MINUTES OF THE MEETING
PUBLIC HEALTH, WELFARE AND SAFETY COMMITTEE
MONTANA STATE SENATE

JANUARY 14, 1985

The meeting of the Public Health, Welfare and Safety Committee was called to order by chairman Judy Jacobson on Monday, January 14, 1985 in Room 410 of the State Capitol Building at 1:00 p.m.

ROLL CALL: All members were present. Karen Renne, staff researcher, was also present.

Many visitors were in attendance. See attachments.

CONSIDERATION OF SB 54: Senator Tom Towe, the chief sponsor of SB 54, of Senate District 46 gave a brief resume of the bill. This bill is an act to make it a felony to purposely or knowingly abuse, neglect, or exploit a person 60 years of age or older.

This bill is the result of a bill passed in the 1983 Legislature regarding elderly abuse. The present law does not have a penalty and this proposed bill would would apply a penalty. This bill which was proposed in the Legacy Legislature would make violations punishable by fines up to $50,000 and maximum jail terms of five years. In many cases older people are not capable of defending themselves against physical or mental abuse and are easily swindled out of valuable estates by family members or friends which they thought they could trust.

Senator Towe reviewed the definitions within the bill.

Regina Middleton of Billings stood in support of the bill. She stated she has worked with the elderly for the past 25 years sometimes for pay and sometimes without. Elderly people are frightened of being without their homes or any money even though they handle their money very carefullly. They sometime lose their will to live when they are defrauded by people who are supposed to love them and care for them.

Ms. Middleton gave an example of an older woman who was left a large ranch when her husband died. Her son through questionable appraisals purchased the ranch from his mother for only $58,000 when in fact it was worth aproximately $325,000. He later convinced his mother to give him the ranch without any further payments so that the government would not take all of her money. He later refused to make the interest payments which were the only money the woman had to live on. Sons and daughters are the most guility for abuse of the elderly. How we treat the elderly is how we will be treated when we are old.

Mary Uber, representing the Legislative Committee of the Legacy Legislature, stood in support of the bill. She told of an elderly woman whose husband died and her daughter moved in with her. The daughter would litteraly lock the elderly woman in the garage for over an hour and left her there. She deliberately parked her car behind her mothers' so that her mother could not go out unless she asked the daughter. If the mother was cooking, she would grab the food from her hands and throw it on the floor. The daughter's treatment kept getting worse and she began hurting her mother physically. Many people told the mother to get out of the house, however, she did not. Many suggested that she have her daughter committed for mental treatment. The number of elderly people being abused each year is growing at an alarming rate. Ms. Uber handed in written testimony to the Committee for their consideration. See attachments.

Wade Wilkinson, representing Low Income Senior Citizens Association, stood in support of the bill. He stated that he was also representing: Montana Senior Citizens Association, Legacy Legislature, Advisory Council, and American Senior Citizens Association.

Doug Olson, representing the Legal and Ombudsman Services and the elderly of Montana, stood in support of the bill. He stated that this past summer he assisted with the drafting of Legacy Legislature Bill 27, which would recognize specific criminal penalties for those persons who abused, neglected, or exploited persons 60 years of age or older. The senior citizens in the Legacy Legislature believed that it was necessary to recognize as specific crimes the abuse, neglect, or exploitation of older persons. At the present time there is no offense that could be charged at all for someone who had a legal or assumed duty to care for an older person's health or nutritional needs and neglected to do so. Mr. Olson handed in written testimony to the Committee for their consideration. See attachments.

Doug Blakely, state Long-Term Care Ombudsman, stood in support of the bill. He stated that due to both the newness of the EAPA and the potential severity of this type of complaint, more specific data has been kept on this topic this year. He referred to the Annual Report which he prepared earlier this year and placed on each legislators desk. See attachments.

Gary Walsh from the SRS stood in support of the bill. He stated that 160 of the elderly were abused last year, of that number reported about 1/2 were valid cases. Sixty percent were cases of neglect, 12% were exploited, and 14% were combination. Fifteen percent of the cases were caused by sons and daughters. There is a real need for a penalty for these crimes.

Charles Briggs representing the Office of the Governor, stood in support of the bill. He stated that there is a real need for a deterent and that the penalties will help. There will probably be more legislation introduced this week in regard to intervention to abuse to the elderly.

With no further proponents, the chairman called on the opponents.

Rose Skoogs, representing the Montana Health Care Association, stated that her group is not pro or con to the bill. They would like to remain neutral. Mrs. Skoogs stated that she disagrees with the testimony that SB 54 could change the trend by impressing on law enforcement officials the seriousness of the crime. She said that severe fines and jail terms will make officials reluctant to prosecute all but the most extreme cases. Most nursing homes discipline abusive employees by firing them. Frequent decisions against prosecution leaves facilities reluctant to file lawsuits. The homes are not getting the support that they need.

The meeting was opened to a question and answer period from the Committee.

Senator Lynch asked about the lawful authority described in the bill.

Senator Hager asked about the word "must" on page 2,line 21. Everyone felt that the word should probably be changed to "may" for the protection of everyone.

Senator Stephens stated that the bill could create a very serious problem for nursing homes.

Senator Himsl asked whether nursing homes would be held accoutable under the bill for merely strapping an elderly resident to a bed.

Senator Towe closed. He stated that if this bill helps one person it is worthwhile.

Senator Stephens left.

ACTION ON SENATE BILL 16: A motion was made by Senator Lynch that SB 16 DO PASS AS AMENDED. Motion carried with all present Senators voting "yea".

ACTION ON SENATE BILL 57: Karen Renne, staff researcher, explained the proposed amendments.

The bill would now attach a sticker to the back of driver's license, similar to the stickers used now on license plates. The Driver's License Bureau will provide each applicant, at the time of application, printed information calling the applicant's attention to the provisions of this bill and each applicant shall be given an opportunity to indicate in the space provided his intent to make an anatomical gift.

Senator Lynch asked Senator Conover about the fiscal impact of this bill now. Senator Conover stated that he did not know at actual dollars and cents figures but it would be considerable less than that proposed for in the original bill.

Senator Himsl asked if the witnesses would still be able to sign and verify the donor sticker. "Yes", they will have two places for witnesses.

A motion was made by Senator Lynch that the proposed amendments to SB 57 be adopted. Motion carried.

Senator Towe stated that on page 1, line 9, following: "donor", he would like to strike all through page 2, line 14.

Senator Lynch stated that he liked the idea of being able to reconsider every four years when ones driver's license is renewed.

Senator Newman stated that the donor cards will always be reconsidered when one renews his/her drivers license and to cancel the donation a person could just scrape the sticker off the back of the driver's license.

Senator Himsl asked about donor banks in Montana. These will be avilable, as told to Senator Conover by some Billings area doctors.

Senator Jacobson stated that 48 states now have this.

Senator Newman stated that he felt that this should be a function of the highway patrol.

Senator Jacobson stated that the patrol should notify the people that this service is available.

A motion was made by Senator Towe that SB 57 be amended as follows: Page 2, lines 9 through 14; following: "donor."; strike: the remainder of lines 9 through 14. A Roll Call Vote was taken. Motion carried by a vote of 4 to 3. See attachments.

A motion was made by Senator Lynch that SB 57 receive a DO PASS AS AMENDED recommendation from the committee. Motion carried.

ANNOUNCEMENTS: The next meeting of the Senate Public Health, Welfare and Safety Committee will be held on Wednesday, January 16, 1985 in Room 410 of the State Capitol Building to consider SB 19 and SB 80.

ADJOURN: With no further business the meeting was adjourned.

Judy Jacobson
CHAIRMAN, SENATOR JUDY JACOBSON

eg

ROLL CALL VOTE

SENATE COMMITTEE PUBLIC HEALTH, WELFARE AND SAFETY

Date JANUARY 14, 1985 SENATE Bill No. 57 Time 2:30

NAME	YES	NO
SENATOR JUDY JACOBSON, CHAIRMAN	✓	
SENATOR J. D. LYNCH, VICE CHAIRMAN		✓
SENATOR TOM HAGER		✓
SENATOR MATT HIMSL	✓	
SENATOR TED NEWMAN	✓	
SENATOR BILL NORMAN		✓
SENATOR STAN STEPHENS	absent at time	
SENATOR TOM TOWE	✓	

Elaine Graveley
Secretary, ELAINE GRAVELEY

Judy Jacobson
Chairman, SENATOR JUDY JACOBSON

Motion: A motion was made by Senator Towe that SB 57 be amended as follows: Page 2, lines 9 through 14; following: "donor"; strike: the remainder of lines 9 through 14. Motion carried.

ROLL CALL

PUBLIC HEALTH, WELFARE & SAFETY COMMITTEE

49th LEGISLATIVE SESSION -- 1985 Date Jan. 7

SENATE SEAT #	NAME	PRESENT	ABSENT	EXCUSED
6	SENATOR JUDY JACOBSON, CHAIRMAN	✓		
5	SENATOR J. D. LYNCH, V.CHAIRMAN	✓		
42	SENATOR TOM HAGER	✓		
30	SENATOR MATT HIMSL	✓		
17	SENATOR TED NEWMAN	✓		
45	SENATOR BILL NORMAN	✓		
14	SENATOR STAN STEPHENS	✓		
26	SENATOR TOM TOWE			

Each day attach to minutes.

