Report to the Legislature

On

Health Related

Ombudsman
And
Advocacy Services

Workgroup Recommendations
December, 1999

Presented by

Office of Ombudsman for Older Minnesotans

Office of Ombudsman for Mental Health & Mental Retardation

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Pursuant to MN Stat. §3.197, the total cost to produce this report is under $1,000.00

PREFACE

The following report is the work product of the members of the working group attempting to design a system with a consumer focus. Members of the working group brought their own experiences and perspectives as well as input from their respective organizations; however, neither the report in full nor individual sections of the report should be interpreted as having the explicit endorsement of the individual organizations represented by members of the working group.

EXECUTIVE SUMMARY

The 1998 Minnesota Session Laws, Chapter 407, Article 2, Section 100 requires the Ombudsman for Mental Heath and Mental Retardation and the Ombudsman for Older Minnesotans to convene a workgroup to develop recommendations regarding all the health related ombudsman and advocacy services provided by the state.

Over the past five years a number of reports, discussions, workgroups and proposals have been forwarded that involve various small agencies of state government. Many of these various proposals failed to gain acceptance because of the difference in mission and type of citizens served by each agency. At the beginning of the study, the work group first discussed the background leading up to this study and reviewed past reports that have examined these offices or similar functions.

The work group identified and discussed the issues that have been expressed about the existing advocacy services provided to citizens in the current health and long term care systems including confusion for consumers, perceptions of passing consumers from place to place, no single entry point, vulnerability of clients, duplication of services, inefficient use of government resources, lack of administrative expertise, skepticism of government, funding, inconsistent data collection, metro and rural service differences, independence, role questions and conflicts of interest. Discussion ensued about the difference between ombudsman and advocacy services versus other state agency functions related to health that might also include some form of citizen assistance that was secondary to a regulatory, public policy or provider responsibility.

The group decided to limit the scope of the discussions and this report to the ombudsman and advocacy services provided by state ombudsman and advocacy offices either directly or through contract services. This included the Ombudsman for Mental Health and Mental Retardation, Ombudsman for Older Minnesotans, Ombudsman for State Managed HealthCare Programs and the Office of Health Care Consumer Assistance, Information and Advocacy (later repealed).

The work group discussed of the following range of options for achieving the goals of the study:

- Maintain Status Quo, no legislative changes;
- Modified Status Quo, co-location and shared services;
- Legislative merger of the two services which focus on health plan issues;
- Legislative merger of the two services which focus on health, safety, rights and benefits for a defined population of vulnerable adults;
- Legislative merger of all four services into one agency.

There was a great deal of discussion about the various options. The work group agreed that efficiency should not be about creating one place that is all things to all people but rather about appropriately connecting people to what is available. Concerns were also raised about the potential for the volume of calls from frustrated health care consumers that could consume and divert resources away from those who are more vulnerable and not able to speak up for themselves. The work group developed certain core principles to follow in developing the recommendation. These included:

1. Independent State Agency
   Independent from
   - Regulating agencies
   - Purchasing agencies
   - Provider agencies
2. Protection from retaliation with removal only for just cause
3. Integrity of current functions
4. Compliance with federal requirements

RECOMMENDATION

It is the work group recommendation that the Office of Ombudsman for Mental Health and Mental Retardation, the Ombudsman for Older Minnesotans and the Ombudsman for State Managed HealthCare Programs be brought together under one administrative head as an independent Ombudsman Center for Health and Human Services.

This merger should allow for efficiency of services and clarity for consumer access but provide protections for the integrity of needs of unique and vulnerable populations.

As an agency with a watchdog role over the health and long term care systems, certain protections must be put in place to prevent retaliation when the agency finds and reports mal-administration of these government provided, purchased or regulated systems.

The draft model contained in the recommendations includes two major functions that do not currently exist: 1. a central access number for consumers and 2. advocacy services for the general public regarding health insurance. Both of these functions would require new funding to be implemented. The three Ombudsman offices could do a number of things to create better coordination and administrative efficiency within their current budgets. It was the consensus of the work group that the staff of this access area could not be entry level employees. The staff of this area must have extensive background and experience in the health care system in order to be able to ask appropriate questions, provide accurate information and direct the citizen to the correct type of service for their needs. These staff would need to have basic knowledge of a vast array of disabilities as well as a comprehensive background in both public and private funding and regulation of the health care system. This staff would need to have strong communication skills with the ability to present information in a number of different ways to be able to deal effectively with different communication styles, sometimes under high stress situations.

Currently there is no one place for consumers with general private pay health care and insurance concerns to call. Both the Departments of Health and Commerce have regulatory authority over various segments of the health care insurance industry. In addition there are a number of self insured, multi-state corporations that are regulated primarily under the Federal ERISA regulation with little or no

state regulatory authority. In 1998 the legislature created the Office of Health Care Consumer Assistance, Information and Advocacy within the Department of Health. Subsequently, that office was repealed. The existing Ombudsman offices currently struggle to handle all of the concerns and calls that are currently generated. Any new population of citizens with advocacy needs would need funding for staffing and program development. Without that funding this population could not be served or would be served at the expense of current vulnerable citizen groups.

Adding the function of a single entry intake point and a general health care consumer advocacy function without sufficient resources would diminish services to all. A single entry point for consumers may not be beneficial to the citizens if there are not enough staff to handle the added volume of calls.

CONCLUSION

In conclusion, the work group recommends that the Ombudsman for Older Minnesotans, the Ombudsman for Minnesota Managed HealthCare Programs and the Ombudsman for Mental Health and Mental Retardation come together under the administrative umbrella of one *independent* state office to serve as The Ombudsman Center for Health and Human Services.

