations related to long-term care. This included providing testimony before the state legislature regarding remote witnessing of advanced directives, submitting written comments on proposed federal staffing standards for long-term care facilities, and submitting written comments on proposed changes to Vermont's Residential Care Facility and Assisted Living Facility regulations.

VII. Systemic Challenges in Long-Term Care:

Ongoing staffing shortages continue to challenge facilities and home health agencies and prevent residents from receiving appropriate care. The inability to maintain consistent and adequate staffing in long-term care, including both management and direct care staff, has negatively impacted the quality, availability, and affordability of care in all settings.

A. Growing numbers of severely disabled Vermonters who live at home are not receiving sufficient care to meet their needs. Many are receiving no care at all.

- A single female client in her early 90's was experiencing significant cognitive decline due to dementia. The client lived alone and wanted to stay in her home. Even after receiving advanced notice, the local home health agency stated that they did not have caregivers to cover the woman's care. The woman ended up being sent to live in a facility far from her hometown.
- Some home health agencies are not able to fill the care needs of their current clients yet continue to take on more clients. They refuse to send aides in for any longer than 2 hours per day, so clients who are eligible for 40-50 hours of care per week are fortunate if they can get 6 hours of care per week. This has led to significant care issues and dangerous conditions for the clients.

B. Nursing facility conditions have declined over the past decade. Significant improvements that have been achieved in long-term care over the years have been lost. Many nursing facility residents are experiencing poor care, especially in the categories of nutrition, hydration, and incontinence care. It is difficult for the VOP to advocate for quality-of-life issues in long-term care facilities, because so much attention is needed to address basic quality of care needs.

- Facility residents are dying of infections that originated from bed sores and inadequate wound care. This should never occur.
- An ombudsman went to a facility recently to visit with residents late in the day and found it nearly empty of staff.
- In a private pay only facility, a resident had to move to the skilled nursing wing. His costs increased, but the care quality declined. For example, the resident has been told he must wait until all the trays have been collected after lunch before he can be toileted. This results in the resident soiling himself and sitting in this state for up to an hour.

C. **Many facilities and home health agencies are not providing residents with a sufficient means to express concerns about the facility nor are they adequately following up on concerns.**
   - A facility social worker reported that she was told by her Director of Nursing to ignore resident pleas for support to complete and submit an official complaint to the facility.
   - Ombudsmen often need to repeatedly press facilities to provide their complaint policies and respond to complaints after they are filed.

D. **Vermont does not have a system in place to increase the amount of money residents who are on Long-Term Care Medicaid can keep for their personal expenses to keep pace with inflation.** This spending power is especially important when facilities are not providing adequate care.

E. **Temporary workers are bleeding funds from facilities.** Short-term contract workers are paid at a much higher rate than longer term staff and are not able to develop the long-term relationships with residents that are vital to quality care.

F. **Rehabilitation therapy is not adequately accessible to Vermonters.** This denies Vermonters the ability to improve, maintain, or slow functional decline and increases the need for more workers to provide long-term care for these Vermonters.

G. **Vermonters are stuck in the hospital because they do not have a discharge location where they can receive care.**
   i. After a fall, a resident was hospitalized. Although the resident improved and returned to "baseline," the facility would not allow him to return. They insisted that he must stay in a rehabilitation facility first, after which they would decide whether he could return. The resident remained at the hospital until a bed opened in a rehabilitation facility. While in the hospital and now the rehabilitation facility, he is paying thousands of dollars per month for his home at the assisted living facility without any guarantee that he will be able to return. The resident and family are left in limbo, looking for an alternative facility in case he is still unable to return to his home in his original facility.