DATE _____

COMMITTEE ON _____

VISITORS' REGISTER

NAME	REPRESENTING	BILL #	Check One	
			Support	Oppose
Dave Lackman	MT Public Health Assn.	SB54	X	
Mary Uber	AARP State Legislative Com. Legacy Legislature	SB54	X	
Regina Mendiola	U.S. Postal Service	SB54	X	
[illegible]	MT Nurses Assoc.	SB54	X	
Rae Skyrm	MT Health Care Assn	SB54		X
Danny Fjelstad				
Bobby Olson	Elderly Legal Servs	SB54	X	
Doug Blakley	Long Term Care Ombudsman	SB54	X	
Charles Brooks	Governor's Office	SB54		

(Please leave prepared statement with Secretary)

STANDING COMMITTEE REPORT

JANUARY 14, 1985

MR. PRESIDENT

We, your committee on PUBLIC HEALTH, WELFARE AND SAFETY

having had under consideration SENATE BILL No. 16,

FIRST reading copy (WHITE color)

REVISE LAWS RELATING TO HEALTH, SOCIAL SERVICES AND TRANSPORTATION

Respectfully report as follows: That SENATE No. 16,

be amended as follows:

1. page 19, line 25 through page 20, line 1.
Following: "Repealer."
Strike: "Sections 50-39-201 through 50-39-203 and 53-24-205, MCA, are"
Insert: "Section 53-24-205, MCA, is"

AND AS AMENDED

DO PASS

~~DO NOT PASS~~

SA 1/14/85 4:40

SENATOR JUDY JACOBSON Chairman.

STANDING COMMITTEE REPORT

JANUARY 14, 1985
..... 19.....

MR. PRESIDENT

We, your committee on PUBLIC HEALTH, WELFARE, AND SAFETY

having had under consideration SENATE BILL 57 No.....

first white
_____ reading copy (_____)
color

AMATOMICAL GIFT DONOR'S STATEMENT ON REVERSE OF DRIVER'S LICENSE

Respectfully report as follows: That SENATE BILL 57 No.....

be amended as follows:

1. Title, line 4.
   Following: "AN ACT"
   Strike: "AUTHORIZING"
   Insert: "PROVIDING FOR THE ATTACHMENT OF"

2. Title, line 5.
   Following: "ACT"
   Strike: "ON"
   Insert: "TO"

3. Title, line 6.
   Following: line 5
   Strike: "REVERSE"
   Insert: "BACK"

4. Page 2, line 4.
   Following: "statement"
   Strike: "provided on"
   Insert: "attached to"

5. Page 2, lines 9 through 14.
   Following: "donor."
   Strike: remainder of lines 9 through 14

~~XXXXX~~
~~SB4A53~~

~~XXXXXXXX~~
~~SB4SF4A53~~

CONTINUED

.....
Chairman.

JANUARY 14, 1995
19

6. Page 2, line 20
Following: "~~indication~~"
Strike: "Statement of anatomical gift"
Insert: "Indication"

7. Page 2, line 21.
Following: "~~gift~~"
Insert: "of intent to make anatomical gift. (1)"

8. Page 2, line 22.
Following: "on"
Strike: "the reverse of"

9. Page 2, line 24.
Following: "when"
Strike: "statement whereby"
Insert: "space for indicating when"

10. Page 2, line 24.
Following: "licensee"
Strike: "may execute"
Insert: "has executed"

11. Page 3, line 2.
Following: line 1
Insert: "(2) The department shall provide each applicant, at the time of application, printed information calling the applicant's attention to the provisions of this section, and each applicant must be given an opportunity to indicate in the space provided under subsection (1) his intent to make an anatomical gift

(3) The department shall issue to every applicant who indicates such an intent a statement which, when signed by the licensee in the manner prescribed in 72-17-204, constitutes a document of anatomical gift. This statement must be printed on a sticker that the donor may attach permanently to the back of his driver's license.

(4)"

AND AS AMENDED

DO PASS

CHAIRMAN, SENATOR JUDY JACOBSON

(This sheet to be used by those testifying on a bill.)

NAME: Regina Middleton DATE: 2-14-85

ADDRESS: 628 Parkhill

PHONE: 259-0739

REPRESENTING WHOM? Legacy Legislature

APPEARING ON WHICH PROPOSAL: SB 54

DO YOU: SUPPORT? X AMEND? / OPPOSE? _____

COMMENT: _____

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

(This sheet to be used by those testifying on a bill.)

NAME: Mary Aiken DATE: 1-14-85

ADDRESS: 245 No. Rim Road

PHONE: 245-3564

REPRESENTING WHOM? AARP State Legislative Committee

APPEARING ON WHICH PROPOSAL: SB 54

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

Elder in Maryland

This material is taken from PSYCHOLOGY TODAY.

TITLE OF THE ARTICLE: ELDERS UNDER SIEGE Author: Peggy Eastman.

SOME ARE PREY TO PHYSICAL AND MENTAL ABUSE

Language and Psychological Abuse

ONE CASE: DAUGHTER DEAREST Used

This material was take from Testimony by Mrs. X, a 79 year old Massachusetts resident before a joint hearing of the Senate Special Committee on Aging and the Select Committee on Aging of the House of Representatives. June 1980

MY HUSBAND DIED TEN YEARS AGO. THE HOUSE BECAME MINE EXCLUSIVELY. MY YOUNGER DAUGHTER, WHO HAD TWO UNFORTUNATE MARRIAGES, WAS WELCOMED BY US ALONG WITH HER CHILDREN. THIS SITUATION AROUSE ABOUT EIGHT YEARS BEFORE MY HUSBAND DIED.

THE PAST THREE YEARS THINGS HAVE GOTTEN STEADILY WORSE. MY DAUGHTER LOCKED ME IN THE GARAGE AND LEFT ME THERE FOR MORE THAN AN HOUR. SHE ALWAYS PARKED HER CAR BEHIND MINE IN THE GARAGE SO I COULD NOT GET MY CAR OUT EXCEPT BY HER PERMISSION.

WHENEVER I TRIED TO COOK A MEAL, SHE WOULD APPEAR AND TURN THE GAS OFF AND REMOVE THE GRILLS SO THAT THE ONLY WAY I COULD COOK WAS TO HOLD THE PAN OVER THE FLAME. IF SHE FOUND ME USING THE ELECTRIC TOASTER OVEN, MY FOOD WAS THROWN ON THE FLOOR AND THE TOASTER OVEN WAS REMOVED AND HIDDEN FOR SEVERAL DAYS.

MY DAUGHTER'S TREATMENT OF ME KEPT GETTING WORSE. SHE ALWAYS HURTING ME PHYSICALLY AND MENTALLY, KICKING ME, PUSHING ME, GRAPPLING WITH ME, TELLING ME TO GET OUT, AT ONE TIME THROWING A DRAWER DOWN THE STAIRS AT ME, CALLING ME NAMES, TELLING ME I BELONGED IN A NURSING HOME AND WHY DIDN'T I GO TO ONE.

I WAS WARNED MANY TIMES TO GET OUT OF THE HOUSE BY MY DOCTOR, MY LAWYER, MY PROTECTIVE CONUNSELOR AND MY ADVISER AT THE MENTAL HEALTH ASSOCIATION. THEY ALL KNEW MY LIFE WAS IN DANGER WHILE I WAS STAYING UNDER THE SAME ROOF WITH THIS EMOTIONALLY VERY SICK 45-YEAR-OLD PERSON. SHE IS A WELL-EDUCATED WOMAN, HAVING GRADUATED FROM COLLEGE, CONTINUED IN GRADUATE SCHOOL AND RECEIVED A MASTER'S DEGREE IN NO LESS THAN — SOCIAL SERVICE.

Why no action taken by these so-called social workers, doctors, lawyers etc?

For 1980, according to Senate Special Committee on Aging and the Select Committee on Aging of the House, the number of abused, neglected, or exploited elderly in the U.S. ranged from 600,000 to 1,200,000 or 4% of the elderly population; and the number continues to increase.

Peggy Eastman is a contributing editor to Self, R.N. and Geriatric Consultant Magazine.

Model laws in Connecticut and S. Carolina See p 168

Please return these materials to Senator Tom Towe.

Abusing the Elderly

Care of aging family members can create stress and frustration within the household. When too little is done to relieve the situation the result is often a hidden form of domestic violence

In the spring of 1981 the Select Committee on Aging of the House of Representatives published a report entitled *Elder Abuse: An Examination of a Hidden Problem.* The report was based on hearings held in various parts of the country—Boston, New York, San Francisco, New Jersey and the District of Columbia—over a period of several years. While these hearings were taking place, newspapers and periodicals devoted considerable space to this form of family violence that has come to public notice only in the past decade.

Since the report appeared, however, much less attention has been paid by the popular press to the abuse of elders even though there is no indication that the problem is less prevalent or solutions closer at hand. Some in the field of gerontology feel that the seeming lack of interest is related to the paucity of funding for further research. I discussed the matter with Dr. Marilyn Block of the University of Maryland's Center on Aging. Dr. Block was project director for one of the few studies that have appeared, *The Battered Elder Syndrome* (1979).

"The media are uninterested unless there's new data for them to comment on. But work in this area has been conducted largely through public funds," she said, "and these have become increasingly scarce in the 1980's. What research money there is, is going mostly into areas that have to do with direct services, like nutrition."

And yet, according to the Select Committee's report, an estimated one million older Americans are abused each year, either physically, psychologically or financially. The actual figure may be much higher because the phenomenon is indeed, as the report's title states, hidden. Children go to school and so are seen regularly by teachers trained to detect and report signs of child abuse. But many elderly men and women who live with middle-aged children seldom leave the house, so that maltreatment may go undetected. The author of an article on "granny bashing" in England has observed that when physical injury is serious enough to require medical attention, busy doctors can fail to perceive the true origin because they are told by the abuser that it resulted from falls associated with the aging process.

The abused themselves are not infrequently a party to the concealment. Out of fear of retaliation, or simply from an instinctive desire to protect their children from difficulties with the law, they may deny the very possibility that a relative has hurt them. It was this type of situation, in fact, that gave Dr. Block the idea for her study.

"I had a friend in Baltimore who was a social worker in a senior citizen center. She noticed that a woman there was always bruised. This seemed strange, since she was steady on her feet. At first the woman insisted the bruises were from accidents of one kind or another, but finally she admitted that a relative was hitting her at home."

The report asserts that elderly women are more likely to be abused than men. But it is also women, usually middle-aged, who find themselves in the role of care provider for an aged parent and are therefore burdened with forms of stress that can precipitate abuse.