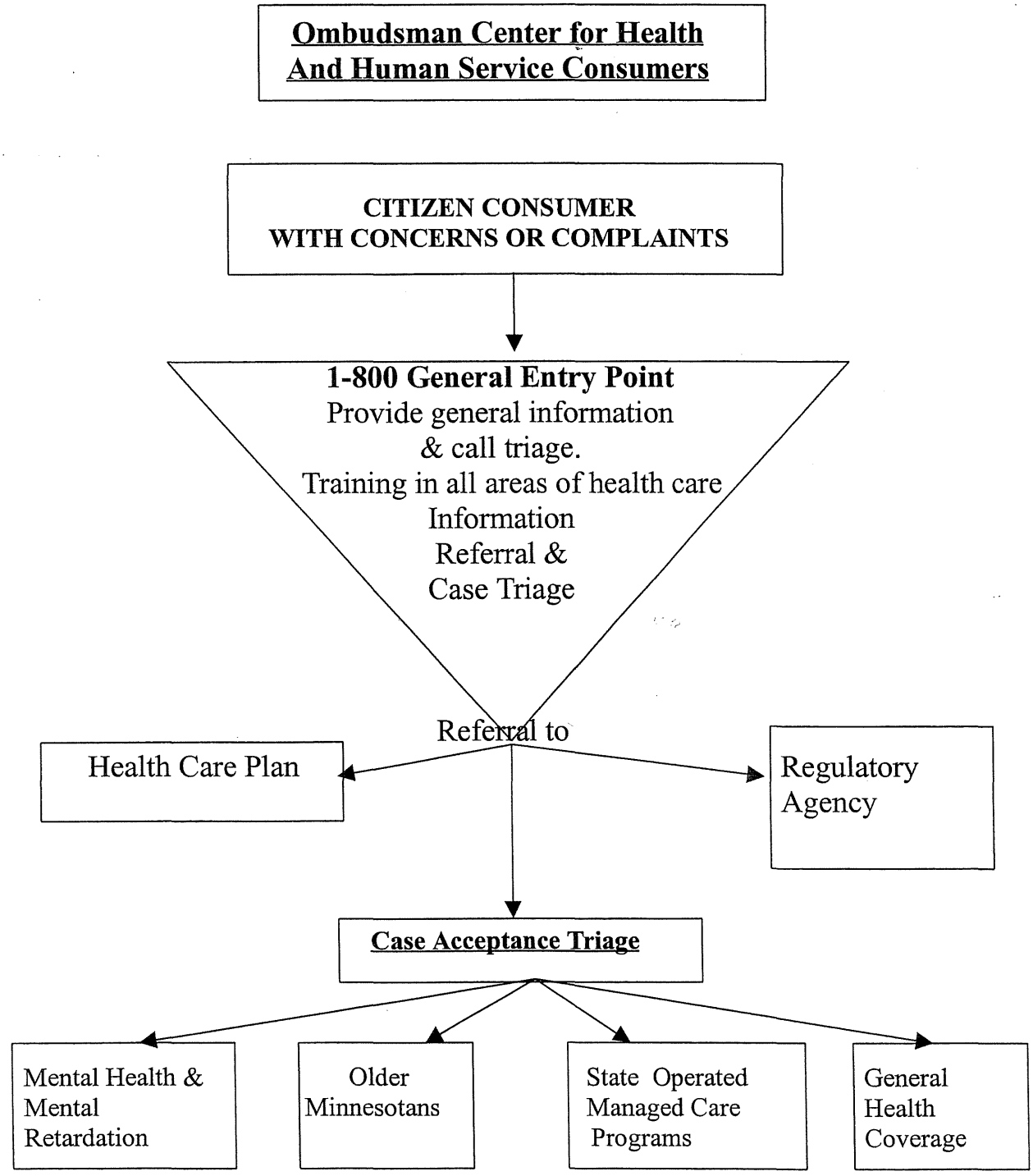
The work group further recommends for efficiency and cost effectiveness that this new center take advantage of the current administrative infrastructure in place in the Office of Ombudsman for Mental Health and Mental Retardation. Administrative functions such as personnel, payroll, purchasing etc, that already exist in this agency. The current service functions would form the basis for different divisions within this center. A strong commitment to integrity of services to the special populations served by the existing programs and maintenance of effort of funding. Any efficiency achieved could go for the development of outreach and information materials for citizens.

This reorganized center should develop common data collection and reporting tools along with improved use of technology including Internet access for more efficient citizen access.

The reorganization of the three existing Ombudsman services could be done with a minimum of change. New services of general health care advocacy and a single point of entry would require development and funding appropriate for those services.

FUNCTIONAL CHART
OF RECOMMENDED SERVICES

Work Flow Design



REPORT OF THE HEALTH RELATED OMBUDSMAN AND ADVOCACY SERVICES WORK GROUP

Introduction

The 1998 Minnesota Session Laws, Chapter 407, Article 2, Section 100 requires the Ombudsman for Mental Heath and Mental Retardation and the Ombudsman for Older Minnesotans to convene a workgroup to develop recommendations regarding all health related ombudsman and advocacy services provided by the state. The purpose of these recommendations is to improve services to consumers in the areas of access, outreach, response and quality outcomes. Recommendations may address new methods for interagency coordination, co-location or consolidation.

1998 Minnesota Session Law Chapter 407, Article 2,Sec. 100. [OMBUDSMAN STUDY.]

The ombudsman for mental health and mental retardation and the ombudsman for older Minnesotans shall convene a work group to develop recommendations for interagency cooperation and/or the consolidation of all health-related ombudsman and advocacy programs provided by state agencies and to address issues to improve ombudsmen and advocacy services to health care consumers, including ease of access, timeliness of response, and quality of outcome. In developing its recommendations, the work group shall consider the unique needs of different populations of health care consumers. It shall also consider:

(1) seamless access for health care consumers;
(2) consumer outreach methods;
(3) opportunities to share resources and training;
(4) nonduplication of effort; and
(5) the feasibility of colocation.

In developing its recommendations, the work group shall confer with and have representatives of consumers, advocacy organizations, the consumer advisory board, the office of health care consumer assistance, advocacy, and information, affected state agencies, the board on aging, and the advisory committee to the ombudsman for mental health and mental retardation. The work group shall make recommendations on how to better coordinate consumer services and submit a report to the legislature by December 15, 1999.

In June of 1998, the Ombudsmen for Older Minnesotans and Mental Health and Retardation sent a letter to a broad-based group of citizens with interest in the activities and outcome of ombudsman and advocacy services in Minnesota's health care delivery systems.[1] The letter was a solicitation of interest in and preliminary draft work plan for the workgroup to be convened. Interest was sought from every person or group that could be identified as having some interest or stake in the outcome. Included in those solicited were state agencies; professional associations; lay and legal advocacy groups; consumer groups; provider groups; legislators and the Governor's office (see appendix).

Any group that expressed interest was invited to participate on the work group at whatever their level of interest. The work group met monthly from July 1998 through October of 1998. During those meetings discussions took place on the scope of the study, the work plan time table, past studies, current programs, legislative intent, work group assumptions, the role of advocacy, the range of options and other models. During November and December of 1998 work began on a draft progress report of work to date.

Background

Over the past five years a number of reports, discussions, workgroups and proposals have been forwarded that involve various small agencies of state government.

[1] See appendix for list of groups contacted and work group members

Many of these various proposals failed to gain acceptance because of the differene in mission and type of citizens served by each agency. There was a great deal of debate about services currently designated for some very vulnerable populations being lost in the rush of concerns being raised by general health care consumers. Also raised were some of the differences between acute health care and preventative medicine versus issues of chronic care with an overlay of social services. Some of the proposals met needs for efficiency but did not meet other critical service needs of the populations to be served. Some of the proposals failed to take into account the wide variety and complexity of systems served which would actually make some of the offices less efficient. Also discussed were the history surrounding the creation of an agency and the costs associated with change.

During the discussion of the creation of the Office of Health Care Consumer Assistance, Information and Advocacy, the issues of how best to serve citizens with health care issues continued to arise because of the ever changing nature of health care and the increasing complexity facing consumers. Concern was raised that with all of the specialization, consumers could be confused and have to make many different calls to reach someone who could assist them and that the various health care consumer services do not have enough information about the other services available.

Consistent issues that have been raised during these discussions include a seamless entry point and possible co-location or merger of the various health related ombudsman programs. Discussion of a seamless entry point must start with an 800 # for consumers to call. Other specific methods of outreach for special populations would still be needed. The concept centered on the concept of "no wrong door". During these discussions the Ombudsman for Mental Health and Mental Retardation, the Ombudsman for Older Minnesotans and the Ombudsman for Minnesota Managed Care Programs[2] agreed there could be some opportunity to improve administrative efficiencies, share services, training and peer support by co-locating the three existing Ombudsman programs' central offices, located in St. Paul. The issue of statutory consolidation is much more complex and requires dealing with a very broad base of differing constituency groups who have had some historical role in the establishment and ongoing functioning of these various offices.

