# *EFFECTIVENESS OF THE STATE LONG TERM CARE OMBUDSMAN PROGRAMS*

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# EXECUTIVE SUMMARY

The ombudsman program was initiated in 1972 as a Public Health Service demonstration project in response to concerns about poor quality of care in nursing homes. In 1978 Congress amended the Older Americans Act (OAA) to require each state to develop a Long Term Care Ombudsman Program (LTCOP). The OAA was reauthorized in 1992, and again in 2000 (through fiscal year 2005), each time with provisions to continue the ombudsman program.

The Older Americans Act stipulates that each state should have a long term care ombudsman program. Responsibilities of the LTCOPs as outlined in Title VII of the OAA include to provide information and educational materials about long term care services, to identify and resolve complaints made by or on behalf of residents, and to intervene in problem situations on behalf of consumers, residents, and their families involving the long term care delivery system. Ombudsmen are also required to advocate to protect the health, safety, welfare and rights of the elderly in long term care settings.

In 1995, the Institute of Medicine (IOM) issued a report declaring that the dramatic changes in health care, Medicare, and Medicaid provide a compelling argument for an ombudsman program to address quality of care and quality of life in long term care settings. In 2000, the Henry J. Kaiser Family Foundation commissioned the Institute for Health & Aging (IHA) at the University of California, San Francisco to conduct a national survey of the offices of state long term care ombudsman programs (LTCOPs). This study follows up on some of the issues raised in the 1995 IOM Report and investigates the role and effectiveness of state long term care ombudsmen in improving quality of care in long term care settings in the fifty states, as well as Washington, D.C. and Puerto Rico.

A nationwide telephone survey with questions generated from the 1995 IOM Report was conducted with ombudsmen representing all 52 state programs. The state ombudsmen were queried about issues including organizational structure, factors contributing to LTCOP effectiveness, interagency coordination, legal assistance, quality of care, managed care, adequacy of resources, political influences, and relationships with other agencies. Secondary data sources, including the AoA's survey of long term care ombudsmen programs (NORS) for FY 1999, were incorporated into the data analysis.

## Key Findings

### Organizational Placement and Interagency Relationships

- While most LTCOPs (71%) are part of their State Unit on Aging (SUA), 12% are located in another state agency, and 17% are located in a nonprofit agency or legal agency.

- More than half of state ombudsmen (55%) report that the placement of their state LTCOP creates difficulties for their ability to fulfill their mandate under the Older Americans Act.

Reported difficulties include lack of autonomy to speak to legislators or the media, conflicts of interest, barriers to policy information, bureaucracy, limited access to resources, and budget vulnerability.

- The most common types of assistance that ombudsmen receive from their SUA include financial support (33%), administrative support (19%), moral support and belief in the program (19%), technical assistance (17%), legal assistance (17%), supervisory support (15%), training and conferences (14%), use of facilities (14%), advocacy for the program (12%), and supplies, resources, and clerical support (10%). Eight state ombudsmen report receiving no assistance from their SUA.

- Most state ombudsmen rate the response of their legal advisor as either "very effective" (58%) or "somewhat effective" (27%). Effectiveness of legal counsel is significantly associated with effectiveness of work with nursing facilities ($p = 0.006$) and overall effectiveness of the LTCOP at the state level ($p < 0.001$).

**Effectiveness of LTCOPs**

- The majority of state ombudsmen rate the overall effectiveness of their program as "very effective" (31%) or "somewhat effective (64%).

- Almost all ombudsmen (98%) report that they are generally able to represent the interests of residents to most state agencies.

- Factors that inhibit the effectiveness of LTCOPs include:
  - Insufficient numbers of paid staff (79%)
  - Insufficient funding (78%)
  - Inadequate autonomy due to the organizational placement of their LTCOP (39%)
  - Insufficient legal service (33%)
  - Inadequate communication methods to share information with local programs (31%)
  - Unsupportive political and social climate in the state (25%)

- In terms of statutorily mandated requirements, ombudsmen rank their programs as most effective at complaint investigation, with 62% of the states indicating that they are "very effective" and 35% indicating that they are "somewhat effective." The other four requirements receive "very effective" and "somewhat effective" ratings of 35% and 52% (for monitoring laws, regulations, and policies), 23% and 64% (for community education), 17% and 67% (for resident and family education), and 23% and 50% (for legislative and administrative policy advocacy).

- When asked if there are any barriers or impediments at the state or federal level that keep them from carrying out their jobs, 39% of ombudsmen say barriers exist at the state level, 12% of ombudsmen report that barriers exist at the federal level, and 22% of ombudsmen report that barriers exist at both the state and federal level.

- Factors that contribute most prominently to the effectiveness of local LTCOPs include: staff and volunteer training (98%) and response time to complaints (98%), degree of collaboration/cooperation with the local nursing home providers (96%), amount of funding (94%) and number of paid staff (94%), ability to obtain needed assistance to deal with complaints (94%), number of visits to nursing homes (94%) and quality of working relationship with other local programs dealing with LTC (94%), number of volunteers (92%), and organizational placement of local LTCOPs (91%).

**Facility Visitation and Complaint Resolution**

- The mean percentage of time ombudsmen spend in nursing homes is 69% (SD 20%, N = 48), compared to 26% (SD 17%, N = 48) for board and care and/or assisted living facilities.

- State ombudsmen rank their work with nursing homes as more effective than their work with board and care or assisted living facilities, but ratings of effectiveness of work with nursing facilities are significantly associated with ratings of effectiveness of work with board and care facilities ($p = 0.001$) and assisted living facilities ($p = 0.003$).

- According to NORS data for FY 1999, nationwide ombudsmen visit 83% of nursing facilities but only 47.4% of board and care facilities. However the percentage of complaints that are fully resolved by ombudsmen are similar in nursing facilities and board and care facilities (58.7% and 54.4%, respectively).

- All state ombudsmen report that nursing facility residents are one of the primary target populations for their services. Other populations targeted include board and care residents (75%), assisted living residents (69%), home care beneficiaries (21%), and managed care clients (12%).

**Systemic Advocacy and Quality of Care Issues**

- According to state ombudsmen, the most important advocacy issues for local LTCOPs to address at the present time include nursing home staffing levels and quality (69%), resident rights (12%), relocation procedures (10%), expansion of the LTCOPs into assisted living (10%), and the need for stricter enforcement by licensing agencies (10%).

- Ombudsman ratings of effective advocacy efforts are significantly associated with ratings of sufficient autonomy, program effectiveness at the state level, program effectiveness at the local level, effectiveness of relationship with citizen's advocacy groups, and effectiveness of program monitoring of policies and regulations.

- The effectiveness of LTCOP advocacy efforts are influenced most by strong nursing home industry lobbying (78%), the relationship between ombudsmen and representatives from their SUA or AAAs (47%), and difficulties with regulatory agencies (42%)

- Most state ombudsmen (83%) report that their relationships with citizen's advocacy groups are "very effective" or "somewhat effective." Effective relationships are significantly associated with effective legislative and administrative policy advocacy ($p < 0.001$).

- According to state ombudsmen, the two most critical quality of care issues for LTCOPs to address are lack of nursing facility staff and poorly trained staff (46%), and malnutrition and dehydration (39%). Other pressing quality of care issues are bedsores/pressure ulcers (15%), incidence and prevalence of falls (14%), dementia care (14%), dealing with patients with behavioral problems (14%), abuse and neglect (14%), symptoms of depression (12 %), quality of life issues (10%), and mental health services (10%).

- The majority of state ombudsmen (87%) report that there is a direct or significant relationship between long term care facility staffing levels and overall quality of care, and 89% of state ombudsmen report that there is a direct or strong relationship between supervision in nursing facilities and overall quality of care.

- Only about one-quarter of state ombudsmen (28%) report that complaints related to managed care are coming to the attention of their state LTCOP, but 71% anticipate that managed care will affect their state LTCOP in the future. Complaints regarding managed care include denial or reduction of services, premature discharge, managed care pulling out of rural areas and leaving seniors without insurance, claim and payment denial, and inadequate services.

**Funding, Staffing, and Volunteers**

- Nationwide, total program expenditures for FY 1999 were approximately $51 million; an increase of almost $4 million from the previous year.

- Approximately two-thirds (67%) of state ombudsmen report that their LTCOP's budget for the last three years was inadequate to fund federal requirements, and 74% state that their budget was inadequate to fund state requirements for the LTCOP. Activities that are most frequently neglected or partially carried out due to inadequate funding include routine visits to facilities (35%), community education and outreach (27%), complaint investigation and resolution/response time to complaints (25%), and development of resident and family councils (22%).

- According to the state ombudsmen, the two major obstacles to obtaining the funding they need to fulfill federal and state mandates are the political climate and perception of the ombudsman program (35%) and the state fiscal situation and the legislative process (27%).

- Program expenditures per LTC bed are significantly associated with the ratio of LTC beds per ombudsman. Ombudsman responses to questions about resource sufficiency indicate that sufficient funding is significantly associated with sufficient staff levels ($p < 0.001$), sufficient volunteers ($p = 0.008$), adequate methods of communication ($p = 0.008$), and effectiveness of work with nursing facilities ($p = 0.008$).

- In FY 1999, there were 974 FTE staff and 8,451 certified volunteer ombudsmen nationwide. The ratio of LTC facility beds per paid program FTE staff was 2,801 for FY 1999, a decrease from 2,832 in FY 1998, and 2,878 in FY 1997.

- When asked to describe turnover of staff and volunteers in the last two years, thirty-six (69%) state ombudsmen report "very low" or "somewhat low" for paid staff, and twenty-four (56%) report "very low" or "somewhat low" for volunteers.

## Recommendations

**Organizational Placement and Structure:**

- *Study findings support the 1995 IOM Report's recommendation that: "No ombudsman program should be located in an entity of government (state or local) or agency outside government whose head is responsible for:*
  - *Licensure, certification, registration, or accreditation of long term care residential facilities;*
  - *Provision of long-term care services, including Medicaid waiver programs;*
  - *Long-term care case management;*
  - *Reimbursement rate setting for long-term care services;*
  - *Adult protective services;*
  - *Medicaid eligibility determination*
  - *Preadmission screening for long-term care residential placements;*
  - *Decisions regarding admission of elderly individuals to residential facilities." (Harris-Wehling et al., 1995; Recommendation 4.1, pg. 124)*

- *LTCOPs should have sufficient organizational autonomy from the state to ensure that ombudsmen may advocate for residents (in accord with their responsibilities as defined by law) without fear of political ramifications. As advised by the 1995 IOM Report: "Ombudsmen must be able to pursue independently all reasonable courses of action that are in the best interest of residents."(Harris-Wehling et al., 1995; pg. 125)*

**Adequacy of LTCOP Resources**

- *Study findings support the need to increase funding to ensure that LTCOPs have adequate resources to fulfill their federal and state mandates. As stated in the 1995 IOM Report, appropriations for the state LTCOPs should be increased to ensure "that all state Offices of the Long-Term Care Ombudsman program are funded at a level that would permit them to perform their current functions adequately." (Harris-Wehling et al., 1995; Recommendation 6.1, pg. 193)*

- *Study findings support the need to ensure the availability of adequate legal services for LTCOPs. As stated in the 1995 IOM Report: "Legal resources are not an end in themselves*

*but are an essential element of the ombudsman programs' infrastructure. Without such resources, the program is greatly hampered in its ability to comply with other mandated provisions in the OAA" (Harris-Wehling et al., 1995, pg. 96).*

- *As recommended by the 1999 report from the Office of Inspector General (OIG, 1999; OEI-02-98-00351), study findings support the need to continue to strengthen the LTCOP's reporting system and to develop a standard for measuring outcomes of ombudsman complaint investigation, education, and advocacy efforts.*

- *Study findings support the need to strengthen the commitment and support of policy makers for the ombudsman program through education, lobbying, publicity, and collaboration with individuals and agencies committed to long term care.*

**LTCOP Efforts to Improve Quality of Care**

- *Ombudsmen must continue to raise public awareness about the issue of nursing facility staffing ratios, and the need to improve recruitment, retention, training, and quality of staff, through advocacy efforts, education of providers and nursing facility staff, and collaboration with agencies committed to long term care.*

- *Study findings support the need for ombudsman visitation and monitoring of LTC facilities to be increased. As the LTC industry continues to shift towards non-traditional settings, policy-makers need to ensure that ombudsmen can meet the needs of increasing numbers of residents in board and care and assisted living facilities.*

- *Study findings support the continued need to promote advocacy efforts for improved quality of care through LTCOP work with citizen's advocacy groups and family and resident councils.*