"There's a tendency for women to assume 95 percent of the care-giving responsibilities," Dr. Block said. "It's especially difficult if a husband tells the wife to look after *his* mother or father. And it may happen that, if both are working and the husband is getting the larger salary, as is generally the case, the wife has to give up her job to become the care provider. Much resentment toward the elderly per-

Why More women in the elderly population who were dependent on their husbands for care and support. They were now in the job market as a worker.

«George M. Anderson, S.J., *is on the staff of St. Aloysius parish in Washington, D.C., and frequently contributes articles on social issues.*»

Testifier: Mary Uber

'Yelling, threats and insults are for some as stinging as a slap'

son can result, particularly among women who've gone back to work in their 40's and 50's after the children are raised and who look forward to some independence."

If the care provider has teen-age children in the home who also need attention, the tension can be still more marked. At the Congressional hearing held in Washington in June 1980, one of those who testified—Dr. Suzanne Steinmetz, an authority in the field of family violence—referred to this situation as the "dilemma of double demands [because] the care givers often find themselves caught between two or more generations."

The thought of a middle-aged child striking an aged parent is shocking to most Americans. In many instances, though, factors like the double generational demands or other tensions trigger the maltreatment, almost against the will of the abuser. The outcome for the latter can be a rending sense of guilt, of being trapped in a pattern of destructive behavior beyond one's control. The following example from the Select Committee's report typifies the anguish that an abuser can feel: "A Massachusetts physician reported a case in which a badly bruised woman was accompanied by her middle-aged daughter who pleaded, 'Please help me, doctor; I'm beating my mother.' " This is hardly the cry of an unfeeling monster. It is, rather, a desperate plea for assistance. But as will be seen later, little is currently available in terms of the kinds of help that would reduce the burdens of the care giver.

Sometimes the elderly person actively precipitates the abuse. "Our study found that the parent can exacerbate an already stressful situation by constant complaining and criticism, to the point of striking the care-giver," Dr. Block said. "Old people are not necessarily saintly, and there are occasions when they are to a considerable extent responsible for their own abuse."

The ill treatment may not be physical at all. Psychological abuse can be equally painful: Yelling, threats and insults are for some as stinging as a slap to the cheek. Or as one witness testified at a hearing held in New York, psychological abuse can take the subtler form of excluding the aged relative from the family conversation, implying unworthiness to participate in the family's daily life. Or else the person may be left alone for long periods in an isolated part of the home, a form of nonphysical neglect which magnifies feelings of helplessness and a low self-esteem from which the elderly relative may already be suffering.

Whether the abuse is physical or psychological, recovery for an older man or woman is much more difficult than for those who are younger. The distinction in this respect between elder abuse and spouse and child abuse was pointed out during the course of a conversation with Kathleen Gardner, assistant staff director of the Select Committee on Aging. It was Miss Gardner who had overall responsibility for preparation of the report.

"The elderly have less physical and emotional resilience and so don't bounce back as fast as children or young adults," she said. "The overall damage is harder to recover from."

There are some indications that physical abuse may be more prevalent in low-income homes because the concomitants of poverty—crowding, poor living conditions, few means of obtaining outside help—intensify the stress of caring for a disabled elderly relative. An example that came to my own attention involved a woman in her 60's who unexpectedly found herself in the position of having to receive into her home a much older sister. Because of a lack of space, the younger sister, who was not well herself, had to give up her bed for the incoming older woman and sleep on a sofa in the living room. At the time I visited, deep resentment was evident and, in terms of language, the beginnings of verbal abuse might have become physical had not a social worker from a senior citizen agency intervened. He eventually arranged for the older sister to be placed in a community residence facility.

But as Miss Gardner observed, elder abuse cuts across all lines when it comes to poverty and affluence, so that generalizations are hard to make, even concerning the sex and age of the abuser. The case of the elderly sister shows, for example, that older people can abuse one another, especially if one of them is frail or disoriented. Moreover, although women rather than men are more frequently obliged to assume the role of care provider, the report concluded that the most likely abusers are sons or sons-in-law, many of them with alcohol or drug-related problems that in themselves can pave the way for abuse.

Greater clarity would prevail had the studies done so far been more extensive. But Dr. Block's in Maryland, as well as the other two (in Massachusetts and Michigan), are based on samples taken from three states only. What is clear is that elder abuse is part of the larger phenomenon of family violence. In her own study, Dr. Block points out that "there seems to be a tendency in American society, as evidenced by the incidence of child and wife abuse, to physically harm the family members who are weak or dependent. That abuse of aged parents could occur is a logical extension of this concept."

One circumstance that may suggest that elder abuse is likely to increase in the years to come is the greater longevity of senior citizens. Miracle drugs have lengthened the life span of Americans, but those who live longer are subject to

a range of physical and mental disabilities that require much in the way of supportive services from family members who themselves may be middle-aged or elderly.

Theoretically the government, either at the Federal or the state level, should provide these supportive services, and yet little is available. Whereas most states allot significant sums for dealing with child abuse, comparatively little is earmarked for protective services for senior citizens. As the report puts it, states commit 87 percent of their protective service budgets to children and only 7 percent to the elderly. Despite the fact that child abuse cases outnumber reported elder abuse cases three to one, the disparity in apportionment of resources is evident.

One of the crueler ironies of the situation is that a family of slender means may be indirectly penalized should an elderly relative receiving S.S.I. (Supplemental Security Income) come to live in the household. Under existing regulations, after the relative moves in, the amount of the monthly benefits is reduced by one-third. For a family already struggling to make ends meet, the added pressure of having to pay for medicines and other items, whose cost exceeds the amount of the reduced benefits, may well result in frustrations which could push the care provider toward abusive behavior.

Partly because of higher tax rates, a number of industrialized countries are able to do more for their elderly and for family care providers than is possible here. In a paper delivered before the Gerontological Society of America in 1981, Mary Jo Gibson of the International Association of Aging made a number of striking comparisons in this regard. Most notable are the Scandinavian countries, in particular Sweden. Not only does Sweden provide home health aides (923 per 100,000 population, as compared to 29 per 100,000 in the United States), it also reimburses family members for performing the equivalent of home health services. Nor is the reimbursement simply to relieve financial pressure. Miss Gibson notes that part of the goal is "to encourage the family caretaker to enroll as a paraprofessional in the home help service at some point in the future." Such far-sightedness concerning long-range goals that affect the quality of life of the elderly is impressive and dramatically different from policies in this country. Dr. Block observed that even were more money available here through higher taxes, legislators might funnel it into defense spending.

Also available elsewhere are various kinds of respite care, services that reduce the strain on family members who assume caretaker roles. One form of respite involves short-term placement of the frail elderly in a nursing facility, allowing the care providers to go away for brief vacations or to rest at home. France, Japan and Denmark all have arrangements of this sort.

In New Zealand there is a Disabled Persons Relief Scheme that entitles those who care for incapacitated elderly persons to four weeks holiday; during this time, the ill person is either placed in a suitable facility, or else a paid care provider is brought into the home. The benefit is apparent from Miss Gibson's assertion that "family members will go on caring for elderly relatives suffering even from severe chronic brain syndrome as long as they can be assured of respite care and support in time of crisis." Some respite care exists here, but to a much more limited degree and often at heavy personal expense because it is not reimbursable through Medicare.

One kind of relief from the tensions involved in caring for an unwell elderly relative that has never been explored would be discussion groups based on the model of Alcoholics Anonymous. Since A.A. meetings are held in rent-free locations, moreover, such groups would be of no cost to either the public or the private sector. Their value would lie in allowing care-givers to meet with one another to air feelings of guilt and resentment frequently kept concealed until they have reached an explosion point.

Oftentimes, too, abusers believe that they are the only ones ever to have behaved in a destructive manner toward their own kin. Filled with shame, they are afraid to discuss the problem even with close friends for fear of horrifying them. The consequent sense of isolation can be intense. Sharing sessions could help to restore a balanced perspective as a first step in the direction of dealing with the home situation in a constructive manner.

Miss Gardner agreed that support groups of this kind would be useful not just to the abuser but to the abused as well.

"Both sides need the chance to vent their feelings," she said. "It might also be that the abused person could help the abusing relative in this way."

Miss Gardner expressed surprise that no church organizations had initiated support groups based on the Alcoholics Anonymous concept. The surprise is the more understandable in view of the fact that most denominations place great emphasis on the stability and harmony of family life.

The forms of abuse considered so far have been nondeliberate, in large measure the result of stress. But much elder abuse is willful. Dr. Block spoke of it.

"The most frequently encountered kind is financial—for instance, demanding the parent's Social Security check," she said. "If the parent refuses, the middle-aged child shouts. If this doesn't work, he hits. The yelling—psychological abuse—usually achieves the desired end."

'Elder abuse is better approached from a helping . . . posture'

But intentional physical abuse is not uncommon. It is the sort which is taken note of by the media because, when detected, it becomes a police matter. In March 1983, The Washington Post described an incident in which a 25-year-old woman was accused of assaulting the 69-year-old grandmother in whose home she lived, breaking several ribs and blackening her eyes. Since the granddaughter was also accused of forging checks in her grandmother's name, the physical battering would appear to have begun as financial abuse.

Although the need for police intervention in cases like this one seems clear-cut, criminal prosecution can, paradoxically, have adverse implications for the abused person if the situation involves dependency. In a monograph on the legal role of protective services for older Americans, Arthur LaFrance, dean of the Lewis and Clark School of Law in Portland, Ore., observes that because "the victim may be dependent upon the perpetrator, convicting and jailing the perpetrator may terminate the home life . . . of the victim. Ironically," he adds—almost as if by way of commenting on the incident described in the Post—"the home may actually be that of the victim."