Several discussions had taken place over the past several years about the possibility of options for co-location. Despite the potential, each office faced a number of technical and financial barriers to moving forward. These barriers included small budgets with little room for seizing opportunities quickly when they arose and long term lease arrangements that did not coincide.

Current Study

At the beginning of the study, the work group discussed the background leading up to this study. Also reviewed were past reports that have looked at these offices or similar functions.

- Making Government More Responsive prepared by the

[2] The executive director of the Office of Health Care Information and Advocacy had not yet been appointed or would have been included in these discussions.

Ombudsman Roundtable in December 1994; and

- Consolidation and Coordination of Health Care Consumer Assistance and Advocacy Offices prepared by the Departments of Health and Commerce in January 1998.

Discussion ensued about the difference between Ombudsman and Advocacy services versus other state health agency functions that might also include some form of citizen assistance but was secondary to a regulatory, public policy, or provider role.

Also during the first two meetings of the work group, existing programs made presentations, including:

- Ombudsman for Mental Health and Mental Retardation
- Ombudsman for Older Minnesotans
- Ombudsman for State Managed Care Programs
- Minnesota Department of Health-Office of Health Care Consumer Assistance, Information and Advocacy.

The overviews included information about how and when each office was established, the current population of citizens served by each agency, organizational structure, funding and the scope of services provided within the context of the authorized powers and duties.

The Office of Ombudsman for Mental Health and Mental Retardation

This agency was established as an independent state agency in 1987. Advocates working on behalf of the mental ill and the developmentally disabled proposed legislation as a result of the *Welsch Consent Decree*. Reasoning behind it came from a lawsuit against the state on behalf of mentally retarded clients living in state institutions, and *The 1987 Adult Mental Health Act*. The agency is funded by a general fund appropriation and has eight regional offices around the state based mainly in the Regional Treatment Centers and a central office in St. Paul. The clients served include those with mental illness, developmental disabilities, chemical dependency and emotional disturbance in children. In addition to provider and social service systems, the office serves children with designated needs in the education system. Today this office serves persons with cognitive disabilities in the community, in hospitals, in institutions, in foster care, and in their day programs throughout Minnesota.

The Ombudsman for Older Minnesotans

Ombudsman services for nursing home residents were developed through the federal Older Americans Act as a result of nationwide problems in nursing home care. Federal funds were provided to support existing nursing home advocacy programs such as the Advocacy Center for Long Term Care, and to begin services in areas of the state where they did not exist.

In 1987 the office was established in state law as a program of the Minnesota Board on Aging. Ombudsman services were later expanded to serve home care clients and Medicare beneficiaries. Today the office advocates for the health, safety, welfare and rights of any person living in a long term care residence, receiving home care service or Medicare covered hospital care. Services are provided through regional staff and volunteers. The federal Older Americans Act still funds the nursing home Ombudsman service while a state general fund appropriation, funds the home care and Medicare hospital services.

Ombudsman for Minnesota Managed HealthCare Programs

The office was created in 1985 within the DHS as a condition of the federal waiver for medicaid managed care. It was originally established to advocate for Prepaid Medical Assistance Program enrollees through the complaint and appeal procedures to ensure that necessary medical services are provided. Minnesota Care enrollees were added later. In addition to the statewide Ombudsman centrally located in DHS, each county that has Medicaid managed care is required to have one designated advocate available to assist enrollees. While the state Ombudsman and the county advocates work together, they report to different units of government.

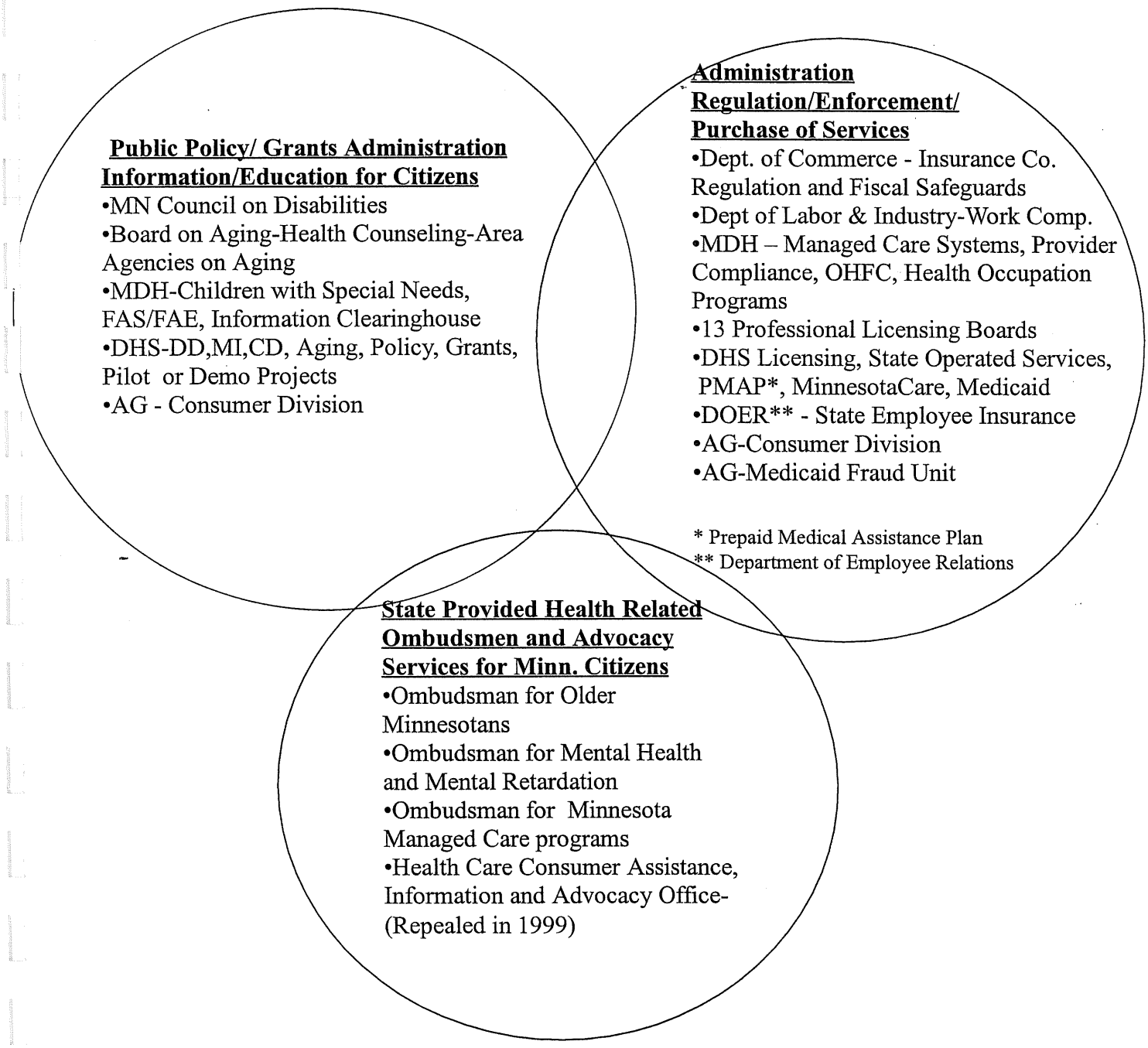
The Office of Health Care Consumer Assistance, Information and Advocacy (Subsequently Repealed)

Legislation to establish this office was passed in 1998 and this office was to be housed in the Minnesota Department of Health (MDH). The legislation called for an executive director appointed by the Commissioner of Health and nine regional advocates. Funding allocated in 1998 did not allow for the full staffing of this office at the time of its creation. This office was to assist all health care consumers with issues and concerns regarding their health care plans regardless of the type of plan they have. This was to include citizens who would not fall under the scope of authority of the other Ombudsman offices. The office was not intended to be an Ombudsman office. The MDH appointed an executive director who participated with the work group during the spring of 1999. During the 1999 legislative session, this office was repealed.