- *Funding and staffing should be increased to allow ombudsmen to fulfill their role in systemic advocacy. Ombudsmen report that systemic advocacy is one of the activities most often neglected because of inadequate funding. Due to the immediate needs of complaint investigation, goals such as legislative advocacy and community education may be set aside. LTCOP funding must therefore be sufficient for ombudsmen to fulfill their roles not only as complaint mediators and investigators, but also educators and advocates for residents.*

- *Program visibility should be increased to ensure continued funding and support from policy makers.*

**Relationship Between LTCOPs and Other Agencies**

- *The Administration on Aging (AoA) should take a more active role in monitoring LTCOP compliance with regulations stipulated by the Older Americans Act.*

- *LTCOPs should continue to work to improve relationships with state agencies that have authority to enforce regulations.*

- *LTCOPs should increase communication between parties (e.g. SUA administration, licensing agencies, and CAGs) by setting up work groups and negotiating memoranda of understanding. Ensure that all parties are aware of the designated roles, responsibilities, and capabilities of ombudsmen.*

- *Relationships between state and local LTCOPs should be enhanced through increased training, supervision and technical assistance, provision of educational materials, and timely information on legislative and advocacy issues.*

- *State Unit on Aging support for the ombudsman program should be strengthened. Ombudsmen and AoA should actively encourage SUAs to increase financial, technical, administrative, and moral support, ensure adequate legal assistance, increase visibility, and support the mission and autonomy of the LTCOP.*

- *LTCOPs should enhance relationships with citizen's advocacy groups by collaborating on legislative agendas, taking part in each others meetings and conferences, co-sponsoring joint training, and forming coalitions with resident and family councils.*

**Future Research**

- *Given the extent of policy change, the increase of ombudsman responsibilities, the growth of alternative LTC settings, and the increasing elderly population, the IOM Report's recommended staff ratio of one FTE ombudsman per 2000 facility beds should be reevaluated. The following issues should be considered in future research:*

  - *The use of FTE staff in the ratio, given that one full-time equivalent staff may be composed of multiple part-time staff, each of whom require training, supervision, resources, and program coordination (and therefore result in increased time and cost).*

  - *LTCOPs require a minimum level of program management and supervision, and this minimum critical mass may increase for coordination of multiple part-time staff. Staff with these responsibilities may not be actively involved in complaint investigation, education and outreach, or advocacy efforts. Smaller LTCOPs are likely to have a higher proportion of staff involved in administrative tasks and not delivering direct services.*

  - *States that are largely rural face specific challenges (such as travel time) due to geographic dispersion and other issues which have historically been noted but not thoroughly examined.*

  - *The effect of turnover among state and local ombudsmen should be examined.*

- *Research should be conducted to help develop criteria for minimum levels of ombudsman program visits, as described in the 1999 report from the Office of Inspector General (OIG, 1999; OEI-02-98-00351).*

- *Develop criteria for regular and consistent reports on ombudsman complaints to applicable state regulatory agencies.*

- *Identify effective strategies/mechanisms through which ombudsmen may address the need for systems change on behalf of residents.*

- *Research should be conducted to support the development of outcome measures, such as those currently being prepared by NASUA, that will allow ombudsmen (both state and local) to evaluate the impact the effects of the program on residents and families. The development of performance measures for systemic advocacy, in addition to complaint investigation and education, will enable programs to evaluate themselves with respect to policy and long-term change.*

- *Research should be conducted on the issue of the organizational structure and placement of the LTCOP that will allow ombudsmen to best meet statutorily mandated requirements, including complaint investigation; resident, family, and community education; and systems level advocacy. Issues of program autonomy and conflicts of interest must be investigated.*

- *Research should be conducted on the assisted living facility industry, specifically on monitoring care and residents' rights.*

- *Research should be conducted on the implications of managed care. Monitor the effects of managed care on long term care services and increase advocacy efforts in the arena of managed care. Focus initially on concerns identified by ombudsmen, such as denial or reduction of services, premature discharges, and claim and payment denials.*

# INTRODUCTION

The long term care ombudsman program (LTCOP) was created in the early 1970s, several years after the establishment of Medicare and Medicaid, in order to address concerns about the quality of care in nursing facilities.

Today, Medicaid is the largest source of payment for long term care services in this country (Kassner and Tucker, 1998). According to Urban Institute calculations prepared for the Kaiser Commission on the Future of Medicaid, approximately one-fourth of total Medicaid expenditures are spent on long term care, and close to 75 percent of the 44.5 billion in Medicaid expenditures for elderly beneficiaries goes to long term care (Wiener *et al.*, 2000). When the 1997 Balanced Budget Act dramatically reduced Medicare program expenditures for nursing home and home health services, greater pressure was placed on state Medicaid programs to provide long term care services. As a result, as Medicaid spending growth continues to increase in the coming years (Bruen and Holahan, 2001), quality of care issues are a growing area of concern.

The 1995 Institute of Medicine report *Real People Real Problems: An Evaluation of the Long-Term Care Ombudsman Programs of the Older Americans Act* observed that the dramatic changes in health care, Medicare, and Medicaid provide a compelling argument for an ombudsman program to address two quality issues: the quality of care and the quality of life of the elderly. The report also projects increased demand for ombudsman-type services as managed care and cost containment play a more prominent role in decision-making about who may enter nursing facilities and access other home and community-based long term care services.

The Older Americans Act stipulates that each state should have a long term care ombudsman program that serves to provide information and educational materials about long term care services, identify and resolve complaints, and intervene in problem situations on behalf of consumers, residents and their families involving the long term care delivery system. Ombudsmen are also required to advocate to protect the health, safety, welfare, and rights of the elderly in long term care settings.

In 2000, the Henry J. Kaiser Family Foundation commissioned the Institute for Health & Aging (IHA) at the University of California, San Francisco to conduct a national survey of the offices of state long term care ombudsman programs (LTCOPs). This study investigates the role and effectiveness of state long term care ombudsmen in improving quality of care in long term care settings in the fifty states, as well as Washington, D.C. and Puerto Rico.

## Study Approach

A nationwide telephone survey of all 52 state ombudsmen was conducted during September/October of 2000. Of those interviewed, 46 are state LTC ombudsmen, and six are other ombudsmen in the state office, including one assistant state ombudsman, one ombudsman for advocacy, policy development, and education, and one ombudsman program coordinator.

The structured interview survey includes quantitative and qualitative questions (Appendix 3). Questions were generated through review of issues raised and recommendations set forth by the 1995 Institute of Medicine report, *Real People, Real Problems*. The state ombudsmen were queried about the following issues:

- Organizational structure at the state and local level
- Factors contributing to the effectiveness of their programs at the state and local level
- Effectiveness of their programs in meeting statutorily mandated requirements
- Interagency coordination
- Coordination between ombudsmen at the state and local level
- Legal assistance
- Clientele
- Quality of care
- Managed care
- Adequacy of funding
- Staff levels and volunteer programs
- Political influences
- Relationship with other agencies such as HCFA, state agencies, and citizen's advocacy groups

This study considers the role of ombudsmen in addressing the quality of care and quality of life needs of long term care residents. Researchers assess state variation with regard to program funding, staffing, ombudsman responsibilities, complaint resolution, and the effectiveness of the program. Measures of effectiveness include percentage of facilities visited, percentage of complaints resolved, and ombudsman-reported effectiveness in fulfilling statutorily mandated requirements such as complaint investigation, community education, resident and family education, legislative and administrative policy advocacy, and monitoring federal, state, and local law regulations and other government policies and actions.

This study also explores factors that may contribute to the effectiveness of LTCOPs, such as funding and staffing per LTC bed, volunteers, autonomy of the program, collaboration with state agencies and citizen's advocacy groups, legal counsel, and the political and social climate of the state. In addition, state practices with respect to monitoring LTC facilities and advocating for residents are assessed. Other key issues explored include the structure and placement of LTCOPs, and how the ombudsman programs have been impacted by managed care.

Secondary data sources, including the AoA's survey of long term care ombudsmen programs (NORS) for FY 1999, are incorporated into the data analysis (Appendix 1).

# HISTORY OF THE LONG TERM CARE OMBUDSMAN PROGRAM

The ombudsman[i] program was initiated in 1972 as a Public Health Service demonstration project in response to concerns about poor quality of care in nursing homes. In 1974 the program was transferred to the Administration on Aging (AoA). After three years state agencies on aging were offered the opportunity to apply for federal funds to develop state-wide programs. In 1978 Congress amended the Older Americans Act (OAA) to require each state to develop a Long Term Care Ombudsman Program (LTCOP). The OAA was reauthorized in 1992, and again in 2000 (through fiscal year 2005).

Following a request for proposals in 1988, the AoA awarded the National Association of State Units on Aging (NASUA) with a grant and the National Citizens' Coalition for Nursing Home Reform (NCCNHR) with a sub-grant to develop a National Center for State LTCOPs. Today the Resource Center, operated by NCCNHR in collaboration with NASUA, supports the ongoing development and operation of all state LTCOPs, trains state ombudsmen, and provides technical assistance to ombudsmen in program development and on long term care issues.

In 1985, state ombudsmen established the National Association of State Long Term Care Ombudsman Programs (NASOP) in order to create a venue for sharing ideas and experiences, and to support a common voice for all state programs. A decade later, local ombudsmen established the National Association of Local Long Term Care Ombudsman (NALLTCO). NALLTCO's mission is to ensure the integrity of local programs and their ability to effectively advocate for residents; exchange and share information, opportunities, and resources; and provide information to policy makers on legislation and regulations impacting local ombudsman programs and long term care residents (NALLTCO, 1996).

Responsibilities of the LTC ombudsmen as outlined in Title VII of the OAA include:

- Identify, investigate, and resolve complaints made by or on behalf of residents
- Provide information to residents about long term care services
- Represent the interests of residents before governmental agencies and seek administrative, legal, and other remedies to help protect residents
- Analyze, comment on, and recommend changes in laws and regulations pertaining to the health, safety, welfare, and rights of residents
- Educate and inform consumers and the general public regarding issues and concerns related to LTC and facilitate public comment on laws, regulations, policies, and actions
- Promote the development of citizen organizations to participate in the program
- Provide technical support for the development of resident and family councils to protect the well-being and rights of residents.

[i] The first ombudsmen were established by the Swedish parliament in the early 1800s to provide a means for citizens to pursue grievances against the government. These "classical ombudsmen" emphasized independence from governmental control, and had the power to investigate complaints and publish findings and recommendations. Over time, other types of ombudsmen emerged, including "citizen advocacy ombudsmen" (i.e., long term care ombudsmen), which were established by statute and whose authority is limited to dealing with issues of designated populations (Gadlin, 2000).

# REVIEW OF RECENT LITERATURE

## Previous Evaluations of State LTCOPs

### *1990 Office of Inspector General's Report on Successful Ombudsman Programs*

In 1990, the Office of Inspector General identified characteristics of the most successful LTCOPs. These include high visibility, frequent facility visits, effective recruiting and training of volunteers, and expeditious handling of complaints. In addition, the report states that the programs must be adequately funded, as this is linked to more professional staff, more frequent facility visits, improved response time to complaints, training and supervision of staff and volunteers, and more involvement in legislative planning and decision-making. Program independence was also identified as a salient characteristic (OIG, 1990; OEI-02-90-02120).

### *1995 Institute of Medicine Evaluation*

In 1995 the National Academy of Sciences' Institute of Medicine (IOM) published *Real People, Real Problems: An Evaluation of the Long-Term Care Ombudsman Program of the Older Americans Act*. The IOM report investigates issues such as state compliance with program mandates; conflicts of interest due to the ombudsman's position as a state employee required to speak out against government regulations, policies, and actions; effectiveness of the ombudsman program; adequacy of resources; and the need for future expansion of the program. It also reports on lack of access to ombudsman services by residents and families, disparities in ombudsman visitation patterns and service provision, and uneven availability of ombudsman legal services. The committee, chaired by Dr. Carroll L. Estes, concludes:

> The ombudsman program serves a vital public purpose and merits continuation with its present mandate. Through advocacy efforts at both the individual resident and the system levels, paid and volunteer ombudsmen uniquely contribute to the well-being of LTC residents—complementing, but not duplicating, the contributions of regulatory agencies, families, community-based organizations, and providers (IOM, Harris-Wehling *et al.*, 1995; vi).

The IOM committee recommends the following:

- Build a nationwide database on key structure, process, and outcome measures for the program
- Enhance each state's ability to operate a unified statewide office of the LTC ombudsman
- Stimulate and guide needed research
- Encourage leadership from the federal government.