Many states now have statutes of one kind or another aimed at protecting older Americans, through measures like mandatory reporting. But reporting statutes have drawbacks. Mr. LaFrance mentions several. Thus, unless there is an immunity provision, some people who suspect abuse may be concerned about liability if they report it. There is also the question of vagueness of definition: It is not always easy for an outsider to be sure that abuse is taking place, particularly if it is psychological. But perhaps the most serious problem related to mandatory reporting is the fact that few states that have it provide the services that would help rectify the abuse situation once it is reported.

"That's why the laws in Connecticut and South Carolina are the best in the country," Dr. Block said. "Both states have services to back up their elder-abuse legislation—respite care, alternative housing, counseling. In Connecticut there's a team approach with doctors and social workers involved. Since the availability of services is publicized, more people are willing to seek help, both abused and abusers."

At the Federal level, Representative Claude Pepper (D., Fla.) and Representative Mary Rose Oakar (D., Ohio) have introduced what is known as the Prevention, Identification and Treatment of Elder Abuse Act (HR 769). It calls for the establishment of a National Center on Elder Abuse that would conduct a countrywide survey to determine its incidence. In addition, the center would maintain a clearing house on all programs related to elder abuse and provide training materials for personnel engaged in dealing with it.

But the bill was introduced early in 1981, and its passage into law appears uncertain under the present Administration, even though its provisions are more modest than the recommendations of the Select Committee's report. The latter include emergency shelter for elderly men and women at risk, amending the S.S.I. program to eliminate reduction of benefits for those who move into a household in which some care is given, making respite care reimbursable through Medicare and providing tax incentives for families who look after their elderly at home.

These and the other recommendations of the report suggest that, apart from cases of willful battering, elder abuse is better approached from a helping rather than from a punishing posture. The authors of the study done at the University of Michigan assert in this connection that "there are no clearly identified villains . . . when, in fact, all participants may be the victims of circumstances in which they are forced to live." But to change such circumstances would require financial commitments that the Federal Government, and most state governments, as yet seem unwilling to make.

Zero Weather at the Hermitage

in memory of Thomas Merton

in the pine squeak cold
the trees speak

a creak of wood

cracks its voice
a freeze to night

the black glints
with snow

footprints approach
to leave
this place
of winter language

the eye moving a pen
across paper
a blank white field
of memory

the voice unlistened
no poem to mark it

RON SEITZ

SENIORS' OFFICE

LEGAL AND OMBUDSMAN SERVICES

TED SCHWINDEN, GOVERNOR

P.O. BOX 232
CAPITOL STATION

STATE OF MONTANA

(406) 444-4676
1-(800) 332-2272

HELENA, MONTANA 59620

January 14, 1985

Senators,
Senate Public Health Committee
Montana Legislature
49th Legislatuve Session
State Capitol
Helena, Montana 59620

Dear Senators:

I serve as the attorney responsible for overseeing the coordination and development of legal services for senior citizens. One of my responsibilities in this role is to assist senior citizens in their advocacy efforts such as planning the Legacy Legislature that is held every other year immediately preceeding the convening of the Montana legislature.

This past summer I assisted with the drafting of Legacy Legislature bill #27 which would recognize specific criminal penalties for those persons who abused, neglected or exploited persons 60 years of age or older. In 1983, the 48th Montana Legislature enacted the "Montana Elder Abuse Prevention Act" which was codified as Title 53, Chapter 5, Part 5 of the Montana Codes Annotated. While this law mandated the reporting by certain professionals of suspected cases of elder abuse, neglect or exploitation, it did not provide any penalties for those persons who abused, neglected or exploited an older person.

As a result of the passage of the Montana Elder Abuse Prevention Act, the state long-term care ombudsman as well as the Department of Social and Rehabilatation Services (SRS) and its local affiliates have received a number of reports of suspected cases that have been substantiated. The details of the type of cases which have been reported can be best related by the ombudsman or personnel from SRS. Under existing Montana law, a number of persons have believed that the perpetrators of the substantiated cases of abuse, neglect or exploitation should have been subject to some sanctions. Existing Montana law allows for charges to be brought only for such crimes as assault, aggravated assault, intimidation, theft or homocide. In a number of cases, these charges would be inappropriate or inadequate.

The senior citizens in the Legacy Legislature believed that it was necessary to recognize as specific crimes the abuse, neglect or exploitation of older persons. At the present time there is no offense that could be charged at all for someone who had a legal or assumed duty to care for an older person's health or nutritional needs and neglected to do so.

The penalty proposed in Senator Towe's bill does not provide a minimum fine or term of imprisonment that must be imposed upon a finding of or plea of guilty. Sentencing is the prerogative of the Judge after receiving a pre-sentence investigation report. The maximum penalties provided in the bill are greater than those allowed for a routine theft charge but are less than that which is currently permitted for an aggravated assault charge (up to 20 years in prison, $50,000 or both).

While a victim may not be permanently physically injured as a result of abuse, neglect or exploitation, that person may suffer irreparable mental anguish that in many cases $50,000 is a grossly inadequate sanction to apply. I will leave to you, as members of the legislature, to decide on what an adequate penalty provision should be to include in this bill. The proposed penalty in Senator Towe's bill is acceptable to me, and I do not believe that it is excessive in light of the fact that there is no minimum that must be imposed.

I am appearing before you today at the request of Senator Towe who has introduced this bill to address the needs of those who served in Legacy Legislature. I also serve as the attorney for the state long-term care ombudsman program which investigates elder abuse complaints in nursing homes. If there are any questions you may have regarding my testimony or my responsibilities concerning elder abuse investigations, I would be more than willing to tryto answer them.

Thank you for receiving my testimony and I hope you will give favorable consideration to Senate Bill #54.

Sincerely,

Douglas B. Olson
Attorney
Elderly Legal Services Developer

STATE OF MONTANA
LONG-TERM CARE OMBUDSMAN PROGRAM

ANNUAL REPORT
FISCAL YEAR 1984
(October 1, 1983 - September 30, 1984)

SENIORS' OFFICE
LEGAL AND OMBUDSMAN SERVICES
P. O. Box 232
Capitol Station
Helena, Montana 59620
(406) 444-4676

Doug Blakley
State Long-Term Care Ombudsman

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INTRODUCTION

The overall purpose of the Long Term Care Ombudsman Program is to work in the area of advocacy with either individual elderly residents of the State's long-term care facilities or all residents of the facilities as a group in order to ensure their health, safety, welfare and rights are protected within the facilities.

Under the federal Older Americans Act (OAA), each state unit on aging is required to establish a Long Term Care Ombudsman Program that performs the following functions as identified in 42 USC 3027, Section 307:

1. Investigate and resolve complaints made by or for older residents living in long-term care facilities that may adversely affect their health, safety, welfare or rights;
2. Monitor the development and implementation of Federal, State and local laws, regulations and policies with respect to long-term care facilities in the State;
3. Provide information to public agencies regarding the problems of older residents of long-term care facilities;
4. Provide training for volunteers and promote the development of citizen organizations to participate in the ombudsman program;
5. Carry out any such duties that the Commissioner of the Administration on Aging deems necessary.

At the present time the specific duties, responsibilities, and limitations of the Long Term Care Ombudsman Program have not been delineated under Montana law.

Funds for the Program come from the following sources:

Title III-B of the OAA. $20,000.00
Title III-B State matching funds. . .(approximately) $3,500.00
Title IV-C of the OAA $50,000.00
(Title IV-C funds pay for a substantial amount of the operation of the Ombudsman Program as well as funding the Elderly Legal Services Developer Program).

The State Long Term Care Ombudsman (LTCO) is the only program staff at the state level. Local services are provided through the State's eleven Area Agencies on Aging (AAA's). They hire and supervise local personnel who provide ombudsman services at the local level. Most of the State's 56 counties have a local individual who is assigned to visit the long-term care facility(s) within their assigned county.

There are approximately 90 nursing homes in the State with about 6,000 beds. The exact number of other long-term care facilities (e.g., personal care homes, retirement/boarding homes) is difficult to determine at the present time due to changes this year in the licensing categories used by the Department of Health and Environmental Sciences. LTCO's are responsible for advocacy efforts within all these long-term care facilities.

SUMMARY OVERVIEW

During the period covered by this report (Federal fiscal year 1983-84, from October 1, 1983 through September 30, 1984), a number of significant changes and accomplishments occurred within Montana's Long Term Care Ombudsman Program. The following section highlights the most significant events. Further details are provided in subsequent sections of the report.

Program Restructuring

In January 1984, the basic method of service delivery at the State level was changed. The State Long Term Care Ombudsman (LTCO) position was changed from a contracted position to a full-time state employee position. Lenore Taliaferro provided services through the middle of January 1984. Doug Blakley was hired at the end of January 1984. The program was shifted from the Department of Social and Rehabilitative Services (SRS) and administratively attached to the Governor's Office. This was a transitional move designed to provide the program with increased independence. Daily supervision of program activities is provided by the Executive Secretary of the Board of Visitors, Kelly Moorse. The Board of Visitors is also administratively attached to the Governor's Office and provides similar advocacy services to residents within the State institutions dealing with developmental disabilities and mental illnesses. Since SRS is the State unit on aging, they still administer the program funds as well as providing supportive services for operating the Ombudsman Program. Legislation to establish a permanent placement and structure for the Ombudsman Program will be introduced in the upcoming legislative session.

Grant Activities

Due to the changes in program structure and personnel, many of the program activities related to reviewing, updating and revising some of the basic components of the program. The most important change occurred in the method of designating local Ombudsman Programs. The designation process is the mechanism used by the State Ombudsman Program to establish an official relationship between the State and local programs and to ensure basic standards for the provision ombudsman services. The State Program and the AAA's worked together to establish more specific guidelines under which local personnel should operate, thus making the designation process a more accurate reflection of what local personnel are doing as ombudsmen. As a result of this process, three designations were developed: Friendly Visitor, Local Long Term Care Ombudsman, and Certified Ombudsman. These designation levels represent a hierarchy of increasing involvement and responsibility. Letters of Understanding have been finalized with eight (8) of the AAA's, and are in the process of being finalized with the other three.