Every State Agency has a customer service function, provides information and assists citizens. This is separate and different than an Ombudsman or Advocacy function.

Health Care &Human Services in Minnesota

Primary Function Areas*



** Every State Agency has a customer service function, provides information, and assist citizens. This chart is meant to show the primary function that dictates the type of customer service and assistance they provide.*

Assessment Phase

The work group spent time discussing the issues and concerns that have been expressed about the existing advocacy services provided to citizens in the current health care system.

Workgroup members were asked to list any concerns that they had heard raised. [3]

- Concerns for the "maze" and confusion to consumers.

  When a citizen has a problem and does not know where to turn, it is frustrating to call various departments only to find out that there is some specialized function somewhere else in government that they need to call.

- Perceptions of passing the consumer from place to place without knowledge of what services are available or whether it is the appropriate referral.

  There was discussion about citizens who get bounced around from place to place only to be told that the place they were referred to is not the right place. Often when an employee of government receives a call that is not within their area of work, they will refer the caller to an area they think might handle a certain issue. That employee may not have correct information about what that other division does. The citizen becomes frustrated by the series of "bad" referrals.

- No single entry point.

  Too many different places for citizens to call about health related matters. Citizens are often confused as to where to turn.

- Questions of reserving Ombudsman/ Advocacy services for the most vulnerable.

  Several groups raised the issue that government can not afford to serve everyone. If that is true then services needed to be prioritized ensuring that those least able to advocate for themselves would receive the highest priority. Concerns were raised that the special population issues would be lost in the volume of average citizens who may be more vocal and politically active.

- Concern of possible duplication of services.

  There was a discussion about the perception that there is overlap and duplication between the various programs since they all assist health care consumers in some capacity. Was there truly overlap where consumer/citizens could be helped by more than one program for the same issue? And if so was it a duplication of services or complimentary services?

- Possible inefficient use of government resources.

  Concepts that have been raised included multiple purchases of office space and office equipment when

[3] The concerns were discussed and each one taken into account during the process.

possible sharing of resources would be more efficient.

- Possible lack of administrative expertise in small agencies.

  Small agencies must comply with all of the rules and regulations that large agencies do. There is a perceived economy of scale when larger agencies can afford to have dedicated staff to a number of complex bureaucratic tasks in the area of administrative support.

- Skepticism that government is not viewed as a vigorous advocate when they work with people in the system.

  There is often a basic distrust of government bureaucracies.

- Concern that if government funds this system, it will be doing the work health plans should be doing for their enrollees.

  If the state funds a comprehensive advocacy and information service for every health care consumer, insurance companies could be relieved of some of their responsibility for customer service and problem resolution services

- Need for consistent data collection and reporting both for systemic policy development as well as program accountability.

  Currently there is different data collected by each agency and it is very difficult to compare what is working and in what systems.

- Concern for perception of differences between metro and rural services.

  Some citizens feel that you get better services in the metro area and others fear the loss of representation and regional offices in outstate Minnesota.

- Concern for the need of the ombudsman or advocate to be independent from the systems they have authority in.

  Some of the advocates/ombudsmen in this report operate within the very system that they have an oversight role over. Questions arise about the ability to act independently to say what needs to be said.

- Role questions and disagreement about the proper role for these services i.e., advice to sue, lack of provided legal assistance, no legal referrals and informed dispute resolution.

  Perception by some that these agencies encourage citizens to sue other parties.

- Questions about conflict of interest, organizational placement and freedom to act.

  Because of different structures, the current programs have different reporting relationships that sometimes have the appearance of conflicts.

Scope

During the discussions, the scope was limited to the four state services that are listed above. While some members were concerned about all consumer services, the legislation speaks to those *advocacy services provided by state Ombudsman and advocacy offices either directly or through contract services.* Thus, the work group did not include the Health Insurance Counseling Programs and the Area Agencies on Aging even though they receive government funds.

Differences & Similarities

While all four of the programs discussed have the health care system as a common denominator, there were distinct differences between the various agencies. Each serves different clients for the majority of their work with some potential for overlap. The differences seemed to split along two distinct pathways. The Health Care Consumer Assistance, Information and Advocacy Office and the Office of Ombudsman for State Managed Care Programs deal more extensively with the payer contract language and whether or not a client has access to needed services. The Ombudsmen for Older Minnesotans and Mental Health and Retardation deal more extensively in chronic health needs including the unique needs of certain disabilities. ***The latter two offices have a mandate to deal in social service, treatment, civil rights and best practice issues.***

The Ombudsman for Mental Health and Mental Retardation has two additional functions that are not part of the other Ombudsmen and advocacy offices. One is the requirement to do Death and Serious Injury Review related to the mentally ill and developmentally disabled. The purpose of the review is to identify opportunities toward prevention of future death and serious injuries to a population with cognitive disabilities who are least able to look after their own interests and safeguards. The second is serving children in the educational system including cross system (education and social services) issues for cooperation and coordination.

Efficiency should not be about creating one place that is all things to all people but rather about appropriately connecting people to what is available.

Service Grid

The following grid demonstrates where the various offices are alike and where they are different.

Health Coverage and Contract Issues- All health care consumers regardless of type of health plan, ability or disability

Office of Health Care Consumer Information (Repealed)

Population served: ***All health care consumers with health care coverage.***

- ✓ Information about consumer rights for all health care consumers
- ✓ Dispute resolution between plans and consumers
- ✓ Advocacy for access to appropriate referrals for health care and other certificate of coverage issues
- ✓ Information about different types of plans

Ombudsman for State Managed Care Programs

Population served: ***Medicaid clients in state operated managed care programs and Minnesota Care clients, vulnerable due to low income or poverty.***

- ✓ Specialized complaint handling regarding contracts of the state operated managed care programs
- ✓ Enrollment information
- ✓ Appeals of health plan decisions for state run managed care programs only
- ✓ Advocacy for clients of state managed care programs
- ✓ Access to appropriate care services
- ✓ Specialized training in contract issues as well as human challenges associated with poverty and publicly funded health care

Social & Health Services Consumers with various levels of disability, chronic care and social services support needs

Office of Ombudsman for Older Minnesotans

Populations served: ***Nursing Home residents Home Health Care recipients Medicare recipients, vulnerable due to need for specialized care.***

- ✓ Information & education for specialized populations
- ✓ Advocacy for special populations
- ✓ Specialized dispute resolution
- ✓ Ability to investigate complaints by consumers and recommend resolution
- ✓ Specialized trained staff for unique needs of Older Minnesotans
- ✓ Clients with a wide range of vulnerability
- ✓ Systems improvement for health and long term services to the elderly

Office of Ombudsman for Mental Health and Mental Retardation

Populations served: ***Mentally Ill, Developmentally Disabled, Chemically Dependent, Emotional Disturbance in Children, vulnerable due to cognitive disabilities.***