Other recommendations specifically address improving state programs' compliance with federal mandates, removing conflicts of interest from the organizational structure of the LTCOPs, improving the effectiveness of LTCOPs, and ensuring the adequacy of resources to meet the

minimum ratio of one full-time equivalent (FTE) paid staff ombudsman per 2000 LTC beds. In addition, the IOM Report observes that the dramatic changes in health care, Medicare, and Medicaid provide a compelling argument for the Ombudsman Program to address quality of care and quality of life for the elderly.

### *The National Ombudsman Reporting System (NORS)*

In FY 1995 state LTCOPs began utilizing the National Ombudsman Reporting System (NORS). NORS was created in response to recommendations from the General Accounting Office of the OIG to develop a systematic method to collect and report data. By 1996, all states began reporting under NORS annually.

With the availability of NORS data, the first LTCOP Annual Report was published in 1995. The report analyzes complaint data, describes the experiences of LTC residents, and details the activities of ombudsman programs nationwide. This study utilizes NORS data from FY 1999 to analyze nationwide trends among state LTCOPs in funding, staff and volunteers, complaint investigation, and other ombudsman activities.

### *1999 Office of Inspector General Study*

In 1999, the Office of Inspector General (OIG) completed a study that focused on conditions in nursing homes in the ten states with the largest nursing home populations (NY, CA, TX, OH, IL, PA, MA, FL, NJ, and TN). Together these states represent 55.8% of the total skilled nursing beds and 53% of complaints to the Ombudsman programs nationally in 1996 (OIG, 1999; OEI-02-98-00350). In testimony before the Senate Special Committee on Aging, George Grob, Deputy Inspector General for Evaluation and Inspections, stated that the ombudsman program is well-designed but limited by inadequate resources:

> Only one of 10 States in our sample had a paid ombudsman to bed ratio higher than the standard suggested by the Institute of Medicine of 2,000 beds. This lack of adequate staffing is particularly evident in the limited extent to which ombudsmen make regular nursing home visits. Some nursing homes may only be visited once or twice a year for a couple of hours. The program is further constrained by the lack of a common standard for complaint response and resolution and limited collaboration with surveyors (Grob, 1999).

The OIG 1999 study presents the following recommendations:

- Develop guidelines for minimum levels of ombudsman program visibility, including criteria for frequency and length of regular visits and staffing ratios
- Formulate strategies for recruiting, training, and supervising more ombudsman volunteers
- Develop guidelines for ombudsman complaint response and resolution times
- Continue to refine and improve the ombudsman program's data reporting system

- Establish ways to enhance coordination between survey and certification and ombudsman programs (OIG, 1999; OEI-02-98-00351).

The 1999 OIG report notes that NORS does not provide extensive performance measurement data, such as information about response and resolution times (OIG, 1999; OEI-02-98-00351). Recently, under a sub-grant from the National Ombudsman Resource Center, NASUA and state ombudsmen have begun developing a model of outcome measures. The hope is that these measures can assist ombudsmen in estimating the value of services residents receive, comparing results among agencies, and examining changes over time. The outcome model that is being developed utilizes NORS as the primary data source, and identifies the various steps that lead from inputs (such as funding, staffing, and volunteers), to outputs (such as facility/resident visits and complaints investigated), to both initial and long term outcomes (such as the initiation of regulatory and law enforcement actions) (NASUA, 2000). Other efforts to measure performance of LTCOPs have resulted in the development of a tool to measure the compliance of local ombudsman programs to the standards recommended by the 1995 IOM Report (Huber *et al.*, 2001).

## Key Issues Explored in Recent Literature

### *Issues Related to Effectiveness: Structure/Placement/Autonomy*

Currently there are LTCOPs operating in all 50 states, the District of Columbia, and Puerto Rico. In FY 1998 there were 587 local and regional ombudsman programs (AoA, 2000). Most state programs utilize volunteers in addition to paid staff. The majority of programs operate within the State Units on Aging, which are either independent or part of a larger state umbrella agency. In addition several programs are operated by other state agencies, legal services agencies, or nonprofit organizations.

Few studies have investigated the effectiveness of LTCOPs based on their organizational structure and location. One analysis of local ombudsman programs in Kentucky compares the effectiveness of programs situated within an Area Agency on Aging (AAA) with programs that are subcontracted out. The study finds that programs not in AAAs verified a significantly higher percentage of complaints and fully or partially resolved a significantly greater percentage of complaints to the satisfaction of the resident or complainant. Huber *et al.* (1996) comment that one possible explanation for this discrepancy is the different emphases of the two types of programs. While both types of agencies address a wide range of complaints, the programs within AAAs (which are planning and coordination agencies focused heavily upon systems development) emphasize resident rights and administrative/systemic issues, while non-AAA programs emphasize resident care and quality of life issues.

### *Conflicts of Interest*

Conflicts of interest undoubtedly arise due to the OAA's mandate that ombudsmen work toward improving LTC facilities for residents even if this involves challenging, recommending, and

facilitating public comment on government policies, laws, and regulations (U.S. Code: Title 42, Section 3058g). The National Association of State Long-Term Care Ombudsman Programs reports that the following circumstances create conflicts of interest:

- The LTCOP is part of an entity that is responsible for licensing or certifying LTC facilities
- The LTCOP is located within an organization that may impair the ability of the ombudsman to objectively and independently investigate and resolve complaints
- The ombudsman role is not seen as independent. (The ombudsman must be free to take action on behalf of residents, to publicly represent the concerns of residents, to bring together individuals who have the authority to solve problems, and to make recommendations to boards, committees, and task forces in developing LTC policy).
- The contract (sponsoring) agency does not understand the ombudsman function. (There must be the recognition that there are inherent conflicts in the job, and a need to support the role and goals of the ombudsman through any conflict) (NASOP, 1989).

To protect against conflicts of interest, the OAA prohibits conflicts of interest with state agencies and legal counsel. State programs are required to establish mechanisms to identify and remove conflicts, and to ensure that the ombudsman:

- Does not have a direct involvement in the licensing or certification of a LTC facility or of a provider of a LTC service
- Does not have an ownership or investment interest in a LTC facility or a LTC service
- Is not employed by, or participating in the management of, a LTC facility
- Does not receive or have the right to receive remuneration under a compensation arrangement with an owner or operator of a LTC facility (§712(f)(3)).

The 1995 IOM report recognizes that "ombudsman programs and individual ombudsmen are particularly vulnerable to actual or perceived conflicts of interest that arise through governance boards" and recommends that the OAA be amended to assert that no ombudsman program should be located in an entity of government (state or local) or agency outside government whose head is responsible for: licensure, certification, registration, or accreditation of LTC residential facilities; provision of LTC services, including Medicaid waiver programs; LTC case management; reimbursement rate setting for LTC services; Adult Protective Services; Medicaid eligibility determination; pre-admission screening for LTC residential placements; or decisions regarding admission of elderly individuals to residential facilities (IOM, Harris-Wehling *et al.*, 1995).

One of the current conflict of interest debates involves the issue of placement of the ombudsman program; specifically whether the LTCOP is made more effective or is compromised when it is situated within a state agency as compared to when the program is fully independent from the state. Autonomy of the LTCOP requires that both state and regional ombudsmen are able to freely speak with media, policy makers, and legislators and that ombudsmen may participate in policy and operational discussions with other agencies.

***Collaboration and Coordination with Other Agencies Including Licensing and Certification***

Ombudsmen frequently interact with other advocates and various representatives of the state and outside agencies within the LTC and health sector. Ombudsmen often work closely with their state surveying agency and the Health Care Financing Administration (HCFA), as well as citizen's advocacy groups, Medicaid and Medicare program representatives, and the Attorney General's office. Some ombudsman programs also work closely with Adult Protective Services (APS).

The 1999 OIG study investigates the coordination between ombudsman programs and state surveying and certification agencies and finds that in 1997 ombudsmen accompanied surveyors only 61% of the time, despite the requirement that they be notified of inspection dates (OIG, 1999; OEI-02-98-00351). The study also reports that only 13% of the total ombudsman abuse complaints ultimately reached the survey agency in 1997, and only 5% of all complaints to the state survey and certification agency originated from ombudsmen (OIG, 1999; OEI-02-98-00330). Based on these findings the OIG recommends that the HCFA facilitate better coordination with the ombudsman program.[ii]

While the degree of coordination with surveying agencies is sometimes low when it comes to complaint investigation, many state ombudsmen work closely with HCFA to strive for common goals in nursing home reform. In 1999, representatives from HCFA met with state ombudsmen at the Annual State LTC Ombudsman Spring Training Conference. The meeting was convened to discuss HCFA's response to former President Clinton's 1998 Nursing Home Initiatives. The goal of this collaboration was to inform ombudsmen of HCFA's activities, generate ideas for the role of the ombudsman and the relationship between ombudsmen and HCFA in these activities, shape the advocacy agenda for state LTCOPs, and determine if progress had been made in key arenas essential to improving resident care. Topics discussed include abuse prevention, nutrition/hydration, staffing, the impact of a prospective payment system on residents, restraint use, complaint investigation and follow-up, facility closing, and appeals of survey findings (Hunt, 1999).

In a 1993 meeting arranged by AoA, ombudsmen met with representatives from APS and elder legal services networks to discuss and make recommendations about coordination between LTCOPs and APS programs. Participants at the meeting determined that while the two programs must work together to better serve their clients, there are important distinctions in their philosophy, functions, mandates, and authorities. For example, while the roles of ombudsmen and APS workers may overlap upon receipt of an abuse complaint, their roles in resolving complaints differ in that APS workers act as agents of the state, whereas LTC ombudsmen act as agents of the resident. The participants recommend that AoA issue a regulation that prohibits an ombudsman from also being an APS worker. In addition, the advantages and disadvantages of

[ii] It is important to note that the low numbers reported in the OIG Report do not necessarily indicate a lack of attention by LTCOPs to abuse complaints. For example, ombudsman programs often investigate and resolve complaints brought to their attention without involving the licensing agency, and some states have outside agencies other than the survey and certification agency that are responsible for investigating abuse complaints. In addition, some ombudsmen may refer complaints related to abuse directly to the licensing agency or may urge and assist the resident to register a complaint directly with the licensing agency, thus not including the complaint record in NORS.

APS and the LTCOP being in the same agency were discussed. Advantages include an increased potential for the agency to see the "big picture," joint training, and equal access to resources and decision-makers. Disadvantages include potential conflicts of interest, lack of opportunity for both programs to assess and critique the other, and potential breaches of confidentiality (AoA, 1993).

### *Adequacy of Legal Counsel*

The OAA requires that state agencies ensure that the ombudsman program has adequate legal counsel available without a conflict of interest. According to the OAA, the role of the legal counsel should be to:

- Provide advice and consultation needed to protect the health, safety, welfare, and rights of residents
- Assist the ombudsman and representatives of the office in the performance of the official duties of the ombudsman and representatives
- Provide legal representation for any representative of the office against whom suit or other legal action is brought or threatened to be brought (U.S. Code: Title 42, Section 3058g).

### *Adequacy of Funding*

All LTCOPs receive federal funding, and most receive additional funding at state and local levels. In FY 1999, ombudsman program funding totaled approximately $51,380,000 (an increase of almost $4 million from the previous year). About 61.3% of the funding is from federal sources (most often Title III of OAA), 26.4% is from states, and 12.3% is from local funds. Overall this was a slight increase in federal funds (3.2%) and a slight decrease (1.4% and 1.8%) in state and local funds, respectively, from the year before (AoA, 2001).

Occasionally individual states carry out studies to assess the effectiveness of their programs. In one such instance, the Utah Department of Human Services contracted with a consulting group to conduct an assessment of their state LTCOP. Interviews were conducted with DHS staff, current and past state ombudsmen, AAA Directors, local paid and volunteer ombudsmen, and individuals from various divisions of the health care sector, financing, legal services, and advocacy. The main theme exposed by the assessment is that the Utah LTCOP is doing an adequate to good job with complaint handling and ombudsman training given the program's resources and structure, but that the program needs additional funding in order to fulfill its state and federal mandates (Utah DHS, 2000).

### *Adequacy of Staff and Volunteer Ombudsmen*

As shown in Table 1, the numbers of full-time equivalent (FTE) paid ombudsman staff and trained and certified volunteers has been increasing over the past few years. In FY 1999 there were 974 FTE paid ombudsman staff and 8,451 trained and certified volunteers. As ombudsman

staffing levels increase, the ratio of LTC facility beds to paid program staff (FTEs) has been slowly and steadily decreasing nationwide. In FY 1999 the ratio of beds to staff for all states was 2,801 (AoA, 2001).