In addition to the designation process, a modification of the reporting and documentation process was instituted to simplify procedures at the local level and provide a data base on complaints that local personnel are resolving through their advocacy efforts at the local level. There is very little information available at the present time to document the kinds of complaints resolved at the local level. The changes are being pre-tested in three AAA's prior to their implementation on a statewide basis.

Another grant objective, to increase the involvement of the private sector in aging services, resulted in activities that had a direct benefit to the designation process. Through a combined effort between the Area XI Agency on Aging, the local Ombudsman, and the State Program, guidelines and protocol between the local program and the long-term care facilities in Missoula are being developed. This process will not only allow both providers and the local program to be actively involved in developing the guidelines, but will assure a mutual level of understanding between the two entities. An additional outcome of the process is the development of the "Certified Ombudsman" designation. This designation will be achieved through a testing process that will ensure a level of proficiency above that currently required of other Ombudsmen. This accomplishment represents a significant advance in program development for ombudsman services, and provides a level of service for other local programs to strive toward.

On-going efforts to publicize the LTCO Program have continued throughout the year through the use of a number of different means. Continued efforts in this area are crucial due to the constant turnover in the intended recipients of the services and the need for those living and working in long-term care facilities to understand the purpose and scope of the program. Community presentations, presentations to professional groups, news releases and articles, interviews, and public service announcements are the major methods utilized by the State Program to educate and familiarize the general public about the program. Site visits to 31 nursing homes and 6 personal care facilities by the State LTCO was another method used to emphasize the existence and responsibilities of the program. Finally, the work of the local LTCO's, through their on-going visits to facilities and their community contacts serves as a vital component in highlighting the program.

Finally, the State Program was directly involved in 77 individual cases involving 227 separate complaints about the care and conditions within long-term care facilities. With the passage of the Montana Elder Abuse Prevention Act (EAPA), there was a significant increase in the number of cases of abuse, neglect and exploitation that the State LTCO was involved in. A joint agreement for handling these

cases was developed by the State LTCO, SRS, DHES, and the Medicaid Fraud Bureau of the Department of Revenue. Under this agreement, the State LTCO was designated as the agency to receive the initial reports of the abuse, etc. that occur within long-term care facilities, and to coordinate investigations into the reports. A total of 43 cases were reported, with a total of 23 cases substantiated. More information on this and other statistics is provided in subsequent sections.

STATISTICAL REVIEW

One of the primary and certainly the most visible functions of the Ombudsman Program is the investigation and resolution of complaints by or on behalf of residents of long-term care facilities. As previously mentioned, there is not currently in place a reporting and documentation system to provide information on the activities of local ombudsman personnel in investigating and resolving complaints that they handle independently. This is a significant gap in the overall picture of the problems that exist within long-term care facilities in Montana, especially since local personnel receive a significant number of complaints that they act upon. A modified system of data collection is currently being pre-tested to evaluate its effectiveness in filling this gap. When refined, the system will be introduced statewide later in the fiscal year.

Several factors have inhibited data collection by local LTCO's in the past. The main problem has been the already large number of duties that local personnel are required to perform in their joint role as Information and Referral Technician and Local Ombudsman. The large number of duties coupled with the relatively low reimbursement most personnel receive make it difficult to require additional demands for extensive, detailed documentation procedures. In many cases, the effort necessary to report problems may exceed that needed to intervene. The new system is striving to balance the need for data with the time available to perform this task.

Thus, all the data reported herein pertains to cases investigated and resolved by the State Program. At the state level, 77 individual cases involving 227 separate complaints were handled. Table 1 shows the annual case and complaint data over the past four years.

TABLE 1: ANNUAL CASE AND COMPLAINT DATA 1980-1984

FFY	80-81	81-82	82-83	83-84
Cases	*	*	106	77
Complaints	64	329	541	227

*No data available.

This is all the annual data that is available. It is difficult to analyze the statistics for trends over this period for several reasons. First, during this period, three different individuals served in the State LTCO position. The basic method of keeping statistics underwent one significant change during this period. While the same basic method

of reporting statistics has remained intact over the past three years, changes in personnel bring different personal styles, approaches, and emphases on the job of data collection and interpretation. This further complicates comparison of annual statistics. A good example of the effects of these differences can be seen in the differences between the 1982-1983 and 1983-1984 statistics, where the number of cases decreased by 29 while the total number of complaints decrease by over 300. Thus, more emphasis is placed here on analyzing the statistics from the current year, while caution is used in comparing them to previously compiled statistics.

Before beginning an analysis of this year's statistics, it is important to put complaint statistics in perspective. One should avoid the tendency to view all complaints as negative occurrences that require intervention of an adversarial nature because a facility is unwilling to correct it. Verified complaints may exist for a number of reasons. Some may result from inappropriate actions by a facility or its staff, others may be due to a number of other factors of which the facility may not be aware or of which they have no control. Some complaints, once brought to the attention of a facility, are resolved in a cooperative manner, others require intervention by regulatory agencies to correct. Also, complaint data reported covers approximately 140 different categories, some of which do not pertain directly to actions taken by facilities (e.g., guardianship problems, financial exploitation by individuals outside a facility, family problems, or problems with governmental programs such as Medicaid or Social Security). Finally, the heading of long-term care facility covers a wide range of service options, from nursing homes to personal care homes to retirement and boarding homes to state institutions. The State office also occasionally becomes involved in complaints from other settings, such as congregate housing settings or hospitals. Thus, generalizations or oversimplifications of the data and the facilities involved should be avoided.

Annual Case Data by Type of Facility

Table 2 lists the number of cases received at the state level by each of the major facility types.

TABLE 2: NUMBERS AND PERCENTAGES OF CASES BY TYPE OF FACILITY

	Number	Percentage
Nursing Homes	65	84
Personal Care/Retirement Homes	9	12
State Institutions	3	4
Other	0	0
TOTAL	77	100

Statistics for personal care homes and retirement/boarding homes are combined here because these licensing categories are unclear at this time due to the changes made at the end of June of this year. At that time, responsibility for licensing personal care homes shifted from the Food and Consumer Safety Bureau of DHES to the Licensing and Certification Bureau of DHES. This is the same bureau that licenses nursing homes and hospitals. Due to financial constraints, the Licensing and Certification Bureau may not begin to issue licenses to facilities under this new category until some time after the start of 1985.

Because of the greater number of nursing homes and the greater number of clients that they serve, one would expect a larger number of cases to pertain to this kind of setting. At the present time, nearly all nursing homes have a local LTCO who visits on a regular basis, while only about half of the personal care facilities have regular visitations. This fact may contribute somewhat to the predominance of cases from nursing home settings. The proportion of cases originating in each of the settings, shown in Table 2 for 1984 is fairly consistent with statistics reported from prior years. Without knowing how referrals to local LTCO's were done previously, or what exact statistical methods were used in previous years, it is difficult at this time to determine if there is any significance to the decrease in cases reported this year over last year.

Complaint Categories

Table 3 shows the ranking and percentages by category of the complaints received at the state level.

TABLE 3: COMPLAINT CATEGORIES BY RANK AND PERCENTAGE

Rank		Percentage
1	Resident Care	38
2	Complaints not against facilities	15.5
3	Resident rights	14
4	Food/nutrition	11.5
5	Administrative	8
6	Building/sanitation/laundry	5
7	Medications	4
8	Physician services	2
9	Financial	2

A breakdown of the exact numbers and the subheadings under each category may be found in Appendix A.

The ranking and percentages for complaint categories are fairly consistent with those of previous years with the exception of the first two categories, "Resident care" and "Complaints not against facilities." While "Resident care"

continued to be the largest category, "Complaints not against facilities" moved from fifth place the last two years to second. The percentages increased by half for both categories also. Both of these changes occurred mainly due to an increase in cases of elder abuse reported to the State LTCO. With the passage of the Elder Abuse Prevention Act (EAPA), all personnel working in long-term care facilities are required by law to report suspected incidents of abuse, neglect or financial exploitation occurring within facilities to the State LTCO. This mandatory reporting requirement resulted in a substantial increase in the number of physical abuse and financial exploitation cases being identified, these complaints being in the "Resident care" and "Complaints not against facilities" categories respectively.

Other individual complaints that in the past have been cited frequently as problem areas within facilities continued to be reported at a high rate. Inadequate levels of staffing and staff training, guardianship issues, fear of retaliation for reporting complaints, inadequate personal hygiene care and general food complaints were the most frequently mentioned concerns.

Finally, some complaints were more specific to a particular type of facility. Inappropriate placement in a facility and inappropriate staff members administering medications to residents were complaints that were problems usually identified as occurring in personal care homes as opposed to other settings.

Elder Abuse

Due to both the newness of the EAPA and the potential severity of this type of complaint, more specific data has been kept on this topic this year. Table 4 shows those cases reported under the EAPA and the outcome of the investigations into the complaint.

TABLE 4: TYPE OF ELDER ABUSE CASES BY OUTCOME

	Abuse*	Neglect	Exploitation	Total
Substantiated	13	2	8	23
Unsubstantiated	10	3	6	19

*Abuse includes cases of physical, verbal, mental and sexual abuse.

All of the substantiated abuse cases involved physical abuse against a resident of a facility. Some of these cases also involved verbal abuse. Most of the cases were substantiated because they were incidents that were observed by another person who could give an eyewitness accounting of the incident. Eleven of the cases involved staff of

the facility abusing a resident, while two were cases of residents abusing other residents. Eleven of the cases occurred in nursing homes, while two occurred in personal care homes. Six of the thirteen substantiated cases were reported by individuals who were not employed by the facility in which they occurred. In all but one of these cases, staff members of the facility had knowledge of the incident but did not report the incident. Failure to report the incident was usually due to a lack of knowledge about the reporting requirement. All facilities have received copies of the EAPA, but many simply post the Act and have not provided training or further information to staff members. Because of the newness of the law, no one to date has been prosecuted for failure to report an incident of suspected abuse. All but two of the unsubstantiated cases were reported by persons who were not employed by a facility.