H. Vermonters are being forced to leave their homes in facilities at high rates. As stated above, involuntary discharge cases made up 11% of the VOP's casework in FY2023. When staffing levels are insufficient, facilities are motivated to get rid of their most time-consuming residents, and involuntary discharges increase. The residents who are victims of involuntary discharge are often the residents with the greatest physical and mental health challenges – the most vulnerable residents. Facilities are failing to engage in person-centered care and care planning to avoid conflicts. Facilities should be training their staff to adequately meet the needs of residents with different types of challenges and supporting staff to work with the residents and their families to address resident needs. Instead, overwhelmed facility staff often blame residents and are punitive in their responses to resident behaviors. In addition, even when the state agrees that an involuntary discharge was unwarranted, if the resident is currently not in the facility due to a hospitalization, the state often reports that they cannot force the facility to allow the resident to return to their home.

VIII. Recommendations:

A. Vermont Must Address the Staffing Shortage

- Vermont should ask all relevant areas of state government to report on any plans they have for improving the long-term care staffing shortage and the timeline for implementation. This should be combined into a comprehensive report on state efforts, so Vermont leaders can assess whether Vermont can improve its approach to this problem. Vermont should then encourage and facilitate conversations among state and local leaders and community members to come up with new and creative solutions to the staffing problem. Local communities cannot be expected to solve the staffing crisis, but they

can play a role in reducing the harm while permanent solutions are being pursued.

- All long-term care facilities should be required to develop an "exit plan" to cease their reliance on temporary workers. Mayo Healthcare, which owns a nursing facility and a residential care home in Northfield, recently announced that it is now free of temporary agency workers. Long-term staff can be better trained and develop stronger relationships with residents, allowing them to provide person-centered care. Because temporary workers are paid a much higher rate than longer term workers, eliminating facility reliance on temporary workers would allow facilities to hire more long-term staff and pay them better.
- Vermont should implement a minimum wage for long-term care workers, ensuring that it keeps up with inflation, is competitive nationally, is a livable wage, and is significantly higher than the state minimum wage so that employees will be attracted and retained for this vital work.
- The federal government is expected to finalize nursing facility minimum staffing standards in the next few months. Vermont should assess the standards when they are released and consider whether additional standards are needed to protect long-term care recipients in our state.
- Vermont should continue to explore and support shared housing for individuals who need assistance at home and individuals looking for housing who are willing to provide care.
- Vermont should provide advice and technical support for individuals who want to hire their own care workers or open a new care home.

B. Improve care quality and resident experience

- All state employees who help to regulate nursing facilities and nursing facility and home health agency employees who receive state dollars should receive annual training in anti-racism, anti-ablism, and dementia care.

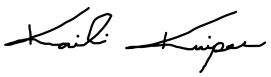
- Vermont should implement an automatic inflationary increase for the "personal needs allowance" for facility residents who are on Long-Term Care Medicaid.
- Long-term care facilities that improperly discharge a resident and refuse to allow them to return should be required to pay the resident for their pain and suffering.
- Vermont must sufficiently fund legal services for Vermont elders and Vermonter's who live with disabilities. Especially during a staffing shortage, access to attorneys is vital for vulnerable Vermonters to enforce their rights and understand their options.

C. Ensure Medicaid and Medicare dollars are being spent on care

- Vermont should require that a minimum percentage of nursing home revenue go towards direct resident care and nutrition.
- Vermont should explore ways to regulate nursing facility contractors for price gouging in situations where the contracting agency shares investors or ownership with the nursing facility. Some facility investors hide profits by investing in affiliated companies, such as cleaning agencies, and paying them at a much higher than market rate. Regulating price gouging would reduce incentives for nursing homes and affiliated entities to decrease investments in care to increase owner profits.

Thank you for taking the time to review the VOP's FY2023 annual report.