- ✓ Information and education for and about special needs populations
- ✓ Specialized dispute resolution
- ✓ Specialized trained staff in unique needs of this population
- ✓ Ability to investigate complaints
- ✓ Service assistance and oversight in areas beyond health care including :
  Social Service System, Education System, Treatment Providers, Civil and Human Rights
- ✓ Death and Serious Injury process for specific populations
- ✓ Specialized systemic reform for persons with cognitive disabilities

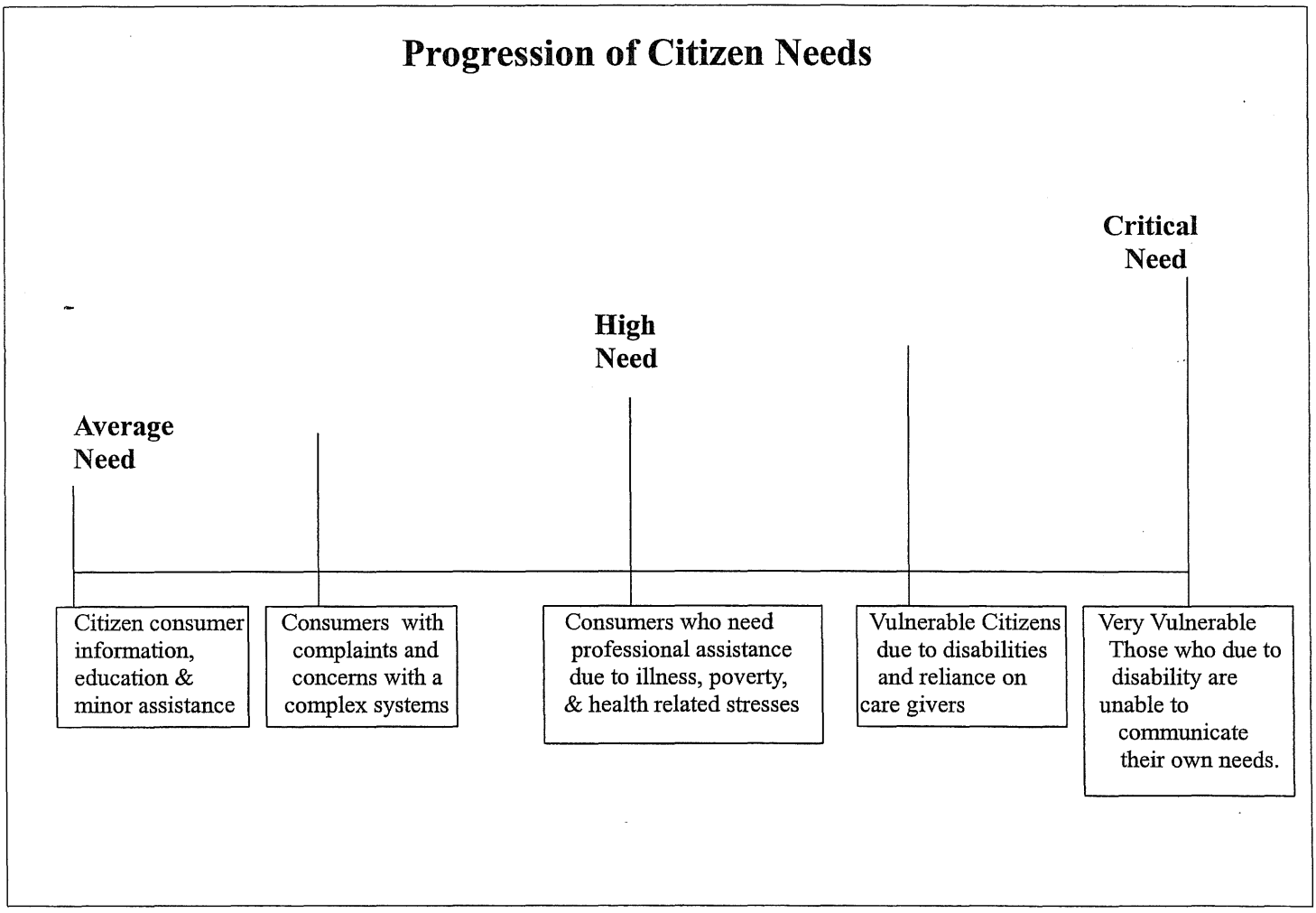
Services Useful to All Minnesotans
- ✓ Information
- ✓ Advice/Consultation
- ✓ Assistance

Vulnerability of Different Types of Citizens

During the discussions, issues and concerns were raised about how much service government can afford to provide. Also questions were raised as to what the intended outcome was supposed to accomplish; was it about providing effective services to all citizens in a highly complex health system or is it about serving more people with the same or less resources? If there are not enough resources, where should government place those limited resources and to what level?

Should resources be applied to only those not able to advocate on their own behalf? Are not all citizens vulnerable when it comes to their own health care? What is the consumer's responsibility to become informed about his or her own health care coverage?

Ombudsman and advocacy services were discussed as a spectrum or progression of needs.



Review of Options

The work group discussed the following range of options for achieving the goals of the study.

- Maintain Status Quo, no legislative changes;
- Modified Status Quo, co-location and shared services;
- Legislative merger of two services which only focus on health plan issues;
- Legislative merger of two services , which focus on matters of health, safety, rights and benefits for a defined population of vulnerable adults;
- Legislative merger of all four services into one agency.

Review of Other Examples of Coordination

Work group members thought that it was important to look at other examples of cooperation or consolidation currently being implemented in Minnesota. There were presentations by other state agencies on what they had done and the lessons learned in their efforts.

Preliminary Recommendation

The work group made a preliminary recommendation for the 1999 Legislative Session; that there must be a common entry number with well trained and experienced staff to provide preliminary information, answer basic questions and link clients to the right person, persons, or agency who can assist them. The work group felt that this should proceed as quickly as possible and could be done without legislation. However funding would be needed to make this happen.

Final Work Group Recommendation

In discussions of a final recommendation, the work group felt that consolidation of all state provided health and human service Ombudsman and advocacy services would provide for the maximum administrative efficiency, allow for consumers to have a single entry point and would allow for common data collection to evaluate services.

However, in order for this option to be implemented properly and be truly consumer responsive, the work group thought that certain core principles must be followed in the development of the new consolidated office. Included in the core principles were the following:

1. The new center must be an independent state agency separate from any agency or system that the office has oversight responsibility over.
2. The center should be protected from political retaliation for exercising their "watchdog" role by providing for removal from office only for "just cause."
3. The office should be:
    - non-regulatory, having no ability to command change but only to review, comment on and make recommendations regarding services;

- non-purchaser, having no responsibility in the purchase of health care services; and

- non-provider, having no authority to provide any of the health care services directly.

4. The integrity of the current services should be maintained.

5. Any new organization should comply any federal requirements.

Without these protections, the office could have conflicts of interest which would prohibit it's ability to comment in an unbiased way on the quality of services provided to Minnesota citizens and advocate for systemic changes.

Discussion of Recommendations for Change

There was originally discussion that the issue of consolidation versus cooperation needed to be answered before any concrete recommendations could be derived. However, one important lesson learned from other examples of consolidation was that time must be spent on building trust between agencies, staff, constituents and policy makers if consolidation was to produce positive results.

The group also discussed the need to keep the consumer as the primary focus of the discussion and planning. There was some concern about what efficiency means to different parties. Some members expressed a concern that the current system may already be financially efficient but not consumer efficient. There is a perceived fear that under some definitions of "efficiency" the result could be an overall reduction of resources for advocacy at a time when consumer need is increasing.