**Table 1: Ombudsman Staff and Volunteers, FY 1999**

| | FTE Ombudsman Staff | Trained/Certified Volunteers | Ratio of Beds to FTE Staff |
|---|---|---|---|
| **FY 1999** | 974 | 8,451 | 2,801 |
| **FY 1998** | 927 | 7,359 | 2,832 |
| **FY 1997** | 887 | 6,795 | 2,878 |
| **FY 1996** | 847 | 6,622 | 2,973 |

**Department of Health & Human Services, AoA, National Ombudsman Reporting System, FY 1999**

From the beginning, volunteers have been an important component of many ombudsman programs. In 1999 the National Long Term Care Ombudsman Resource Center investigated the use of volunteers in state programs. Findings include:

- 45 (87%) ombudsman programs utilize volunteers
- The number of volunteers in state programs varies from as few as four to as many as 3500
- Of the 45 states that use volunteers:
  - 38 authorize volunteers to handle complaints
  - 37 have a certification process for their volunteers
  - 25 provide volunteers with liability insurance (MacInnes and Hedt, 1999).

In 1997-98, the Wisconsin LTCOP participated in a statewide evaluation of nursing home regulation by the Legislative Audit Bureau. The Bureau's report concludes that while assisting with the resolution of individual problems of nursing home residents should be the highest priority of ombudsmen, ombudsmen are not maintaining an adequate presence in all nursing homes and are not performing active outreach to increase consumers' knowledge of program services. These problems are attributed in part to understaffing of the ombudsman program. (Wisconsin had one ombudsman for every 6,264 beds at the time). The report also notes that compared to other states, Wisconsin allots a smaller percentage of OAA federal funding for the ombudsman program (Wisconsin Legislative Audit Bureau, 1998).

Two state studies, in Iowa and Oregon, have focused on the work and effectiveness of volunteer ombudsman programs. The study in Iowa finds that volunteers who handle more complaints assign greater importance to their activities and feel more effective than those who handle fewer complaints. Responses from 778 volunteers also indicates that support, cooperation, and assistance from administrators of facilities increase feelings of efficacy (Keith, 1999).

In Oregon, an analysis of 1992 abuse complaint reports finds that the presence of a volunteer ombudsman in a facility is tied to greater numbers of abuse complaints and substantiated abuse complaints, and more survey deficiencies. Nelson *et al.* (1995) note that these findings are likely to be linked to the fact that in Oregon volunteer ombudsmen are required to report abuse. Volunteers are also trained to request a report of investigation findings and to take part in the

survey process, and this might lead to an increase in substantiated abuses and an increase in survey deficiencies.

### *Staff and Volunteer Training*

LTC ombudsman training requirements in the OAA instruct state LTCOPs to establish procedures and develop training based on AoA standards and in consultation with representatives of citizen groups, LTC providers, and ombudsmen. The OAA requires that ombudsman training content include investigative techniques and federal, state, and local laws, regulations, and policies (U.S. Code: Title 42, Section 3058g; Hunt, 2000). The 1995 IOM report set forth the following ideal outcomes of training:

- All representatives have an understanding of LTC consumers, facilities, services, or their management, but no prohibited ties with facilities, services, or their management
- All representatives have knowledge or understanding of the variety of regulatory functions (licensing, survey, certificate of need, rate setting, etc.) and their effects on LTC consumers but no prohibited ties with regulatory agencies
- The program maintains a reputation as one staffed by well-prepared, knowledgeable workers familiar with the latest developments and trends and generously able to help others learn its knowledge and skills. Training is conducted in a manner developed to foster and encourage the ongoing improvement and skills of every representative of the office (IOM, Harris-Wehling *et al.*, 1995).

Many LTCOPs have individualized their training programs to address specific requirements or circumstances in their states. State programs have also worked together to develop and test large-scale training efforts. For example in 1995, when former President Clinton announced Operation Restore Trust (an initiative to fight Medicare and Medicaid fraud), five state ombudsman programs (from CA, NY, IL, FL, and TX) were part of the core team. Working with HCFA, the OIG, and the AoA, the LTCOPs from these five states launched statewide training programs to educate ombudsmen and other professionals about fraud, waste, and abuse.

### *Complaint Investigation*

In FY 1999 ombudsmen nationwide opened 147,340 cases and closed 130,255 cases involving 215,650 individual complaints; 80.1% of complaints originated in nursing home settings, and 17.6% in board and care or assisted living facilities. The remaining complaints originated in non-facility settings. Three-quarters (74.3%) of nursing home complaints and 68.5% of board and care complaints were resolved or partially resolved to the resident or complainant's satisfaction (AoA, 2001).

NORS breaks down complaints into five categories: residents' rights, resident care, quality of life, administration, and complaints not against the facility. The percentage of complaints falling into each category for FY 1999 is displayed in Table 2.

**Table 2: Complaints by Category in Nursing Facilities and Board and Care Facilities, FY 1999**

| | Nursing Facilities | Board and Care Facilities |
|---|---|---|
| **Residents' Rights** | 32.0% | 35.3% |
| **Resident Care** | 32.6% | 21.4% |
| **Quality of Life** | 19.5% | 24.1% |
| **Administration** | 9.9% | 12.2% |
| **Not Against the Facility** | 6.1% | 7.0% |

**Department of Health & Human Services, AoA, National Ombudsman Reporting System, FY 1999**

According to the 1999 OIG study, total nursing home complaints increased 44% between 1989 and 1994 in the ten states surveyed. When the complaints are categorized for these years, the largest growth is in administrative complaints (188%), followed by resident rights complaints (125%), complaints about food and nutrition (89%), and complaints about resident care (72%) (OIG, 1999; OEI-02-98-00350).

Between 1996 and 1997 total complaints in the ten states increased 7% overall, and the complaint to bed ratio increased from 65 to 69 per 1,000 beds. When complaint data are categorized into resident care, resident rights, quality of life, administration, and complaints not against the facility, resident care complaints (including personal care complaints such as pressure sores and hygiene, lack of rehabilitation services, and the inappropriate use of restraints) increased the most (13%) between 1996 and 1997 (OIG, 1999; OEI-02-98-00350).

In 1997 the ten most frequently reported complaints comprised one-third of all nursing home complaints that year, including three related to insufficient nursing home staffing: unanswered call lights, dignity and respect/staff attitudes, and shortage of staff. Others among the top ten include poor hygiene, physical abuse, and improper handling of accidents (all of which can also stem from insufficient staffing). Finally, the OIG report notes an increase in 13 of 25 quality of care deficiencies in recent years, including lack of supervision to prevent accidents, improper care for pressure sores, and lack of necessary care for the highest practicable well-being (Grob, 1999).

### *Quality of Care*

A recent study funded by HCFA focuses on quality of care in nursing home facilities. According to the report, the top ten facility deficiencies for certified facilities in 1998 are food sanitation, accidents, quality of care, pressure sores, care plans, assessments, accidents, housekeeping, dignity, and restraints (Harrington *et al.*, 2000).

A second study focusing on quality of care investigates stakeholders' opinions regarding important measures of nursing home quality for consumers. For this study, Harrington *et al.* (1999) interview state ombudsmen, administrators, directors of nursing, state survey agency training coordinators, and nursing home advocates. Out of these groups of stakeholders, ombudsmen are most likely to rank residents' rights in their top three quality indicator

categories. They are also more likely to rank residents' behavior and facility practices higher than the administrators and directors of nursing. Of the 15 major categories of quality indicators, the categories most frequently ranked in the top three by state ombudsmen (N = 41) are resident rights (92.7%), quality of care (80.5%), quality of life (73.2%), resident behavior (63.4%), admission/transfer (58.5%), and resident assessment (39.0%).

### *The Impact of Facility Staffing on Quality of Care*

Ombudsmen have identified insufficient facility staff as the major institutional LTC concern, and link low staffing to poor quality of care for residents (AoA, 2000). The relationship between nursing facility staffing levels and quality of care is supported by a finding that inadequate staffing and supervision results in careless feeding techniques that can result in malnutrition (Kayser-Jones, 1997).

Ombudsmen in the 1999 OIG study agree that staffing shortages pose a serious quality of care problem:

> The type and extent of survey deficiencies and ombudsman program complaints... suggest that nursing home staffing levels are inadequate. Common personal care problems such as lack of nutrition and poor care for incontinence suggest that staffing is inadequate to provide the level of care needed to avoid these problems. Furthermore, specific complaints about nursing home staff are some of the most common types of ombudsman program complaints in 1997 (OIG, 1999; OEI-02-98-00060).

A recent Commonwealth Fund report poses possible staffing options that could improve quality of care in the arena of nutrition and hydration. Report recommendations for staffing improvements include:

- Adoption of a national minimum direct-care staffing ratio for mealtimes
- Improvement of management and supervision of direct-care staff
- Better use of professionals in nutrition and hydration services
- Provision of initial and continuing in-service education for nursing assistants
- Making more personnel available at mealtimes (Burger *et al.*, 2000).

### *Scope of Services: Board and Care and Assisted Living Facilities*

The OAA mandate specifies that in addition to their responsibilities for nursing home residents, ombudsmen cover board and care facilities and other adult care homes, including assisted living facilities. Because states have discretion in determining the regulation of facilities other than nursing homes, ombudsman programs vary in the degree to which they investigate complaints and advocate for residents in board and care and assisted living facilities.

In FY 1996, only 17% of closed complaints were from board and care and "similar adult care" facilities. Though the number of board and care and assisted living facilities increased 18% between FYs 1996 and 1998, ombudsmen are still visiting these facilities less regularly than nursing homes. In FY 1999 ombudsman staff and volunteers made "friendly visits" (not in response to a complaint) in 83.1% of nursing homes but only 47.4% of board and care homes (NASUA, 1999; AoA, 2001).

A recent manual designed to assist ombudsmen in their advocacy efforts for assisted living residents presents several concerns specific to these facilities, including questionable providers who take advantage of the fact that assisted living facilities are not licensed; underserved high-need residents; inadequate activity programs; lack of oversight coordination; and transfer and discharge issues. In addition, ombudsmen report that they sometimes have difficulties gaining access to assisted living residents, that they feel limited due to inadequate resources of the ombudsman program, and that they encounter facilities that are reluctant to cooperate with ombudsmen because they are unfamiliar with the program (NASUA, 1999).

When analyzing the effect of regulation on the quality of care in board and care facilities, Hawes and associates (1995) find that in states with extensive regulation of board and care, facility staff are much more likely to know the name and phone number of the ombudsman. The facility staff in states with high regulation are also more likely to call an ombudsman and more likely to refer families or residents to an ombudsman in the event of a problem. Regulation is also associated with better quality of care by the following findings:

- Licensure alone is effective in ensuring that homes provided care above a threshold of minimum performance
- Extensive regulatory systems reduce the prevalence of unlicensed homes
- Extensive regulatory systems and licensure are effective in promoting better safety, quality of life, and quality of care
- Regulation achieves positive effects on quality without producing an excessively institutional model of care (Hawes *et al.*, 1995).

### *Systems-Level Advocacy*

In addition to investigating complaints, ombudsmen are responsible for monitoring and evaluating policy changes. Many ombudsmen work directly with legislators to advocate on behalf of residents, and as a group the National Association of State LTC Ombudsman Programs (NASOP) advocates for positions that benefit residents and responds to requests for information at the federal level.

Ombudsmen are also responsible for informing the public about LTC issues and educating facility staff and the greater community about the ombudsman program and laws and regulations. Ombudsmen disseminate information through the use of posters, brochures, media spots and public forums, toll-free numbers, community outreach efforts, telephone hotlines, and in-service training for facility staff. By taking part in training at nursing facilities, ombudsmen raise staff awareness about residents' rights and quality of care issues. Ombudsmen also promote the

development of resident and family councils, which serve to support, educate, and inform residents and their family members, and also provide a vehicle for action on concerns and complaints (IOM, Harris-Wehling *et al.*, 1995).

In 1998, NASOP adopted a position paper regarding the representation of LTC residents. One of the core principles is the independence of the ombudsman program:

> Program independence is the vehicle that enables ombudsmen to carry the message of residents, to ensure that the laws and regulations are being applied. A LTCOP that functions with independence can effectively give voice to residents' concerns within individual facilities and at local, state, and federal government levels and fulfill the advocacy responsibility called for in the OAA.