Respectfully Submitted,



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Appendix 1

HISTORY AND ROLE OF THE OMBUDSMAN PROGRAM

I. History

A. At the National Level:

The Long-Term Care Ombudsman Program originated as a five-state demonstration project to address quality of care and quality of life in nursing homes. In 1978 Congress required that states receiving Older Americans Act (OAA) funds must have Ombudsman programs. In 1981, Congress expanded the program to include residential care homes. The Nursing Home Reform Act of 1987 (OBRA '87) strengthened the Ombudsman's ability to serve and protect long-term residents. It required residents to have "direct and immediate access to ombudspersons when protection and advocacy services become necessary." The 1987 reauthorization of the OAA required states to ensure that Ombudsmen would have access to facilities and to patient records. It also allowed the state Ombudsman to designate local Ombudsmen and volunteers to be "representatives" of the State Ombudsman with all the necessary rights and responsibilities.

The 1992 amendments to the OAA incorporated the Long-Term Care Ombudsman program into a new Title VII for "Vulnerable Elder Rights Protection Activities." The amendments also emphasized the Ombudsman's role as an advocate and agent for system-wide change.

B. In Vermont:

Vermont's first Ombudsman program was established in 1975. Until 1993, the State Ombudsman was based in the Department of Aging and Disabilities (DAD), currently DAIL (Department of Aging and Independent Living). Local Ombudsmen worked in each of the five Area Agencies on Aging. In response to concerns that it was a conflict to house the State Ombudsman in the same Department as the Division of Licensing and Protection, which is responsible for regulating long-term care facilities, the

legislature gave DAD the authority to contract for Ombudsman services outside the Department.

DAIL has been contracting with Vermont Legal Aid (VLA) to provide Ombudsman services for over 20 years. The Vermont Long-Term Care Ombudsman Program at VLA protects the rights of Vermont's long-term care residents and Choices for Care participants. The program also fulfills the mandates of the OAA and OBRA '87. The State and Local Ombudsmen work in each of VLA's offices, which are located throughout Vermont.

In 2005 the Vermont legislature expanded the duties and responsibilities of the Vermont Long-Term Care Ombudsman Program. Act No. 56 requires Ombudsmen to service individuals receiving home-based long-term care through the home- and community-based Medicaid waiver, Choices for Care.

II. Vermont Office of the State Long-Term Care Ombudsman's Advocacy Role

Vermont's Office of the State Long-Term Care Ombudsman is also known as the Vermont Ombudsman Project or VOP. The VOP is housed in Vermont Legal Aid. The VOP is staffed by advocates called long-term care ombudsmen. Ombudsmen are trained to resolve problems that long-term care recipients experience regarding their care.

A. The VOP's focus

- Work one-on-one with long-term care recipients to promote their dignity and safety.
- Advocate for changes that lead to better care and greater quality of life for all long-term care recipients.

B. The VOP's clients

- The VOP helps individuals who receive long-term care in

- Nursing homes
- Residential care homes
- Assisted living residences
- Home and community-based settings through Choices for Care

C. The VOP's responsibilities and duties include:

- Visiting nursing homes, residential care homes, and assisted living residences regularly to interact with residents and monitor conditions.
- Investigating problems and concerns about long-term care services and supports.
- Helping individuals make their own decisions about their long-term care services and supports.
- Assisting persons receiving Choices for Care with issues related to their long-term care services and supports in the home and community-based settings.
- Educating care providers about the rights and concerns of Vermonters receiving long-term care services and supports in facilities and at home through Choices for Care.
- Identifying problem areas in the long-term care services and support systems and advocating for change.
- Acting as "explainers" for individuals who wish to execute an Advanced Directive
- Providing information to the public about long-term care services and supports.

D. The VOP is an independent voice:

- The VOP is housed within Vermont Legal Aid, an independent non-profit. This organizational structure enhances the VOP's ability to operate free of outside influence.

- No ombudsman or immediate family member of an ombudsman is involved in the licensing or certification of long-term care facilities or providers, nor do they work for or participate in the management of any long-term care facility.
- Individual conflicts of interest for ombudsmen are identified and remedied.
- Each year the Commissioner of the Department of Aging and Independent Living (DAIL) certifies that the VOP can carry out its responsibilities and duties free of conflict of interest. (See Appendix 3, last page of this report).