Questions that were raised were What is muddled: the health care system or the advocacy? Given the complexity and the rapidly changing health care delivery systems, how much can realistically be achieved under a one-stop shop system? Could staff of a one-stop shop be sufficiently trained in all aspects of health care both acute and chronic, as well as contractual rights under the various types of health care insurance payment systems? In addition to understanding treatment and insurance issues, the staff would need to understand aspects of social services, civil and human rights. Any new system would need to recognize that to be efficient, some division of labor would be necessary.

Discussion followed about what could be done immediately without any legislation needed. Included in that was a common 800 number for consumers, well trained and experienced triage specialists, common space to operate from, publications for consumers on how to navigate the health care system, and co-location of services without fundamental change in agency focus or authority. During the discussion of the work group, the following was discussed as a standard:

Efficiency should not be about creating one place that is all things to all people but rather about appropriately connecting people to what is available.

Discussion occurred about the potential for the volume of calls from non-disabled, but frustrated consumers, to consume and divert resources away from those not able to speak

up for themselves. Some current clients of the various Ombudsman programs do not have access to a telephone and some would need the assistance of communication assistance devices to communicate at all.

One example given was from the Minnesota Managed Care Ombudsman program. It was originally set up to handle concerns from the Medicaid managed care consumers and then was expanded to include Minnesota Care consumers. This change dramatically increased the calls to the program diverting time and resources from the original Medicaid population, whom were believed to be more disenfranchised due to their poverty, than MinnesotaCare Consumers. The group thought that any recommendations developed should guard against diversion of resources away from the very vulnerable since this may be the only safeguard some of them have.

One other item considered was the original purpose of the programs. Is that purpose still consistent with the needs of the populations served today and how will any changes impact that purpose? There is a need to insure against the "law of unintended consequences."

Central themes that emerged include the ideas of no wrong door for consumers, common access or entry point and appropriate first response. Also discussed was the concept of improved outreach to inform consumers of what services are available.

Technology was another area discussed. Making sure that data collected by various agencies allows for accurate comparisons and sufficient information to allow for opportunities to identify areas for improvement.

In reviewing the options listed the following was discussed:

- Maintain Status Quo, no legislative changes. While many of the goals of the work group could be achieved in theory, this option was not believed to be viable due to the rapid changes in the health care industry.

- Modified Status Quo, co-location and shared services. This option has been the basis of discussion over the past three years. This option could be implemented without any change in legislative authority but would also continue many of the problems that exist today including parts of the system, reporting to different departments continuing the fragmentation of services, agency priority battles, turf protection issues and extensive bureaucracies where there is a need for inter-agency agreements.

- Legislative merger of two services which only focus on health plan issues; and legislative merger of two services, which focus on matters of health, social services, safety, rights and benefits for a defined population of vulnerable adults. These two options were discussed by the group and were seen as having some merit in light of the fact that two of the services focus on the health insurance plan and contractual rights and two of the services focus on health care and the social service system put in place to protect very vulnerable populations who are disenfranchised by their disabilities or their vulnerabilities.

- Legislative merger of all four services into one agency. This option was viewed as being the most consistent with

what the committee believed to be the direction of the work group. This option would provide for administrative efficiencies, would allow for bringing a common focus to Ombudsman services in the health care service delivery system and provide for better information on what issues were emerging in the health care industry and service delivery systems.

To make this work, each division of this new center would operate consistent with their current legislation but under the new center which would provide the administrative support. Given the unique needs of the more vulnerable populations, this would continue to recognize the purpose for each of the offices and would allow time for staff to build trust. Over time, opportunities for changes would emerge allowing for greater efficiency based on experience. This is based on lessons learned from the Work Force Center development, which was one of the examples of coordination reviewed by the workgroup.

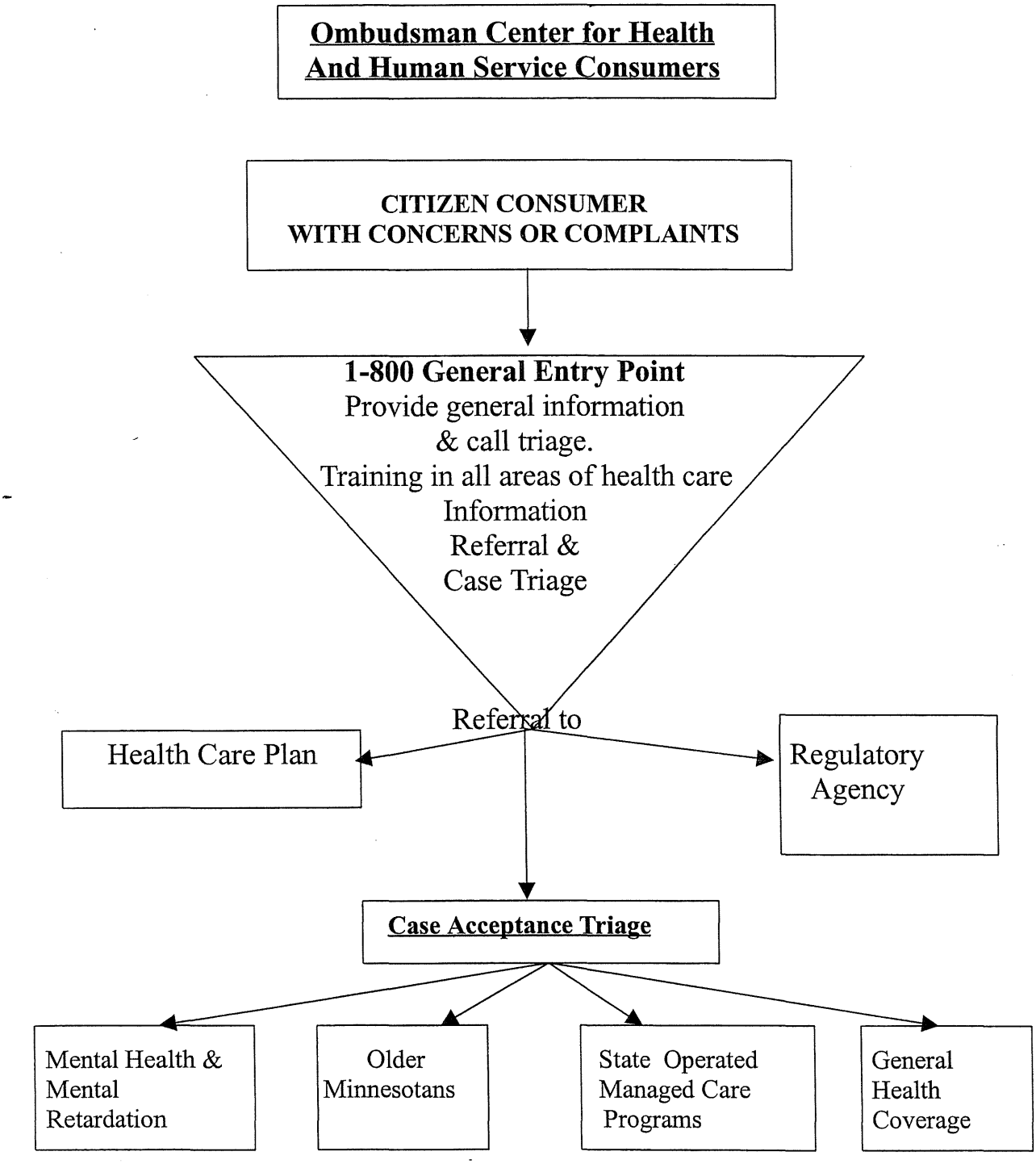
The committee felt that certain protections should be put in place to ensure that services to very vulnerable not be diverted away to other functions. To make this plan work for the citizen, resources would be needed for the creation of the single entry point/triage and the advocacy services for general health care consumers. There will be some efficiency obtained in the administration of such an office but the integrity of the division services should remain intact.