According to NASOP's position paper, criteria that enable ombudsmen to most effectively advocate for LTC residents include:

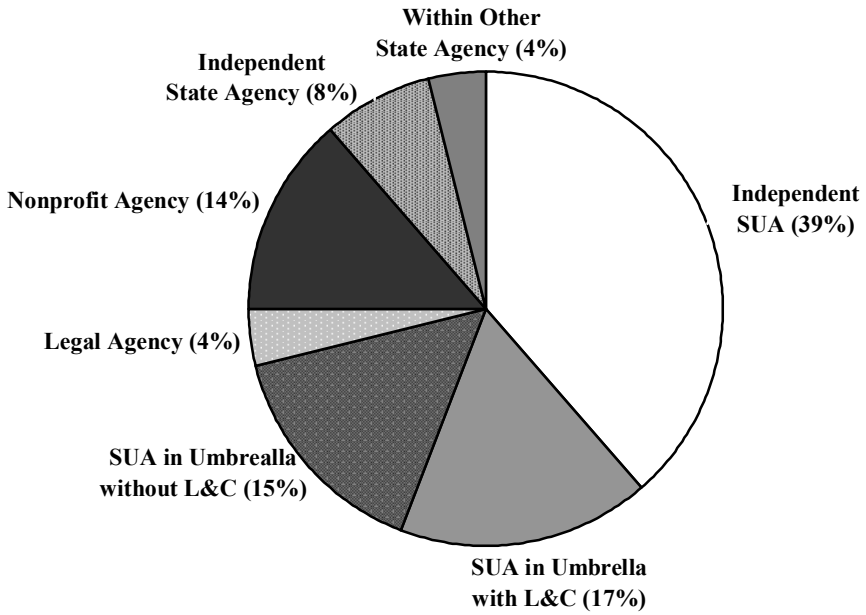
- The LTCOP is unencumbered in its response to complaints made by or on behalf of individual residents. This includes working within facilities to resolve problems, representing residents in administrative hearings, public hearings, and seeking appropriate intervention from other agencies or organizations.
- The LTCOP is unencumbered in its ability to responsibly represent the concerns and interests of LTC consumers through ombudsman program public reports, forums, printed information, and media contacts.
- The LTCOP is unencumbered in making public recommendations and providing educational material to legislators, policy makers and the media to effect positive change for LTC residents (NASOP, 1998).

# FINDINGS

## Organizational Structure of State LTCOPs

Thirty-seven (71%) of the LTCOPs are part of their State Unit on Aging (SUA). Of these, 39% are in an independent SUA and the remainder are in SUAs within umbrella agencies that either include a licensing and certification agency (17%) or do not (15%). In addition, seven (14%) are located in a nonprofit agency, four (8%) in an independent state agency, two (4%) in another umbrella state agency, and two (4%) in a legal agency.

**Figure 1: Organization of State LTCOPs**




**State LTCOP Survey (Question 2), Institute for Health & Aging, UCSF, 2001**

Thirteen (25%) of the LTCOPs have experienced a change in their organizational placement in the last five years. Five state ombudsmen report that their LTCOP became independent from their SUA and moved into another state or independent agency, with reasons including the need to avoid a conflict of interest with the state agency, a structural change that placed the ombudsman in a less advocacy-oriented role, and a budget change that transferred funds in order to make the program more effective. Three LTCOPs experienced a placement change whereby their program was incorporated into aging services due to consolidation of resources or senior services, or to the creation of a new department. Three LTCOPs were elevated within their departments because the ombudsman program became a higher priority in the agency. Other changes in organizational placement include a LTCOP moving from the cabinet for families and children to the health cabinet, and a LTCOP advocating for and gaining increased independence within its SUA.

Twenty-eight state ombudsmen (55%) state that the placement of their state LTCOP creates difficulties for their ability to fulfill their mandate under the Older Americans Act. Difficulties in service provision due to organizational placement are organized in Table 3 based on placement of the state LTCOP.

## Table 3: Difficulties in Service Provision Due to Organizational Placement of State LTCOP

**State LTCOPs in an independent SUA (39%)**

- Lack of autonomy to speak to legislators and the media
- Conflicts of interest with SUA
  - Advocacy efforts hindered
  - Ombudsmen prohibited from criticizing state agencies
  - SUA is also responsible for Adult Protective Services
- No direct access to information about policy issues
- Executive director is appointed by governor

**State LTCOPs in a SUA within an Umbrella Agency with a Licensing and Certification Agency (17%)**

- Lack of autonomy to speak to legislators and the media
- LTCOP is not considered or contacted about policy issues
- Conflicts of interest with SUA and/or umbrella organization
  - SUA also makes recommendations to state agency regarding licensing of facilities.
  - SUA is also responsible for Adult Protective Services, administers Medicaid choice, determines nursing home eligibility, and owns and operates LTC beds
- Consumers confused because they think ombudsmen are licensing regulators
- LTCOP must compete for the attention and interest of the director of the umbrella agency
- Cumbersome bureaucracy in terms of budget management and lines of authority

**State LTCOPs in a SUA within an Umbrella Agency without a Licensing/Certification Agency (15%)**

- State ombudsman is required to keep the entire hierarchy informed of LTCOP activities
- Lack of autonomy to speak to legislators and the media
- Gap in legal services because LTCOP's legal advisor cannot represent residents

**State LTCOPs in a Nonprofit Agency (14%)**

- Autonomy limited by parent organization
- No access to state amenities due to tight budget

**State LTCOPs in an Independent State Agency (8%)**

- Lack of protective umbrella agency allows for budget vulnerability

**State LTCOPs in Another State Agency (4%)**

- Unable to advocate at state level
- Conflict of interest as part of state government

**State LTCOPs in a Legal Agency (4%)**

- *No specific difficulties due to placement were reported*

**State LTCOP Survey (Questions 2 & 3), Institute for Health & Aging, UCSF, 2001**

State ombudsmen utilize a number of strategies to deal with the difficulties caused by the organizational placement of the program. In the event of conflicts of interest, one strategy is to work with individuals who have more autonomy to advocate for residents and communicate with legislators and the media, such as volunteer ombudsmen, local ombudsmen, and representatives from citizen's advocacy groups. Communication between parties, including the SUA administration and licensing and certification agencies is essential, and several state ombudsmen have set up workgroups or negotiated contracts of understanding. Some ombudsmen have attempted to work with the media to expose conflict of interest issues. Others report that focusing on education of state agency directors, as well as legislators, has proven effective.

## Effectiveness of State LTCOPs

When asked to rate the overall effectiveness of their LTCOP at the state level, ombudsmen are generally positive. The majority rate their programs as "very effective" (31%) or "somewhat effective" (64%). Only three ombudsmen rate their programs as "neutral (2%) or "somewhat ineffective" (4%). When state ombudsmen are questioned about individual factors that may or may not contribute to the effectiveness of their state LTCOPs (Table 4), fifty-one (98%) report that their LTCOP is generally able to represent the interests of residents to most state agencies.

Further questioning, however, reveals that a number of factors inhibit the effectiveness of LTCOPs, including insufficient numbers of paid staff (79%), insufficient funding (78%), insufficient numbers of volunteers (78%), inadequate autonomy due to the organizational placement of their LTCOP (39%), insufficient legal service (33%), and inadequate communication methods to share information with local programs (31%). More than one-quarter (28%) report that they cannot carry out federal mandates independently from other state agencies and parties, and 25% report that their state political and social climate is not supportive of their LTCOP. Other factors that reportedly influence the effectiveness of state LTCOPs include the independence of the program, the relationship with local programs (including issues of control and unity), turnover of state and local ombudsmen, support from the legislature, support from the aging network, and public recognition of the program.

**Table 4: Factors Contributing to Effectiveness of State LTCOPs**

| | Yes (%) | Respondents (N) |
|---|---|---|
| Ability to represent interests of residents to most state agencies | 100 | 52 |
| Good relationship with Licensing & Certification | 96 | 51 |
| Good working relationships with HCFA | 93 | 44 |
| Uniform database | 86 | 51 |
| Good working relationship with LTC industry | 88 | 51 |
| Freedom of LTCOP's activities from excessive legislative or regulatory restrictions | 85 | 52 |
| Agreement with position of employees' unions regarding staffing practices | 85 | 26 |
| Clearly defined lines of authority and accountability for state and local ombudsmen | 82 | 51 |
| Supportive political and social climate | 76 | 49 |
| Ability to carry out federal mandates independently from other state agencies and parties | 72 | 50 |
| Adequate communication methods to share information with local programs | 69 | 48 |
| Sufficient legal service available | 67 | 51 |
| Sufficient autonomy due to organizational placement | 61 | 51 |
| Sufficient number of volunteers | 22 | 45 |
| Sufficient funding | 22 | 50 |
| Sufficient number of paid staff | 21 | 52 |

**State LTCOP Survey (Question 5), Institute for Health & Aging, UCSF, 2001**

Table 5 displays how state ombudsmen rate their LTCOP's performance in meeting statutorily mandated requirements. Overall, the ombudsmen rank their programs as most effective at complaint investigation, with 62% of the states indicating that they are "very effective" and 35% indicating that they are "somewhat effective." The other four requirements receive "very effective" and "somewhat effective" ratings of 35% and 52% (for monitoring laws, regulations, and policies), 23% and 64% (for community education), 17% and 67% (for resident and family education), and 23% and 50% (for legislative and administrative policy advocacy).

**Table 5: Effectiveness of LTCOPs in Meeting Statutorily Mandated Requirements (N = 52)**
Percentages may not add up to 100 due to rounding (for exact percentages see Appendix 2)

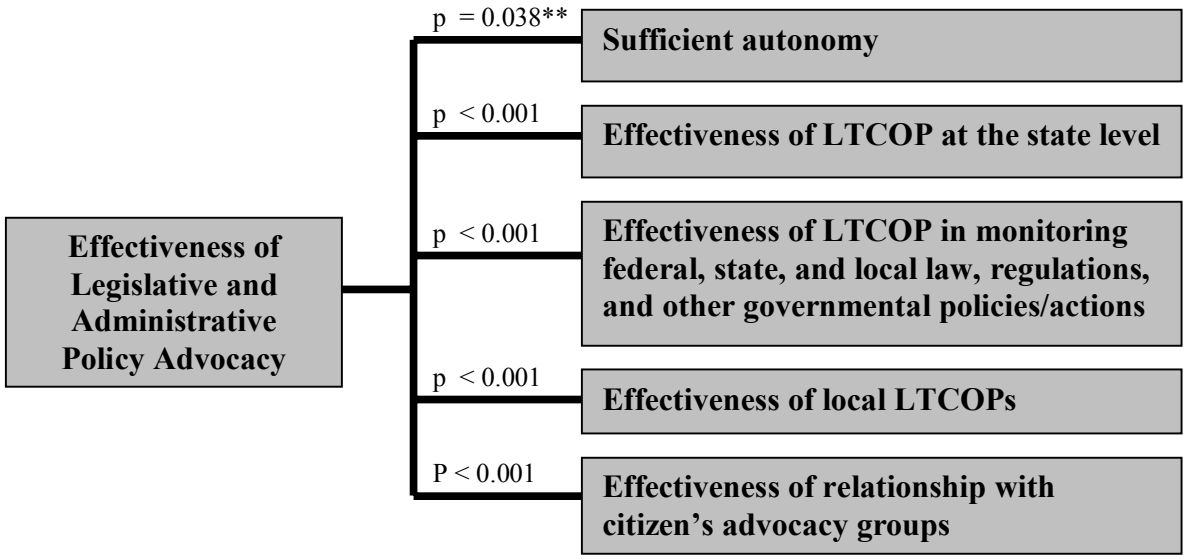
| **Statutorily Mandated Requirement** | Very Effective (%) | Somewhat Effective (%) | Neutral (%) | Somewhat Ineffective (%) | Very Ineffective (%) |
|---|---|---|---|---|---|
| Complaint investigation | 62 | 35 | 2 | 0 | 2 |
| Community education | 23 | 64 | 6 | 6 | 2 |
| Resident and family education | 17 | 67 | 10 | 2 | 4 |
| Monitoring federal/state/local law, regulations, and other government policies/actions | 35 | 52 | 8 | 6 | 0 |
| Legislative & administrative policy advocacy | 23 | 50 | 17 | 8 | 2 |

**State LTCOP Survey (Question 6), Institute for Health & Aging, UCSF, 2001**

Responses from ombudsmen regarding the effectiveness of their advocacy efforts and how effectively they monitor laws and regulations are significantly associated with each other ($p < 0.001$) and also with their ratings of program effectiveness at the state level ($p < 0.001$ for both associations). Effectiveness of systems advocacy is profiled in Figure 2. Effectiveness of

monitoring laws and regulations is also significantly associated with effectiveness of work with nursing facilities ($p = 0.003$) and work with board and care facilities ($p = 0.002$). In addition, effectiveness of community education and resident and family education are significantly associated with percentage of nursing facilities visited ($p < 0.001$ and $p = 0.001$, respectively), and with effectiveness of complaint investigation ($p = 0.009$ and $p = 0.005$, respectively; Appendix 1).