A profile of substantiated physical abuse cases indicates that the case usually involves an aide either striking an elderly resident or using excessive force to get the resident to comply with orders given by the aide. Facilities usually discharge an aide who has resorted to the use of inappropriate force. While the problem of physical abuse in all these cases is a serious one, none of the residents involved has sustained injuries requiring medical attention or hospitalization, so no criminal prosecution has resulted from physical abuse cases to date.

With the exception of one unsubstantiated case, all of the cases of financial exploitation have involved inappropriate actions by either the family or friends of the resident. Cases are frequently reported by nursing home administrators who become aware of questionable actions. Cases in this area are most often quite complicated ones that require a substantial amount of investigation by the State LTCO, the Elderly Legal Services Developer and local Adult Protective Service Workers. Guardianship and conservatorship issues and family dynamics frequently play a dominant part in these cases. At present, two of the substantiated cases are being pursued by County Attorneys and may lead to prosecution. In other substantiated cases, the result is often the establishment of some sort of protective oversight or a change in the existing arrangements for oversight.

Complaint Resolution

Table 5 presents data on the outcome of investigation into individual complaints.

TABLE 5: PERCENTAGES OF COMPLAINT RESOLUTION BY CATEGORY

Substantiated by strong standard	36%
Substantiated by weak standard	18%
Cannot prove or disprove	30%
Invalid by strong standard	16%
	100%

Further explanation and exact figures for each resolution category can be found in Appendix B. These resolution categories are the ones suggested by The Administration on Aging (AOA), and are used so Montana's data can be compared with that from other states. In comparing the outcome of complaint investigations for different facility types, there are virtually no difference in the proportions with which complaints were resolved. Current statistics were also very similar to those figures reported in prior years. With the exception of statistics for elder abuse cases, statistics are not kept that indicated resolution of complaint investigations by complaint areas.

LONG-TERM CARE ISSUES

Programmatic Issues

1. Program development. As previously mentioned, some significant changes in the basic designation system occurred. These changes were designed to provide a more accurate description of the duties and responsibilities of local ombudsman personnel. Input was solicited from all AAA's and local ombudsman personnel during the spring training sessions on a proposed set of guidelines. Each Area was then contacted individually in order to tailor requirements to individual Area needs and circumstances. Thus, when the final Letters of Understanding were finalized with each Area, both the State Program and the AAA's had agreed to a set of expectations and procedures for the provision of local services.

The designation system was expanded to include three designation levels: Friendly Visitor, Local Long Term Care Ombudsman, and Certified Ombudsman. The majority of AAA's (9) have indicated they would use the Local LTCO designation and its guidelines (see Appendix C). The State Program and Area VI, the Area that will be using the Friendly Visitor designation, are in the process of finalizing the set of guidelines for that designation. The State Program and Area XI are currently in the process of developing guidelines, a training manual, and a certification test for the Certified Ombudsman designation.

In response to concerns expressed by local personnel, AAA Directors, and long-term care providers pertaining to the level of training provided to local personnel, several changes in the method of providing training and information will occur in the upcoming grant year. The State LTCO is developing a training and procedures manual that will act as a basic informational resource for all local personnel and will eliminate some of the need to repeat much of the basic programmatic information at all of the training sessions. This will allow the training sessions to deal with a wider range of topics and provide personnel with more diversified information. The State LTCO will also be preparing short quarterly overviews on various topics to provide updated information to local personnel on current topics of importance within the long-term care field.

An effort will also be made next year to explore alternate methods of providing ombudsman services through AAA's. Further program development and improvement in services are closely tied to the amount of funding available to the program. Without resources to help support local efforts, the time and extent of services that can be provided will continue to be effected.

2. Ombudsman legislation. The establishment of the Long Term Care Ombudsman Program in Montana law has been an on-going concern. While the Older American's Act (OAA) spells out the basic requirements that state programs must meet, each individual state has the ability to develop programs that meet their own specific needs and situations. Establishing the authority, scope and structure of the state and local programs has the advantage of both recognizing the programs and setting parameters for their operation. Additionally, some of the federal requirements (e.g., access to facilities and resident records, confidentiality and access to ombudsman records) require the enactment of state legislation.

There have been indications that legislation will be introduced in the upcoming legislation. The Governor, in his address to the 16th Governor's Conference on Aging, stated he would "request legislation to permanently establish the ombudsman program within the Governor's Office." The most important issues that need to be addressed by legislation are how the program will be structured and where within state government it will be placed, whether local programs are supported financially, and what types of facilities and individuals within the facilities will be served by the program. How the program is structured and where it is housed has a direct effect on its independence and its ability to advocate on behalf of all residents within long-term care facilities. In order to continue to have local personnel present in facilities at a level that makes the program effective, a minimum level of funding needs to be provided to AAA's to at least cover travel expenses incurred by local ombudsmen. The only funds presently available for ombudsman services are provided through the OAA. These funds are used to operate the State Program and the Legal Services Developer Program. What little is left over at the end of each fiscal year is distributed to the AAA's, but the amount is minimal and when divided up between 11 AAA's, is negligible. Thus, local ombudsman services are currently being added on to the responsibilities of the Information and Referral Program, and put a strain on the resources of that Program. The issue of who the program serves will be covered in the next section.

The LTCO and ELSD are presently meeting with the staff of the Governor's Office to discuss these and other issues pertaining to Ombudsman Legislation.

3. Expansion of program duties. Both nationally and within Montana, the issue of who ombudsman programs should serve is receiving a lot of consideration. Amendments to the OAA in 1981 increased the scope of ombudsman services to include personal care settings. Recent trends, such as the development of swing beds within hospitals and the

increase of community based long-term care services, have resulted in additional settings that ombudsman services are being asked to monitor or provide assistance. Congregate housing for the elderly is still another setting where assistance has been requested. Given the constant funding levels for state programs over the last six years and the difficulty in securing funds for local programs, it is increasingly difficult for ombudsman services to meet the demands of assisting in new settings, let alone meet the additional demands of monitoring personal care settings. Swing beds are an area that state programs seem to be most inclined to consider adding because of its similarity to nursing home care. Swing beds are designed to provide temporary nursing home care in hospital settings when a nursing home bed is not available locally. It is a model that is primarily used in rural areas. There are currently 23 hospital settings in Montana with a total of 129 licensed swing beds that can provide this kind of care. Additional hospitals are applying to convert some of their beds as swing beds also. Since the individuals in these beds require nursing type services, some can be expected to need ombudsman services. Because most facilities using swing beds are joint hospital-nursing home facilities, the extension of services to this model in Montana would not be as difficult as in other settings, and is recommended by the State LTCO.

Institutional Issues

1. Staffing levels. The issue of the level of staffing within long-term care facilities is a controversial one that can have a pervasive impact on the quantity and quality of care provided to residents of facilities. The issues of quantity of care necessary and its quality can be very subjective. One person's expectations of what is appropriate can vary greatly from the next person's. Thus, determining levels of staffing necessary is no simple task. Further complicating the problem is the ever changing needs of residents, as well as continual turnover in residents themselves. Inadequate levels of staffing place increased pressures on the staff working to meet the demands of a larger number of residents. Combined with other factors that may be present such as low wage levels for aides, inadequate training, high turnover, and the demanding nature of the job, understaffing can result in patient care being done inappropriately, in an untimely manner, or not at all.

Many patient care complaints received by ombudsmen come as a direct or indirect result of inadequate levels of understaffing. The most common are inadequate personal hygiene care for residents, unanswered call lights, inappropriate use of restraints, staff attitudes, and abuse situations. One frequent and telling remark that ombudsmen often hear from people making complaints on behalf of a resident is, "I'm glad that I can come to the facility and make sure that my resident is getting the care that they need. I

wonder what those who don't have someone visiting them do?" Many family members report being in facilities on a frequent basis and giving care to their residents to make sure the resident's needs are being met. Again, overgeneralizations to all facilities is not appropriate. Some facilities staff at higher than required levels to ensure that the residents have all their needs met.

The roots of the problem of understaffing are complex, and based mainly in regulatory and fiscal issues. Facilities have minimum staffing levels that they must meet. These levels are set by both federal and state laws and regulations. Unfortunately, minimum levels can become maximum levels, and may not meet the changing demands of patient needs or of a changing resident population. Many aspects of the system of reimbursement for care cause problems that end up effecting resident care. Budgetary belt-tightening at the state and federal levels continues to put pressure on the reimbursement rates for care. Combined with the ever increasing inflationary spiral of medical costs, facilities are forced to make cuts, and personnel services, being the largest line item in the budget, can receive the largest cuts.

Because of the complexity of the problem, solutions are not easy. Since most people do not have a second facility available locally, they cannot simply take a resident out of a facility and place them in another one if they are not satisfied with the level of care without having to face the prospect of long trips or less frequent visits. Thus, free market principles are not usually an option that has a great impact on facilities. Action needs to be taken on both the systemic and local levels. One method being explored in other states involves financial incentives for facilities providing above average levels of care and imposing intermediate sanctions on facilities for poor quality care. Unannounced inspections of nursing homes is another option under consideration in Montana that could improve the quality of care and monitor staffing issues more closely. Locally, involvement of family and community members in community or resident councils, if they exist, can be an effective way to bring pressure on facilities that have problems.

2. Personal care homes. Personal care homes are a licensing category that has undergone considerable change this year. Residents of these facilities are individuals that need 24 hour supervision and assistance in performing activities of daily living, but do not have the level of medical needs that a resident of a nursing home would. New rules were adopted by DHES in June of this year as a result of changes made in the 1983 legislature that pertained to licensing of personal care homes. The changes were made to meet federal requirements, and provide more specific requirements for home that will ensure the health, safety and welfare of residents. Licensing will be done by the

Licensing and Certification Bureau of DHES, which is also responsible for licensing nursing homes.