Core Principles

1. Independent State Agency
   Independent from
   - Regulating agencies
   - Purchasing agencies
   - Provider agencies
2. Protections from retaliation and removal only for just cause
3. Integrity of current functions
4. Compliance with federal requirements

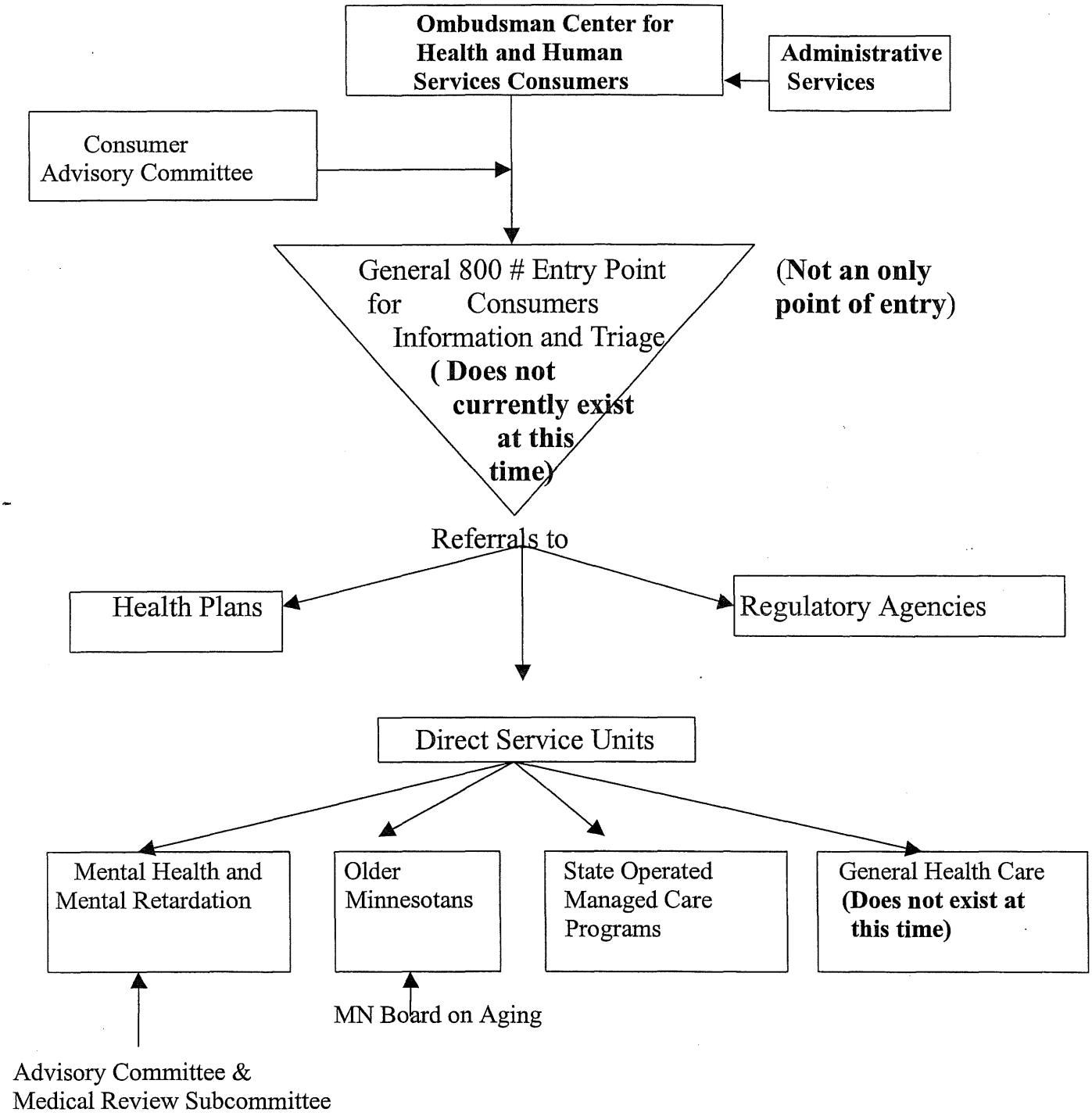
FUNCTIONAL CHART
OF RECOMMENDED SERVICES

Work Flow Design



Draft Organizational Chart of Ombudsman Center For Health and Human Service Consumers

Organizational/Administrative Design Chart



As a core principle there needs to be recognition of the role the federal government plays in the funding of the Older Minnesotans Ombudsman. All federal funding requirements must be met to prevent the loss of federal funding for this service.

Administrative infrastructure already exists within the Office of Ombudsman for Mental Health and Mental Retardation in that is the only entity that is currently independent as a state agency. The new center should build upon that infrastructure. This would be the most efficient way to establish such an agency but safeguards would need to be put in place so that all divisions would receive equal administrative services with out cost increases over the current allocations.

Some current Ombudsman functions have either an advisory committee unique to their population or a funding stream from a particular board that may have interest in the agency function. Those existing specialty advisory groups should remain connected to their existing functions as they provide valuable guidance and expertise.

An additional benefit of this plan would allow the budgets of the various divisions to be presented to the legislature in one place under the Ombudsman Center for Health and Human Services.

Conclusion

It is the recommendation that all current Ombudsman and advocacy functions of the health related and human service areas of state government are brought together under one administrative head as an independent state agency.

This agency should allow for efficiency of services, clarity for consumer access but provide protections for the integrity of needs of unique and vulnerable populations.

As an agency with a watchdog role over the health care system, certain protections must be put in place to prevent retaliation when the agency finds and reports mal-administration of these government provided, purchased or regulated systems.

Funding

The draft model contained in the recommendations includes two major functions that do not currently exist. The three Ombudsman offices could do a number of things to create better coordination and administrative efficiency within their current budgets. However, developing and staffing a single information and service access number would require additional funding. It was the consensus of the work group that the staff of this access area could not be entry level employees. The staff of this area must have extensive background and experience in the health care system in order to be able to ask appropriate questions, provide accurate information and direct the citizen to the correct type of service for their needs. These staff would need to have basic knowledge of a vast array of disabilities as well as a comprehensive background in both public and private funding and regulation of the health care system. This staff would need to have strong communication skills with the ability to present information in a number of different ways to be able to deal effectively with different communication styles, sometimes under high stress situations.

The second function that does not exist is a place for consumers with general private pay health care and insurance concerns to call. Both the Departments of Health and

Commerce have regulatory authority over various segments of the health care insurance industry. In addition there are a number of self insured, multi-state corporations that are regulated primarily under the Federal ERISA regulation with little or no state regulatory authority. In 1998 the legislature created the Office of Health Care Consumer Assistance, Information and Advocacy within the Department of Health. Subsequently, that office was repealed. The current Ombudsman offices currently struggle to handle all of the concerns and calls that are currently generated. Any new population of citizens with advocacy needs would need funding for staffing and program development. Without that funding this population could not be served or would be served at the expense of current vulnerable citizen groups.