**Figure 2: Factors Significantly Associated with LTCOPs' Effective Advocacy Efforts***




* Based on ombudsman-reported data
** See Appendix 1 for statistical tests

**State LTCOP Survey (Questions 4, 5g, 6d, 6e, 10, 42; Appendix 1), Institute for Health & Aging, UCSF, 2001**

Nursing homes are the primary focus of LTCOPs. When ombudsmen approximate the percentage of time their state LTCOP spends concentrating on different types of facilities, the mean percent time for nursing homes is 69% (SD 20%, N = 48), compared to 26% (SD 17%, N = 48) for board and care and/or assisted living facilities. Forty-three state ombudsmen report that their programs spend at least half of their time in nursing home facilities, whereas only five programs spend more than half of their time in board and care and/or assisted living facilities. Most state programs spend very little time focusing on home care (Mean 2%, SD = 3%, N = 51), in part because Older American Act funds cannot be used for home or community-based services.

State ombudsmen rank their work with nursing homes as more effective than their work with board and care or assisted living facilities (Table 6). Almost all of the ombudsmen rate their work with nursing homes as "very effective" or "somewhat effective" (47% and 49%, respectively). For board and care, 29% rate their work "very effective," and 56% rate their work

"somewhat effective," and ratings for assisted living facilities are similar (29% and 54%, respectively). And while none of the state ombudsmen rated their work with nursing homes as "somewhat ineffective" or "very ineffective," 7% and 11% of states rate their work in these categories for board and care and assisted living, respectively.

Ratings of effectiveness of work with nursing facilities are significantly associated with ratings of effectiveness of work with board and care facilities ($p = 0.001$) and assisted living facilities ($p = 0.003$). Ratings of effectiveness of work with board and care facilities and work with assisted living facilities are also significantly associated ($p < 0.001$; Appendix 1).

**Table 6: Effectiveness of State LTCOP's Work with Facilities**

Percentages may not add up to 100 due to rounding (for exact percentages see Appendix 2)

| Facility | N | Very Effective (%) | Somewhat Effective (%) | Neutral (%) | Somewhat Ineffective (%) | Very Ineffective (%) |
|---|---|---|---|---|---|---|
| Nursing Homes | 51 | 47 | 49 | 4 | 0 | 0 |
| Board & Care | 41 | 29 | 56 | 7 | 7 | 0 |
| Assisted Living | 35 | 29 | 54 | 6 | 6 | 6 |

**State LTCOP Survey (Question 8), Institute for Health & Aging, UCSF, 2001**

Table 7 reports the percentage of nursing facilities and board and care facilities visited by state LTCOPs during FY 1999, and the percentage of complaints resolved to the satisfaction of the resident or complainant at both types of facilities.

**Table 7: Percentage of Facilities Visited and Complaints Resolved to the Satisfaction of the Resident or Complainant, FY 1999**

| State | Nursing Facilities | | Board & Care Facilities | |
|---|---|---|---|---|
| | Facilities Visited (%) | Complaints Fully Resolved (%) | Facilities Visited (%) | Complaints Fully Resolved (%) |
| **All States** | **83.1** | **58.7** | **47.4** | **54.4** |
| **AK** | 53 | 61.3 | 57 | 60.9 |
| **AL** | 56 | 47.9 | 42 | 42.4 |
| **AR** | 100 | 43.5 | 100 | 64.1 |
| **AZ** | 78 | 25.9 | 8 | 31.3 |
| **CA** | 100 | 48.1 | 100 | 44.6 |
| **CO** | 100 | 51.9 | 100 | 45 |
| **CT** | 100 | 83.5 | 66 | 84.9 |
| **DC** | 100 | 16.1 | 50 | 79.5 |
| **DE** | 100 | 26.4 | 10 | 17 |
| **FL** | 55 | 33.8 | 36 | 34.4 |
| **GA** | 100 | 69.4 | 93 | 72.2 |
| **HI** | 96 | 39.6 | 14 | 20.3 |
| **IA** | 0 | 56.5 | N/A | 75 |
| **ID** | 100 | 44.9 | 100 | 42.2 |
| **IL** | 94 | 67.1 | 94 | 66.3 |
| **IN** | 100 | 49.7 | N/A | 54.2 |
| **KS** | 33 | 35 | 100 | 33.8 |
| **KY** | 100 | 47.6 | 88 | 49.4 |
| **LA** | 99 | 64.8 | 100 | 66.7 |
| **MA** | 100 | 77.3 | 100 | 74.6 |
| **MD** | 94 | 59 | 8 | 43.7 |
| **ME** | 84 | 65.5 | 24 | 66.5 |
| **MI** | 100 | 53 | 2 | 50.8 |
| **MN** | 96 | 67.7 | 1 | 69.1 |
| **MO** | 59 | 65.2 | 19 | 45.7 |
| **MS** | 100 | 67.5 | 100 | 41.9 |
| **MT** | 100 | 35.6 | 100 | 43.8 |
| **NC** | 100 | 67.7 | 95 | 59.1 |
| **ND** | 67 | 60.6 | 65 | 69 |
| **NE** | 26 | 61.1 | 18 | 56.3 |
| **NH** | 32 | 37.2 | 7 | 33.6 |
| **NJ** | 71 | 74.8 | 49 | 61.3 |
| **NM** | 100 | 32.8 | 69 | 23.9 |
| **NV** | 87 | 95.4 | 68 | 91.7 |
| **NY** | 67 | 61.4 | 30 | 60.2 |
| **OH** | 100 | 57.7 | 40 | 49.5 |
| **OK** | 100 | 51.9 | 100 | 61.2 |
| **OR** | 89 | 66.2 | 35 | 53.8 |
| **PA** | 100 | 41.8 | 100 | 32.7 |
| **PR** | 18 | 100 | 60 | 99.8 |
| **RI** | 34 | 74.6 | 8 | 70.8 |
| **SC** | 78 | 57.6 | 12 | 60.5 |
| **SD** | 100 | 39 | 47 | 21.3 |
| **TN** | 63 | 47.2 | 17 | 31.1 |
| **TX** | 91 | 72.1 | 8 | 80.1 |
| **UT** | 86 | 66.6 | 59 | 63.4 |
| **VA** | 74 | 71.2 | 42 | 79.5 |
| **VT** | 100 | 72 | 88 | 60.7 |
| **WA** | 77 | 53.4 | 36 | 54.6 |
| **WI** | 42 | 40.8 | 6 | 48.9 |
| **WV** | 89 | 53.5 | 14 | 42.2 |
| **WY** | 97 | 39.5 | 64 | 44.6 |

**Department of Health & Human Services, AoA, National Ombudsman Reporting System, FY 1999**

While there is a striking disparity between the percentage of nursing facilities and the percentage of board and care facilities visited, there is a significant association between these two measures by state, indicating a tendency for states to be fairly consistent in the degree to which they emphasize regular visits ($p = 0.009$). Similarly, there is a significant association between the percentage of complaints resolved to the satisfaction of the complainant in nursing facilities and board and care facilities ($p < 0.001$; Appendix 1).

## Organizational Structure and Effectiveness of Local LTCOPs

Fifteen (33%) state ombudsmen report that changes have taken place in the organizational placement of their local ombudsman programs in the past five years. Of these, six report an increase in local ombudsmen or the creation of new local programs (due to an increase in state

funding, a need for greater coverage and accessibility, or to shift the program from the state to the community level). Four state ombudsmen report that local ombudsman programs previously under an AAA were subcontracted out by the AAA. Reasons for this change include a conflict of interest because the AAA was also administering the Medicaid home care program, and trouble finding qualified workers in a rural community. In two states subcontracted programs were brought back under the AAA umbrella due to poor performance with contractors and administrative problems. Other placement changes include three local programs moving from one agency to another (e.g., AAA to AAA, or AAA to another contract service agency).

When asked to rate the effectiveness of their local LTCOPs, 41% of state ombudsmen rate their local programs as "very effective" and 55% as "somewhat effective." Effectiveness ratings for local LTCOPs are significantly associated with effectiveness ratings for work with nursing facilities ($p = 0.009$), legislative and administrative policy advocacy ($p < 0.001$) and monitoring of laws and regulations ($p < 0.001$; Appendix 1).

Factors contributing most prominently to the effectiveness of local LTCOPs are listed in Table 8 and include: staff and volunteer training (98%) and response time to complaints (98%), degree of collaboration/cooperation with the local nursing home providers (96%), amount of funding (94%) and number of paid staff (94%), ability to obtain needed assistance to deal with complaints (94%), number of visits to nursing homes (94%) and quality of working relationship with other local programs dealing with LTC (94%), number of volunteers (92%), and organizational placement of local LTCOPs (91%).

In addition to the factors listed in Table 8, several state ombudsmen report that communication between state ombudsmen, local ombudsmen, and volunteers contributes to effectiveness. Other factors include advocacy skills of local ombudsmen, past experience of ombudsmen in long term care facilities and in social work, communication with providers, the use of full-time versus part-time employees, commitment to the mission of the ombudsman program at the local level, and length of time that the ombudsman program has been established.

**Table 8: Factors that Contribute to the Effectiveness of Local LTCOPs**

| | Factor contributes to effectiveness (%) | Respondents (N) |
|---|---|---|
| Staff and volunteer training | 98 | 48 |
| Response time to complaints | 98 | 47 |
| Degree of collaboration/cooperation with the local nursing home providers | 96 | 47 |
| Amount of funding | 94 | 50 |
| Number of paid staff | 94 | 50 |
| Ability to obtain needed assistance to deal with complaints | 94 | 49 |
| Quality of working relationship with other local programs dealing with LTC | 94 | 47 |
| Number of visits to nursing home residents | 94 | 47 |
| Number of volunteers | 92 | 47 |
| Organizational placement of local LTCOPs. | 91 | 45 |
| Quality of working relationship with L&C agency and/or survey agency | 90 | 48 |
| Employee consistency (rate of turnover) | 88 | 49 |
| Ability to obtain legal services | 79 | 47 |
| Convenience of travel to facilities | 76 | 46 |
| Agency policies or protocol that allow for contact with the media or legislators | 74 | 46 |
| Quality of working relationship with HCFA | 54 | 39 |

**State LTCOP Survey (Question 11), Institute for Health & Aging, UCSF, 2001**

## Topical Advocacy Issues

Thirty-six (69%) state ombudsmen report that nursing home staffing is one of the most important advocacy issues for local LTCOPs to address at the present time. Issues raised regarding staffing include the need for minimum staffing ratios, training and quality of staff, problems with recruitment and retention of staff, and the need for criminal background checks of facility staff. Related to staffing are concerns about quality of care (15%) and staff training about specific issues (14%) including best practices, language barriers, medication administration, and special care units. Other advocacy issues include ensuring/protecting residents rights (12%), the need for better relocation plans and procedures (10%), expansion of the ombudsman program into assisted living (10%), and the need for stricter enforcement by licensing agencies (10%). Ombudsmen also raise issues of abuse and neglect, sufficient funding for the ombudsman program, dementia care, quality of life, managed care, financial exploitation, and inappropriate guardianships.

## Interagency Coordination

When asked to rate the relationship between their state LTCOP and local programs, 76% of the state ombudsmen report it is "very effective," and 22% report it is "somewhat effective." The most common forms of support given to local programs by the state LTCOP are training and supervision (73%) and technical assistance (64%). Other forms of support include educational materials and information regarding legislation and advocacy issues (47%), consultation (36%), development of policies and procedures (27%), advocacy (22%), volunteer training and materials (18%), legal assistance and representation (18%), financial assistance and funding for special projects and conferences (13%), and data analysis/complaint tracking (9%).

All state ombudsmen from LTCOPs with local programs report having regular contact with local ombudsmen to discuss advocacy issues and policies and procedures. The most prominent forms of communication are mailings (96%) and meetings (96%), followed by visits (89%) and e-mails (89%), tele-conference calls (64%), and newsletters (39%). Other types of communication include training sessions, conferences, fax/e-mail legislative alert systems, on-site job shadowing, and participation in local ombudsman committee meetings. Ombudsman responses to questions about their methods of communication with local programs indicate that adequate communication methods are significantly associated with effectiveness of work with nursing facilities ($p = 0.003$; Appendix 1).

According to state ombudsmen, the most common types of assistance received from their SUA include financial support (33%), administrative support (19%), moral support and belief in the program (19%), technical assistance (17%), legal assistance (17%), supervisory support (15%), training and conferences (14%), use of facilities (14%), advocacy for the program (12%), and supplies, resources, and clerical support (10%). Eight state ombudsmen report receiving no assistance from their SUA.