Because of a shortage of personnel and funding, the Licensing and Certification Bureau is presently unable to issue licenses to new facilities or to convert the licenses of facilities currently providing personal care services under the old Food and Consumer Services license. DHES is attempting to get approval for additional funds to hire both temporary personnel to cover immediate needs and more permanent help to assist in future licensing demands. This is necessary not only to meet the increased licensing demands, but to ensure the enforcement of existing regulations.

Due to the change-over in licensing responsibilities and the lack of current DHES licenses, ombudsmen are the only group monitoring conditions in personal care homes and responding to complaints about them. While the actual number of facilities (about 20) and residents (about 250) are small compared to nursing homes, the lack of active regulatory oversight leaves residents in potential jeopardy. Ombudsmen interventions cannot always resolve problems. When interventions are unsuccessful, it is very difficult to proceed because of the lack of alternatives for referral.

3. Elder abuse. The basic intent of the EAPA was to provide information on the extent of this problem in Montana. EAPA has met this objective fairly well for abuse occurring in long-term care facilities. Approximately 25% of the substantiated cases of abuse have occurred in long-term care facilities. This high rate of substantiated cases is undoubtedly the result of a higher rate of reporting rather than a higher rate of incidence.

Given the mandatory reporting requirements that all personnel working in facilities have, the penalties for failing to report any suspected incidents of abuse, and the greater visibility of abuse within facilities, abuse occurring in facilities is more likely to be reported. As the statistics indicated, however, nearly half of the substantiated cases that occurred in facilities were reported by individuals who were not employed by the facility. In most of these cases, staff were aware of the abuse but failed to report it to the State LTCO. As with cases occurring in the community, individuals having knowledge of abuse do not report it for a number of reasons: they are reticient to become involved; they give the perpetrator the benefit of the doubt; they do not want to "snitch or gossip"; they feel that the incident is an isolated one and won't happen again; or they do not know where or how to report the abuse.

On-going efforts are necessary to make staff and the general public aware of the problem, its signs and symptoms, and what can be done about it. Specific training of staff on

elder abuse and abuse reporting, as well as ways of dealing with stress that can lead to abuse, need to be provided in facilities. The State LTCO is working on producing training materials during the upcoming grant year to address this need. An additional video similar to the one produced this past grant period is also being contemplated for the upcoming grant period. The recently completed video is a dramatization that deals with general elder abuse issues, especially those occurring in the community.

Revisions of the EAPA are anticipated in the 1985 Legislature. One problem that has come to light is the inability to track staff members that are discharged for abuse. This problem is especially difficult for discharged aides, since they are not licensed like nurses are. Given the difficulty that facilities may experience in finding people to fill aide positions, obtaining a job as an aide is usually easy. The possibility of an aide being discharged for abuse at one facility and going down the road and getting hired at another facility is very real. This is an issue that needs to receive some attention when reviewing information collected by the EAPA.

4. Other legislative issues. During the short period of time the current State LTCO has been in the position, other issues have come up that have an impact on residents of facilities, but have not been addressed in the same depth as the previously mentioned issues. The following listing of issues are ones that will also be addressed in the upcoming legislative session:

resident rights
health care containment
certificate of need for long-term care beds
unannounced inspections of long-term care facilities

FUTURE ACTIVITIES

This section outlines objectives that the State LTCO will be undertaking as part of the 1984-5 Advocacy Assistance Grant.

1. Assist in the development of legislation for the Ombudsman Program.
2. Develop additional training materials on elder abuse (including possibly another video).
3. Continue efforts to publicize the existence and functions of the Ombudsman Program (including the development of a poster that can be used in facilities).
4. Provide training and technical assistance to local ombudsman programs (including the development of a training and resource manual and quarterly information and resource materials).
5. Continued technical training for the State LTCO.
6. Develop training and educational materials on the subject of resident rights.
7. Monitor the development of state and federal laws, regulations, and policies as they pertain to long-term care facilities.
8. Continue to work on issues pertaining to elder abuse (including investigation of abuse cases and the development of informational and resource materials on elder abuse that can be distributed to facilities).
9. Encourage the development of resident councils in facilities (including developing a resource file on different council models and the effectiveness of these models).
10. Explore alternative methods of providing ombudsman services with AAA's.

APPENDIX A

SENIORS' OFFICE

LEGAL AND OMBUDSMAN SERVICES

TED SCHWINDEN, GOVERNOR

P.O. BOX 232
CAPITOL STATION

STATE OF MONTANA

(406) 444-4676
1-(800) 332-2272

HELENA, MONTANA 59620

ANNUAL STATISTICS

A. RESIDENT CARE (86) 38%

A-1	Inadequate hygiene care	(7)	A-16	Dehydration	
A-2	Bedsores, decubitus ulcers	(2)	A-17	Doctor not called	(1)
A-3	Not dressed	(1)	A-18	Staff attitudes	(6)
A-4	Not turned	(1)	A-19	Staff poorly trained	(7)
A-5	Not walked, exercised	(2)	**Lack/poor quality of:**		
A-6	Improper restraints	(5)	A-20	Restorative nursing	(2)
A-7	Unanswered help calls	(2)	A-21	Rehabilitation (OT,PT,ST)	(2)
A-8	Inadequate supervision of resisent	(3)	A-22	Social Services	
A-9	Kept up too long		A-23	Dental	
A-10	Improper accident procedures	(2)	A-24	Diagnostic	(1)
A-11	Resident falling	(3)	A-25	Activities (leisure, religious)	
A-12	Physical abuse	(18)	A-26	Inadequate care plan	(1)
A-13	Mental abuse	(3)	A-27	Poor medical equipment (wheel-chair, walker, hearing aid, etc.)	(2)
A-14	Verbal abuse	(7)			
A-15	Neglect (specify)	(6)	A-28	clothing in poor condition	(1)
			A-29	Other (specify)	(1)

B. PHYSICIAN SERVICES (4) 2%

B-1	Schedule of visits	(1)	B-5	Not responsive in emergency	
B-2	Billing		B-6	Does not take Medicare/Medicaid	
B-3	Inaccessible, unresponsive	(1)	B-7	Other (specify)	(1)
B-4	Diagnosis, treatment	(1)			

C. MEDICATIONS (10) 4%

C-1	Not given according to orders	(1)	C-4	Shortage	(1)
C-2	Administered by inappropriate staff	(4)	C-5	Given against resident's will	
C-3	Over-sedation	(4)	C-6	Other (specify)	

D. FINANCIAL (4) 2%

D-1	Billing/accounting wrong, denied		D-6	Questionable charges	(1)
D-2	Access to own money denied		D-7	Misuse of personal funds by facility	(2)
D-3	Not informed of charges	(1)			
D-4	Charged for services not rendered		D-8	Deposits, other money not returned	
D-5	Charges not approved in advance		D-9	other (specify)	

E. FOOD/NUTRITION (26) 11.5%

E-1	Cold	(3)	E-8	No water available	(1)
E-2	Unappetizing, little variety	(6)	E-9	Nutritionally poor	(5)
E-3	Choices		E-10	Religious preference not followed	
E-4	Snacks		E-11	Insufficient amount	(2)
E-5	Not assisted in eating	(1)	E-12	Unsanitary	(1)
E-6	Special diet not followed	(3)	E-13	Time span	
E-7	Preferences not considered	(1)	E-14	Lack of utensils	
			E-15	Other (specify)	(3)

F. ADMINISTRATIVE (18) 8%

F-1	Understaffing	(8)	F-8	Bed not held	
F-2	Admissions procedures	(2)	F-9	Room changes/assignment	(
F-3	Admission refused due to Medicaid status		F-10	Roommate conflict	
			F-11	Improper use of staff	
F-4	Discharge plans, procedures	(1)	F-12	Medical transportation	
F-5	Improper placement	(2)	F-13	Language barrier (incl. sign lang.)	
F-6	Transfer due to Medicaid status	(1)	F-14	Laundry procedures	(1)
F-7	Other improper transfer	(2)	F-15	Other (specify)	

G. RESIDENT RIGHTS (32) 14%

G-1	Restriction on right to complain		G-14	Denied rights	(2)
G-2	No grievance procedures		G-15	Visiting hours	
G-3	Religious rights restricted		G-16	Mail opened/not delivered	(
G-4	Civil liberties, voting restricted		G-17	No phone privacy	(1)
G-5	Social/community activities restricted	(4)	G-18	Not treated with respect, dignit	(6
G-6	Medicaid discrimination other than admission or transfer	(2)	G-19	Physical abuse by other resident	(3
			G-20	Verbal abuse by other resident	
G-7	Religious discrimination		G-21	Use of possessions restricted	
G-8	Race discrimination		G-22	Kept in facility against will	(
G-9	Sex discrimination		G-23	Threats of eviction from facility	(1
G-10	Not informed of condition		G-24	Fear of retaliation by facility	(6)
G-11	Not informed of rights, policies		G-25	Personal items lost, stolen, or used by others	(
G-12	Confidentiality of records				
G-13	Disallowed access to own records		G-26	Violation of privacy	(1)
			G-27	Denied sharing room w/spouse	
			G-28	Other (specify)	

H. BUILDING, SANITATION, LAUNDRY (12) 5%

H-1	Cleanliness	(1)	H-9	Bed, bedside equipment	(
H-2	Safety factors (exits, fire, railings)	(4)	H-10	Storage space (amount, security)	
			H-11	Supplies	
H-3	Offensive odors	(1)	H-12	Heating	(
H-4	Appearance		H-13	Cooling, ventilation	(
H-5	Pests		H-14	Lighting	
H-6	Bathrooms		H-15	Water temperature	
H-7	Linens	(1)	H-16	Outside garbage area	
H-8	Handicap assessibility	(1)	H-17	Other (specify)	