Adding the additional services of a single entry point and a general health care consumer advocacy function without sufficient resources would diminish services to all. A single entry point for consumers is not beneficial to the citizens if there are not enough staff to handle the added volume of calls.

In addition to the actually staffing of these added services, funding would need to be provided for the costs associated with such a merger including planning, staff development, training and the appropriate technology to achieve the goal of access, accountability and outcome measures. For example, the work group noted that development of the Work Force Centers required an appropriation of $9 million dollars for development and implementation. This plan would probably not cost that much but would require some additional funding for move and development costs.

Progress in Action

The Office of Ombudsman for Mental Health and Mental Retardation and The Office of Ombudsman for Older Minnesotans proceeded to co-locate in August of 1999 achieving one of the major goals of the two agencies.

Also under development is a manual listing all of the various places within government that regulate the health care system or assist consumers. The Office of Ombudsman for Mental Health and Mental Retardation, working with a consultant, is developing this manual that can be shared with all agencies that deal in some aspect of health care. This would allow for the development of the "no wrong door" concept by providing all state agencies and advocacy groups with a tool of general understanding of the various roles of the different state agencies in the health care system. This would start to address the concern that we not be all things to all citizens but that anyone will be able to direct the citizen to the correct service with the fewest number of calls or transfers. This manual will be prepared and published regardless of the outcome of this study.

Summary

In conclusion, the work group recommends that the Ombudsman for Older Minnesotans, the Ombudsman for State Managed HealthCare Programs, and the Ombudsman for Mental Health and Mental Retardation come together under the administrative umbrella of one *independent* state agency to serve as The Ombudsman Center for Health and Human Services.

The work group further recommends for efficiency and cost effectiveness that this new agency take advantage of the current infrastructure in place in the Office of

Ombudsman for Mental Health and Mental Retardation for administrative functions such as personnel, payroll, purchasing etc. The current service functions would form the basis for different divisions within this agency and there needs to be a commitment to integrity of services to special populations and maintenance of effort of funding. Any efficiency achieved could go for the development of outreach and information materials for citizens.

This reorganized agency should develop common data collection and reporting tools along with improved use of technology including Internet access for more efficient citizen access.

Much of this could be done with the three existing Ombudsman services with a minimum of change. However, if the legislature determines that there is a need for a central intake and triage and a general health care consumer advocacy function it would need to provide funding for the development, implementation and ongoing operation of these services.

All state agencies that deal in health care need to do a better job of coordinating information and services to all citizens of Minnesota.

APPENDIX

- Interest Solicitation List
- Work Group Membership List
- January 1999 Progress Update

MAILING LIST FOR INTEREST IN PARTICIPATION IN THE
HEALTH RELATED OMBUDSMAN AND ADVOCACY WORK GROUP

- Commissioner Minnesota Department of Health
- Commissioner Department of Human Services
- State Ombudsman for Managed Care Programs
- David Giese- Health Dept
- Mary Ann Fena-Health Dept
- Sue Stout – MN Nurses Association
- Mary Jo George – M.S. Society
- Tom Brick – MN State Council on Disabilities
- Maureen O'Connell – Southern Minnesota Regional Legal Services
- John Gross – Department of Commerce
- All members of the House and Senate Health Care Finance Committees
- All members of the Health Care Policy Commission
- All members of the House and Senate Health and Human Services Policy Committees
- Jim Varpness – DHS
- Board on Aging
- Mary Kennedy – DHS
- Elaine Timmer – DHS
- Chief of Staff-Office of the Governor
- Iris Freeman – Advocacy Center for Long Term Care
- Linda Sutherland – Health Dept
- Jerry Kerber – DHS
- Korina Allen – AARP
- All members of the Health Care Consumer Advisory Board
- Ombudsman Roundtable Members
- 14 Area Agencies on Aging
- Michael Scandrett – Minnesota Council of Health Plans
- Ombudsman for MH-MR Advisory Committee Members
- Minnesota Disability Law Center
  - Luther Grandquist
  - Anne Henry
  - Pat Siebert
  - Pamela Hoopes
  - Kathy Kosnoff
- Bob Brick – ARC of Minnesota
- Tom Johnson – Alliance for the Mentally Ill
- Tom Witheridge –Mental Health Association of Minnesota
- Minnesota Association of Mental Health Residential Facilities (MAMHRF)
- Erica Buffington – Mental Health Consumer/Survivor Network of MN

COMMITTEE MEMBERS

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Minnesota State Council on Disability

Bill Conley
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Kathie Harrington
Minnesota Hospice Organization

Tom Johnson
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Kathryn Kmit
Minnesota Council of Health Plans

Angie McCollum/Ginny Prasek
Minnesota Managed HealthCare Ombudsman

Maureen O'Connell
Legal Services Advocacy Project

Diane O'Connor
Minnesota Nurses Association

Roberta Opheim
Office of Ombudsman for Mental Health and Mental Retardation

Kent Peterson
Minnesota Department of Health

Darrell Schreve
Minnesota Health & Housing Alliance

Andrea Skolkin
Metro Area Agency on Aging

Christeen Stone
AARPSLC

Linda Wejcman
Minnesota State Representative

Sharon Zoesch
Office of Ombudsman for Older Minnesotans

Tom McSteen
Office of Health Care Consumer Advocacy

HEALTH RELATED OMBUDSMAN AND ADVOCACY SERVICES PROGRESS REPORT
January 1999

- In 1998 the Minnesota Legislature required the Ombudsman for Mental Heath and Mental Retardation and the Ombudsman for Older Minnesotans to convene a workgroup to develop recommendations regarding all the health related ombudsman and advocacy services provided by the state; for the purpose of improving services to consumers in the areas of access, outreach, response and quality outcomes. Recommendations are due by December of 1999 and may address new methods for interagency coordination, collocation or consolidation.

- Letters of solicitation of interest were sent to a broad base of interested stakeholders. Those who expressed interest met monthly from July 1998 through October of 1998 and discussions took place on the scope of the study, the work plan time table, past studies, current programs, legislative intent, work group assumptions, the role of advocacy, the range of options from complete merger to simply working better together. Other models including the work force centers were also reviewed.

- The work group reviewed the background leading up to this study and past reports that have looked at these offices or similar functions. Discussion ensued about the difference between Ombudsman and Advocacy services versus other state health system functions that might also include some form of citizen assistance but was secondary to a regulatory, public policy, or provider role.

- Central topics that have emerged for continued discussion include the ideas of **no wrong door** for consumers, **common access or entry point**, and **trust building** between current services and **appropriate first response**. Also discussed was the concept of **improved outreach** to inform consumers of what services are available and **technology** to ensure that data collected by various agencies allows for accurate comparisons and sufficient information to allow for opportunities to identify areas for improvement.

- **Preliminary Recommendation**--The work group came to consensus on one preliminary recommendation, that there must be a common entry number with well trained and experienced staff to provide preliminary information, answer basic questions and link clients to the right person, persons, or agency who can assist them. The work group felt that this should proceed as quickly as possible and could be done without legislation. However some funding might be needed to make this happen.

- The work group will continue it's discussions to develop more recommendations and work with the new Office of Health Care Assistance, Information and Advocacy to complete it's report by December of 1999.