Twenty-seven (54%) state ombudsmen report that there are types of assistance they would like to receive from their SUA that they are not currently receiving, including more financial support and assistance in seeking additional funding (30%), visibility and support for their mission (14%), independence and/or support for autonomy from the state agency (8%), and legal support (8%). Other requests for assistance include more information on resources available for ombudsmen, better communication and a mutually supportive relationship, and less conditions on receipt of funding.

## Legal Assistance

State ombudsmen obtain legal counsel most frequently through the Attorney General's Office (46%), in-house counsel (27%), state departments or agencies (25%), and outside agencies or attorneys (19%). Legal assistance at the state level is also obtained through pro bono agencies and Title III-B legal services agencies and legal assistance developers. (Under Title III, states are required to identify legal problems and legal service needs of older persons and have a legal assistance developer to provide legal and advocacy assistance for older persons in greatest economic or social need).

Most commonly the scope of legal assistance at the state level encompasses resident advocacy (58%), benefits rights advocacy (56%), entitlements (52%), and civil remedies (42%). Other forms of legal assistance include interpretation of laws, policies, procedures, and regulations; consultation in hearings and lawsuits; access to patient records; and advice about the autonomy of the ombudsman program.

State ombudsmen report seeking legal advice from zero to 200 times in the last year (Mean = 39%, SD = 62%, N = 50). The majority of state ombudsmen (66%) report that they sought legal advice less than 25 times in the last year, while 22% report seeking legal advice 50 or more times

in the last year. 58% of state ombudsmen rate the response of their legal advisor as "very effective" and 27% rate the response "somewhat effective." Effectiveness of legal counsel is significantly associated with effectiveness of work with nursing facilities ($p = 0.006$) and overall effectiveness of the LTCOP at the state level ($p < 0.001$; Appendix 1).

In terms of local LTCOPs, legal assistance is primarily obtained through a legal services attorney (47%) and Title III-B legal services (43%). Other legal counsel includes the SUA (29%), the Attorney General's Office (28%), private attorneys (28%), and legal assistance developers (22%). Some state ombudsmen also report that their local programs utilize non-SUA umbrellas, in-house attorneys, nonprofit legal aid, AAA legal services, insurance attorneys, and county attorneys. State ombudsmen report a large variation in terms of frequency of calls they receive from local ombudsmen requesting legal assistance (Range = 0 to 200, Mean = 36%, SD = 49%, N = 40). Ten (25%) state ombudsmen report five or less requests in the past year, while twelve (30%) state ombudsmen reported 50 or more legal assistance requests from local ombudsman programs.

## Clientele

All state ombudsmen report that nursing facility residents are one of the primary target populations for their services. Other populations targeted include board and care residents (75%), assisted living residents (69%), home care beneficiaries (21%), and managed care clients (12%). In addition some state ombudsmen report that their programs are responsible for mental health patients, elderly persons in community care, any person over 60 years in age, residents in rehabilitation facilities, homeless persons, hospitalized patients in potential need of long term care services, and family members of LTC residents.

## Quality of Care

According to state ombudsmen, the two quality of care issues that are most critical for LTCOPs to address at present are lack of nursing facility staff and poorly trained staff (46%), and malnutrition and dehydration (39%). Other pressing quality of care issues are bedsores/pressure ulcers (15%), incidence and prevalence of falls (14%), dementia care (14%), dealing with patients with behavioral problems (14%), abuse and neglect (14%), symptoms of depression (12 %), quality of life issues (10%), and mental health services (10%). In addition, ombudsmen report focusing on restraint use, personal care and hygiene, medication administration errors, and problems specific to assisted living facilities. Almost all of the ombudsmen (98%) report that their programs are currently addressing these issues. Table 9 presents specific quality of care issues and strategies ombudsmen use to address these issues.

## Table 9: Quality of Care Issues and State LTCOP Strategies for Addressing These Problems (*Number of Respondents*)

| |
|---|
| **Inadequate staffing levels and training (24)** |
| *Communicating with regulatory agency* |
| *State ombudsmen speak at conferences to publicize the issue* |
| *Established panel on workforce issues in long term care* |
| *Providing public testimony* |
| *Working with AARP on state-wide public broadcasting* |
| *Legislative advocacy* |
| *Collaborating with other state agencies* |
| *Participate in training of facility staff* |
| *Using the HCFA staffing study to raise awareness* |
| *Staffing ratios committee will be making legislative recommendations at next session* |
| *Volunteer program and staff will be monitoring how facilities use funds for staffing* |
| *Working to pass bills to increase Medicaid reimbursement for direct care staff* |
| *Trying to improve the training requirements for staff* |
| *Working with large coalition of advocates and providers to improve wages of caregivers* |
| **Malnutrition/dehydration and weight loss (20)** |
| *Meeting with nursing home staff about concerns* |
| *Discussing malnutrition/dehydration at quarterly meeting* |
| *Registering complaints with state licensing agency* |
| *Informing residents and family members about issues regarding poor care* |
| *Systemic advocacy* |
| *Examining the single task worker concept* |
| *Researching into prevalence of problems* |
| *Organizing statewide conference on nutrition and hydration* |
| *Educating public about malnutrition and dehydration issues* |
| **Bedsores/pressure ulcers (8)** |
| *Registering complaints with state licensing agency* |
| *Informing residents and family members about issues regarding poor care* |
| *Systemic advocacy* |
| *Participating in task force with Department of Justice* |
| *Participating in quality initiative with providers, families, physicians, advocates, and regulatory agencies* |
| **Incidence and prevalence of falls (7)** |
| *Statewide training discussion about identifying when unnecessary risks are taken* |
| *Community and family education about fall prevention and risk assessment* |
| *Working closely with survey units to identify high-risk facilities and increase volunteer presence* |
| **Dementia care (7)** |
| *Working with assisted living facilities to train personnel about dementia care* |
| *Formed interagency committee on mental health issues* |
| *Offering assistance and training for staff* |
| *Additional training for ombudsmen to recognize and deal with dementia problems appropriately* |
| **Behavioral issues (7)** |
| *Discussing problem of "shipping behavior problem patients to psychiatry units" with psychiatry facilities and nursing home industry* |
| **Abuse and neglect (7)** |
| *State agency looking into changing the abuse statute* |
| *Participating in legislative testimony* |
| *Educating public about abuse and neglect issues* |
| *Sharing information with citizen's advocacy groups* |
| **Symptoms of depression (6)** |
| *Looking into getting funds to address depression issue* |
| *Monitoring Department of Health deficiencies of nursing homes* |
| *Educating public about depression issues* |
| *Developing presentations for LTC nurses and social workers* |

| |
|---|
| **Quality of life (5)**<br>*Educating public about quality of life issues*<br>*Increasing staff awareness*<br>*Organizing department and regional meetings with providers about how to develop supportive and caring relationships between residents and staff*<br>*Making complaint investigations and recommendations on an individual basis* |
| **Mental health services (5)**<br>*Formed interagency committee on mental health issues*<br>*Researching into prevalence of problems*<br>*Educating providers about problems in mental health services*<br>*Additional training for ombudsmen on mental illness issues* |
| **Restraint use (4)**<br>*Staff training about the difference between physical restraints and appropriate restraints*<br>*Educating public about reduction of bed-rail use* |
| **Personal care and hygiene (4)**<br>*Advocacy at local level*<br>*Committee working on hygiene issues*<br>*Regular visits to check on basic hygiene, dress, and oral hygiene* |
| **Medication administration (4)**<br>*Advocacy at local level*<br>*Educating community about the consequences of errors in medication*<br>*Increasing staff awareness; training about interactions of medications*<br>*Taking legislative action*<br>*Educating AARP and CAGs about this issue* |
| **Requests for assistance (2)**<br>*Advocacy at local level*<br>*Ongoing advocacy at facilities* |
| **Inadequate resident assessments (2)**<br>*Training on resident assessments at next conference*<br>*Advocacy at local level*<br>*Offering assistance on case-by-case basis* |
| **Discharge procedures (2)**<br>*Educating community about improper discharge procedures*<br>*Educating providers about discharge procedures*<br>*Distributing forms with ombudsman program contact information so that residents are aware of their right and ability to appeal* |
| **Accidents and improper handling (2)**<br>*Trying to enforce law that nursing homes must report accidents and improper handling to LTCOP* |
| **Language barrier (1)**<br>*Educating community about language barrier problem*<br>*Increasing staff awareness* |
| **Inappropriate placements (1)**<br>*Educating AARP and CAGs about inappropriate placements* |
| **Criminal background checks (1)**<br>*Lobbying for registry of unlicensed personnel to eliminate people with criminal backgrounds* |
| **Exploitation (1)**<br>*Working with investigation and referrals regarding Medicaid fraud*<br>*Presentations in facilities about exploitation* |
| **Access to home care (1)**<br>*Developing home-care advocacy program to address increasing number of home care complaints*<br>*Print home care brochure to send out to all providers in state*<br>*Developing regulation that will require home care providers to inform consumers about LTCOP* |

**State LTCOP Survey (Question 23), Institute for Health & Aging, UCSF, 2001**

Only about one-quarter of state ombudsmen (28%) report that complaints related to managed care are coming to the attention of their state LTCOP. Complaints regarding managed care include denial or reduction of services, premature discharge, managed care pulling out of rural

areas and leaving seniors without insurance, claim and payment denial, and inadequate services. Only four (39%) of the state ombudsmen dealing with managed care complaints have found the current tracking system of these complaints adequate.

While only eight (16%) state LTCOPs are advocating in the arena of managed care, thirty-one (71%) state ombudsmen anticipate that managed care will affect their state LTCOP in the future. When asked what kinds of effects they anticipate, responses include increased complaints regarding access to and quality of services, premature discharges, reimbursement problems, and resident rights issues. Several ombudsmen suggest that they anticipate being asked to help develop a state ombudsman program for managed care in the future.

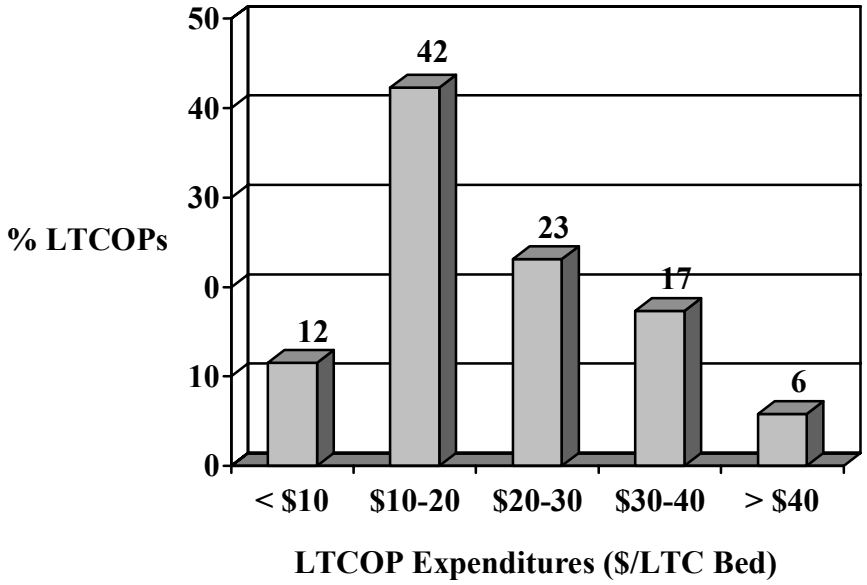
A large majority of state ombudsmen (87%) report that there is a direct or significant relationship between long term care facility staffing levels and overall quality of care. One ombudsman qualified this response, stating: "Staff increases and staffing levels are a good start but not the total solution. You can throw money at the problem but if it's not effectively used, if [the staff] are not respected... you're not going to have a workforce that cares." Another ombudsman commented, "If we required administrators to be Certified Nursing Assistants for just one day, we'd have ratios imposed immediately."

The large majority (89%) of state ombudsmen report that there is a direct or strong relationship between supervision in nursing facilities and overall quality of care. One ombudsman commented: "[There is a] huge relationship. In fact, some of the things that are attributed to short staffing are really failures in the system to have good supervision and training. The problem is just as much that as a lack of numbers." Another ombudsman said, "When we see lots of turnover in administrators and directors of nursing, we see quality of care go down the toilet... And also lots of facilities have poor supervision because the staff is becoming more paper-centered, less people-centered." A third ombudsman commented, "[Supervision is] very important but also facilities where there is staff empowerment show better quality of care. It's supervision versus micromanagement. Aides should have some decision-making power."