E. Long-Term Care Ombudsman Certification Process

Before becoming a certified ombudsman, all paid staff and volunteers must complete a comprehensive training program. The training program requires 20 hours of classroom training and independent study, and an additional 30 hours spent shadowing a local ombudsman. When a trainee passes a conflict-of-interest review and background check, satisfactorily completes both the classroom and facility-based requirements, and no concerns arise regarding the individuals' suitability for the job, they will officially be certified as a certified representative of the office.

F. Staffing for the Vermont Long-Term Care Ombudsman Program:

- In federal fiscal year 2023 (October 1, 2022 to September 30, 2023), paid full-time VOP staff consisted of one State Long-Term Care Ombudsman and five local ombudsmen.
- With oversight by paid staff, certified volunteer ombudsmen monitor facilities and assist residents with their issues and concerns. In FY 2023, volunteer ombudsmen contributed 253 hours to the program. One volunteer ombudsman retired towards the end of FY2023, leaving us with one volunteer ombudsman.

- Our small staff covers Vermont's 145 long-term care facilities (over 6200 beds) and all individuals receiving long-term care in Vermont through the Choices for Care program.
- Thanks to additional funding from the Vermont legislature, we have avoided the need for layoffs and hired a sixth full-time, paid ombudsman in October 2023. This returns the program to pre-2022 staffing levels.

Appendix 2

JANUARY 2024 STAFF ROSTER
Vermont Long-Term Care Ombudsman Program

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Local Ombudsmen:

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VERMONT

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Commissioner's Office
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Agency of Human Services

December 15, 2023

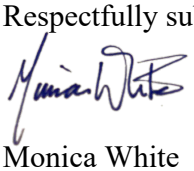
Kaili Kuiper, State Long Term Care Ombudsman
Vermont Legal Aid
264 North Winooski Avenue
Burlington, VT 05401

Dear Ms. Kuiper,

Pursuant to 33 V.S.A. §7503(10), on or before January 15 of each year the Office of the State Long-Term Care Ombudsman must "[s]ubmit to the General Assembly and the Governor a report on complaints by individuals receiving long-term care, conditions in long-term care facilities, and the quality of long-term care and recommendations to address identified problems." 33 V.S.A. §7509 provides that the Department of Disabilities, Aging and Independent Living ("Department") shall prohibit any Ombudsman, either paid or volunteer, Vermont Legal Aid staff and board, or any immediate family member of any Ombudsman, or Vermont Legal Aid staff and board, from having any interest in a long-term care facility or provider of long- term care which creates an organizational or individual conflict of interest in carrying out the Ombudsman's responsibilities and directs the Department's Commissioner to establish a committee of no fewer than five persons, who represent the interests of individuals receiving long-term care and who are not State employees, to assure that the Ombudsman is able to carry out all prescribed duties in the Older Americans Act and in state statute without a conflict of interest.

The Department utilizes the DAIL Advisory Board as the aforementioned committee. During its regularly scheduled monthly meeting on October 12, 2023 a subcommittee reported that assurances were received from you, the State Long Term Care Ombudsman, that to the best of your knowledge no Vermont Legal Aid staff, board, volunteers or their immediate family members have any interest in a long-term care facility or provider of long-term care which creates an individual or organizational conflict of interest in carrying out the Ombudsman's responsibilities. By a unanimous vote the committee determined that the Ombudsman is able to carry out all prescribed duties without a conflict of interest, and the committee recommended that the Commissioner convey its assessment to both the General Assembly and the Governor as required by statute. This writing serves that purpose and is hereby submitted as an appendix to the Ombudsman's annual report, as required by 33 V.S.A. §7509(b).

Respectfully submitted,



Monica White
DAIL Commissioner

CC: Jason Pelopida, State Unit on Aging Director, DAIL
Jeanne Hutchins, Chair, DAIL Advisory Board