J. NOT AGAINST FACILITY (OTHER PROBLEMS) (35) 15.5%

J-1	Financial (bad debts, exploitation)	(12)	J-7	Insurance	
			J-8	Guardianship, conservatorship, power of attorney	(10)
J-2	Medicaid not providing services				
J-3	Medicaid reclassification	(2)	J-9	Family problems	(
J-4	Other Medicaid problem except discrimination	(1)	J-10	Wills	
			J-11	Outside social services agency	
J-5	SSI, Social Security		J-12	Inappropriate placement	(
J-6	Medicare		J-13	Other (specify)	(

APPENDIX B

LONG TERM CARE OMBUDSMAN COMPLAINT SURVEY 4 TH QUARTER 7/1 TO 9/30/84

SENIORS' OFFICE OF LEGAL AND OMBUDSMAN SERVICES (SOLOS)

	SNF/ICF	PC	Rm/Rtr	State Instit.	Other	TOTAL	CUMULATIVE
A. CASES							
1. Number of Cases (TOTAL)	28	6		1		35	
2. Number of Cases Carried Over.	6	2				8	
3. Number of Cases Opened.....	22	4		1		27	77
4. Number of Cases Resolved....	4			1		5	
5. Number of Cases Closed.....	24	4				28	
6. Number of Cases Pending.....							
B. COMPLAINTS							
1. Number of Complaints (TOTAL).	55	12		2		69	227
2. Number of Complaints Verified:							
a. Strong Standard.....	26	5		1		32	83
b. Weak Standard.....	13			1		14	41
c. Cannot prove or disprove..	9	2				11	68
d. Invalid by strong standard	7	5				12	35

DEFINITIONS:

CASE: Contact by a complainant, facility, group, etc. about concern(s) that result in an investigation.
COMPLAINT: Separate area or issue identified by complainant as problematic (e.g. food, patient care, rights, etc.).
OPENED: Cases initiated within this reporting period.
CARRIED OVER: Cases from last reporting period that required further work this period.
RESOLVED: Corrected or in the process of being corrected.
CLOSED: Resolution accomplished and parties satisfied, including Ombudsman.
PENDING: Cases that were not resolved this period and will be carried over next period for continued investigation.

VERIFICATION: (See above [B], a, b, c, d)

a. Substantiated by documentation, eye witness reports, deficiency citing by DHES, internal corrective actions taken, etc.
b. No hard documentation but investigation partially substantiates complaint.
c. Investigation did not provide sufficient evidence to reliably determine the validity or invalidity of complaint.
d. Investigation finds evidence contradictory to reported complaint and substantiated by investigating authorities.

SNF - Skilled Care Facility licensed by the Licensing and Certification Bureau of the Dept. of Health and Environmental Sciences.
ICF - Intermediate Care Facility licensed by the Licensing and Certification Bureau of the Dept of Health and Environmental Sciences.
PC - Personal Care Facility licensed by the Licensing and Certification Bureau of the Dept. of Health and Environmental Sc
RM/RTR - Residential Care Facility licensed by Food & Consumer Safety Bureau, Dept of Health and Environmental Sciences.
STATE INST. - Facilities under the jurisdiction of the Department of Institutions.
OTHER - Adult Foster Care, Unlicensed Facility, or Complaints related to family, legal, or local, state or federal programs

APPENDIX C

Mission Statement

The primary purpose of ombudsman services is to help patients or residents who are over 60 and who reside in long-term care facilities (skilled or intermediate nursing homes, personal care homes, retirement homes) to assert their rights and express their grievances on issues pertaining to their health, safety, welfare and rights within long-term care facilities.

Local Long Term Care Ombudsmen provide residents and those concerned about them with an access point to meet this purpose. They serve as a resource in resolving concerns and complaints about quality of care and quality of life issues through the use of a broad spectrum of strategies that include educating residents about their rights and responsibilities within a facility, promoting self advocacy, advocating on behalf of a resident, and referring complaints for intervention by state agencies. As an integral part of ombudsman services, local LTCO's seek to provide an objective review of complaints. If the complaints are substantiated, they assist in the complaint resolution process and conduct follow-up on implemented strategies.

The following is a set of guidelines that local personnel who are designated as Long Term Care Ombudsmen should use in meeting the mission statement of the program.

1. Visit your assigned facility(s) a minimum of once per month.
2. Submit a report on your visit(s) to the facilities to your AAA Director so they can forward it to the State offices.
3. Familiarize yourself with the facilities you visit. You should have a working knowledge of the following areas: key staff within the facility and what they are responsible for; the ownership of the facility (i.e., is it locally owned, owned by a chain, etc.); is there a resident council or community council, when does it meet, who runs it, how effective is it; the facility's grievance procedures and their effectiveness; the kinds of different daily activities through which you can meet other residents.
4. Familiarize the personnel in the facility with how the LTCO program functions, and how you as a local LTCO fit in.
5. Establish a relationship with the administrator of the facility that will continue to allow you access to local facilities. While there has not been any significant problems with access to this point, LTCO's do not have any legal mandate that allows them to function within facilities in Montana. Thus, the relationship with the administrator is crucial. LTCO's should find out what kind of procedures the administrator wants to establish, if any, for the LTCO entering the facility for visits. A minimum quarterly visit

should be held with the administrator to maintain the relationship that LTCO's have established. Any problems with access should be reported to the state LTCO immediately.

6. In those facilities that have resident councils, LTCO's should try to attend a council meeting at least semi annually, if the administrator will allow participation. This allows the LTCO the opportunity to work with an established entity within the facility that has similiar goals and increases the LTCO's knowledge of potential problems within the facility as well as residents within the facility that are working to resolve them.

7. LTCO's should use the following hierarchial guidelines when involved in the reporting, investigation, verification, and resolution of complaints:

a. LTCO's need to take some action on all complaints reported to them, be it to promote self advocacy, intervene personally, or to refer.

b. The major complaint area that local LTCO's should operate in pertains to problems arising in the course of daily living within facilities (e.g., food complaints, lost or missing personal articles, staff attentiveness, problems relating to use of personal spending money, or rights issues). Other problems may be appropriate for referrals commonly used as an I&R technician. A list of specific areas that should be referred to the state office first is provided below. Area Directors may have further requirements that should be adhered to.

c. For those complaints that LTCO's do get involved in, the first step that should be taken is to promote self advocacy by the complainant, if at all possible. This increases self determination and allows the complainant to develop skills to resolve their own complaints in the future. Strategies to use in approaching an administrator and background information on rights should be provided.

d. If the complainant is unable to resolve the problem through self advocacy, the LTCO may intervene with the resident or on their behalf, at the request of the resident.

e. For those complaints that the LTCO has had limited experience in handling in the past or with which they feel that they need assistance, they should consult with their area director or the state LTCO.

f. For those complaints that require intervention by other state agencies or require the intervention of the state LTCO, a referral should be made, using established Area procedures. In making referrals to the state LTCO, have as much detailed information available as possible in order to facilitate the investigation process.

8. Confidentiality in all phases of the complaint process should be maintained. The identity of the complaintant and information pertaining to the investigation should not be disclosed to anyone other than the LTCO's immediate supervisor and the state LTCO. Any records generated by

the LTCO should be secured in a safe place or destroyed on completion of the investigation.

9. Because of their accessibility to facilities, local LTCO's are in a unique position to assist in following up on complaints that have been resolved, to ensure that the resolution steps are being implemented at the local level.

The following limitations should be observed by local LTCO's:

1. Local LTCO's should not give statements to the media on any matters pertaining to investigations they have information about.

2. Local LTCO's should not initiate any investigations into any allegations of elder abuse, neglect or exploitation that they come into contact with. Any information pertaining to elder abuse should be immediately reported to the state LTCO, if it occurs within a long term care facility, or to their local Adult Social Worker if it occurs within the community. Under the new Elder Abuse Prevention Act, these two entities have responsibility for initiating procedures for the investigation into allegations.

3. Any complaints that pertain to legal matters should be referred to the Elderly Legal Services Developer in the Seniors' Office in Helena.

4. Any complaints that pertain to medications or eminent medical danger situations (e.g., infected bedsores) should be immediatly brought to the attention of the administrator or director of nursing of the facility and reported to the Area Director and state LTCO.

The state LTCO is available to answer any questions pertaining to ombudsman issues, and can be contacted by calling the toll free number, 800-332-2272.

(This sheet to be used by those testifying on a bill.)

NAME: Gary Walsh DATE: 1-14-85

ADDRESS: 111 Sanders, Helena

PHONE: 444-3865

REPRESENTING WHOM? Soc & Rehab Serv

APPEARING ON WHICH PROPOSAL: SB 54

DO YOU: SUPPORT? X AMEND? _____ OPPOSE? _____

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

PROPOSED AMENDMENT OF SB 57

1. Title, line 4
Strike: "AUTHORIZING"
Insert: "PROVIDING FOR THE ATTACHMENT OF"

2. Title, line 5
Strike: "ON"
Insert: "TO"

3. Page 2, line 4
Strike: "provided on"
Insert: "attached to"

4. Page 2, line 20
Strike: "Statement of anatomical gift"
Insert: "Indication"

5. Page 2, line 21
Strike: "~~of intent to make anatomical gift~~."
Insert: "of intent to make anatomical gift. (1)"

6. Page 2, line 22
Strike: "the reverse of"

7. Page 2, line 23
Strike: "~~space for indicating~~"
Insert: "space for indicating"

8. Page 2, line 24
Strike: "~~when~~"
Insert: "when"

9. Page 2, line 24
Strike: "statement whereby"

10. Page 2, line 24
Strike: "~~has executed~~ may execute"
Insert: "may execute"

11. Page 3, line 2

Following: line 1

Insert: "(2) The department shall provide each applicant, at the time of application, printed information calling the applicant's attention to the provisions of this section, and each applicant shall be given an opportunity to indicate in the space provided under subsection (1) his intent to make an anatomical gift.

(3) The department shall issue to every applicant who indicates such an intent a statement which, when signed by the licensee in the manner prescribed in 72-17-204, constitutes a document of anatomical gift. This statement must be printed on a sticker that the donor may attach permanently to the back of his driver's license.

(4)"

Requested by Senator Conover