## Program Funding

Nationwide, total program expenditures for FY 1999 were approximately $51 million; an increase of almost $4 million from the previous year. A breakdown of program expenditures per LTC Bed is displayed in Figure 3. Program expenditures by state as reported in NORS are displayed in Table 10. In addition to overall expenditures, program expenditures per LTC facility bed has been calculated.

**Figure 3: LTCOP Expenditures per LTC Bed**




**Department of Health & Human Services, AoA, National Ombudsman Reporting System, FY 1999**

When asked about funding over the past three years, two-thirds of state ombudsmen (67%) report that their LTCOP's budget was inadequate to fund federal requirements, and close to three-quarters (74%) state that their budget was inadequate to fund state requirements for the LTCOP. Activities that are most frequently neglected or partially carried out due to inadequate funding include routine visits to facilities (35%), community education and outreach (27%), complaint investigation and resolution/response time to complaints (25%), and development of resident and family councils (22%). Other neglected activities include systemic advocacy, volunteer recruitment and supervision, monitoring board and care and assisted living facilities, working with licensing and certification agencies, training, and data analysis to identify trends.

When asked to estimate the amount of additional funding their state LTCOP would need to carry out currently neglected state and federal requirements, twelve (26%) ombudsmen estimate $200,000 or less, ten (21%) ombudsmen estimate between $250,000 and $700,000, and nine (19%) ombudsmen estimate over $750,000. According to the state ombudsmen, the two major obstacles to obtaining this funding are the political climate and perception of the ombudsman program (35%) and the state fiscal situation and the legislative process (27%). Other report obstacles include the ombudsman program not being a priority within the state agency, opposition and lobbying by the nursing home industry, and the fact that nursing home residents are generally not able to lobby for themselves.

Twenty (40%) state ombudsmen report additional state mandates (either funded or unfunded) that increase their programs' costs. These include a responsibility for clients within the realms of mental health, home care, managed care, the prison system, the community, and the developmentally disabled.

About one-third (39%) of the state ombudsmen report an increase in their budget from last year. This budget increase had the effect of increasing resources, salaries, and training materials for ombudsmen and volunteers (47%), increasing the number of staff (42%), increasing the quality and quantity of services available for residents (26%), and expanding the volunteer program (16%). About one-quarter (29%) of the state ombudsmen report a change in the composition of funding sources in the last three years, primarily due to increased funds from the state. Causes for the change in funding sources include legislative activity and renewed commitment by policy makers, advocacy by local ombudsmen, and utilization of the 1995 Institute of Medicine report recommendations to obtain more funding.

Ombudsman responses to questions about resource sufficiency indicate that sufficient funding is significantly associated with sufficient staff levels ($p < 0.001$), sufficient volunteers ($p = 0.008$), adequate methods of communication ($p = 0.008$), and effectiveness of work with nursing facilities ($p = 0.008$; Appendix 1).

**Table 10: Total Expenditures and Funding per LTC Facility Bed for All States, FY 1999.**

| State | Expenditures ($000's) | Number of Facility Beds | LTCOP Funding Per Facility Bed |
|---|---|---|---|
| **All States** | **$ 51,380** | **2,728,398** | **$ 18.83** |
| **AK** | $ 264 | 2,149 | $ 122.85 |
| **AL** | $ 429 | 35,296 | $ 12.15 |
| **AR** | $ 429 | 29,939 | $ 14.33 |
| **AZ** | $ 732 | 40,615 | $ 18.02 |
| **CA** | $ 6,733 | 265,447 | $ 25.36 |
| **CO** | $ 1,061 | 34,503 | $ 30.75 |
| **CT** | $ 697 | 34,966 | $ 19.93 |
| **DC** | $ 257 | 4,722 | $ 54.43 |
| **DE** | $ 262 | 6,650 | $ 39.40 |
| **FL** | $ 1,106 | 159,796 | $ 6.92 |
| **GA** | $ 1,809 | 65,964 | $ 27.42 |
| **HI** | $ 130 | 6,818 | $ 19.07 |
| **IA** | $ 297 | 39,406 | $ 7.54 |
| **ID** | $ 346 | 11,673 | $ 29.64 |
| **IL** | $ 2,302 | 119,742 | $ 19.22 |
| **IN** | $ 547 | 58,301 | $ 9.38 |
| **KS** | $ 334 | 32,155 | $ 10.39 |
| **KY** | $ 1,007 | 33,493 | $ 30.07 |
| **LA** | $ 1,114 | 41,896 | $ 26.59 |
| **MA** | $ 2,086 | 62,063 | $ 33.61 |
| **MD** | $ 724 | 45,473 | $ 15.92 |
| **ME** | $ 506 | 16,861 | $ 30.01 |
| **MI** | $ 1,113 | 98,157 | $ 11.34 |
| **MN** | $ 1,382 | 74,239 | $ 18.62 |
| **MO** | $ 955 | 78,735 | $ 12.13 |
| **MS** | $ 646 | 24,480 | $ 26.39 |

| State | Expenditures ($000's) | Number of Facility Beds | LTCOP Funding Per Facility Bed |
|---|---|---|---|
| **All States** | **$ 51,380** | **2,728,398** | **$ 18.83** |
| **MT** | $ 99 | 10,433 | $ 9.49 |
| **NC** | $ 1,473 | 93,432 | $ 15.77 |
| **ND** | $ 308 | 10,071 | $ 30.58 |
| **NE** | $ 125 | 27,344 | $ 4.57 |
| **NH** | $ 273 | 11,480 | $ 23.78 |
| **NJ** | $ 1,245 | 74,019 | $ 16.82 |
| **NM** | $ 456 | 12,046 | $ 37.85 |
| **NV** | $ 339 | 9,057 | $ 37.43 |
| **NY** | $ 2,489 | 158,879 | $ 15.67 |
| **OH** | $ 3,950 | 123,514 | $ 31.98 |
| **OK** | $ 796 | 46,099 | $ 17.27 |
| **OR** | $ 599 | 37,371 | $ 16.03 |
| **PA** | $ 2,563 | 169,025 | $ 15.16 |
| **PR** | $ 211 | 8,736 | $ 24.15 |
| **RI** | $ 296 | 13,424 | $ 22.05 |
| **SC** | $ 724 | 37,556 | $ 19.28 |
| **SD** | $ 134 | 11,886 | $ 11.27 |
| **TN** | $ 508 | 52,148 | $ 9.74 |
| **TX** | $ 3,297 | 163,268 | $ 20.19 |
| **UT** | $ 316 | 11,242 | $ 28.11 |
| **VA** | $ 940 | 65,004 | $ 14.46 |
| **VT** | $ 295 | 5,914 | $ 49.88 |
| **WA** | $ 1,091 | 58,366 | $ 18.69 |
| **WI** | $ 1,016 | 74,288 | $ 13.68 |
| **WV** | $ 458 | 15,821 | $ 28.95 |
| **WY** | $ 106 | 4,436 | $ 23.90 |

**Department of Health & Human Services, AoA, National Ombudsman Reporting System, FY 1999**

## Staff and Volunteers

In FY 1999, there were 974 FTE staff and 8,451 certified volunteer ombudsmen nationwide. Table 11 provides a breakdown of staff, certified volunteers, and other volunteers for each state, as reported in NORS for FY 1999. Nationwide, the ratio of LTC facility beds per paid program FTE staff was 2,801 for FY 1999, a decrease from 2,832 in FY 1998, and 2,878 in FY 1997.

**Table 11: Staff and Volunteer Ombudsmen By State, FY 1999**

| State | FTE Paid Program Staff | Volunteer Ombudsmen | Ratio of Beds to FTE Ombudsmen |
|---|---|---|---|
| **All States** | **974** | **14,264** | **2801** |
| **AK** | 2 | 3 | 1075 |
| **AL** | 11.7 | 0 | 3017 |
| **AR** | 10 | 0 | 2994 |
| **AZ** | 8.3 | 120 | 4870 |
| **CA** | 107.7 | 1621 | 2465 |
| **CO** | 17.2 | 107 | 2011 |
| **CT** | 15 | 189 | 2331 |
| **DC** | 4 | 19 | 1181 |
| **DE** | 6 | 68 | 1108 |
| **FL** | 18.5 | 266 | 8638 |
| **GA** | 43 | 80 | 1534 |
| **HI** | 2 | 0 | 3409 |
| **IA** | 3 | 3850 | 13135 |
| **ID** | 9.2 | 4 | 1269 |
| **IL** | 43.7 | 434 | 2738 |
| **IN** | 12 | 17 | 4858 |
| **KS** | 7 | 41 | 4594 |
| **KY** | 15.1 | 290 | 2224 |
| **LA** | 22.7 | 196 | 1846 |
| **MA** | 35 | 327 | 1773 |
| **MD** | 20.3 | 103 | 2246 |
| **ME** | 9.5 | 68 | 1775 |
| **MI** | 25.1 | 125 | 3911 |
| **MN** | 19 | 209 | 3907 |
| **MO** | 20.8 | 319 | 3794 |
| **MS** | 17.2 | 40 | 1423 |

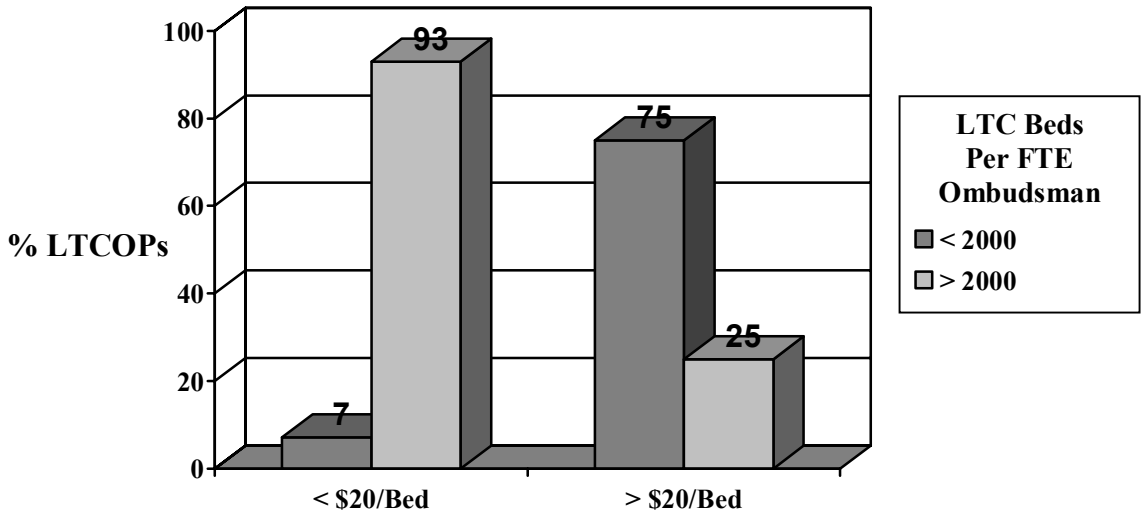
| State | FTE Paid Program Staff | Volunteer Ombudsmen | Ratio of Beds to FTE Ombudsmen |
|---|---|---|---|
| **All States** | **974** | **14,264** | **2801** |
| **MT** | 8 | 9 | 1304 |
| **NC** | 26.3 | 1525 | 3553 |
| **ND** | 4 | 70 | 2518 |
| **NE** | 2.5 | 18 | 11161 |
| **NH** | 6 | 46 | 1913 |
| **NJ** | 21 | 240 | 3525 |
| **NM** | 8.5 | 132 | 1417 |
| **NV** | 8 | 0 | 1132 |
| **NY** | 45 | 700 | 3531 |
| **OH** | 79 | 230 | 1563 |
| **OK** | 17 | 195 | 2712 |
| **OR** | 6 | 251 | 6229 |
| **PA** | 51.4 | 508 | 3291 |
| **PR** | 9 | 10 | 971 |
| **RI** | 5 | 27 | 2685 |
| **SC** | 18 | 0 | 2086 |
| **SD** | 8 | 0 | 1486 |
| **TN** | 10 | 216 | 5215 |
| **TX** | 51.7 | 847 | 3160 |
| **UT** | 9.7 | 12 | 1159 |
| **VA** | 18.8 | 54 | 3467 |
| **VT** | 4.6 | 25 | 1286 |
| **WA** | 19.5 | 568 | 2993 |
| **WI** | 18 | 75 | 4127 |
| **WV** | 10.5 | 10 | 1507 |
| **WY** | 4 | 0 | 1109 |

**Department of Health & Human Services, AoA, National Ombudsman Reporting System, FY 1999**

Overall, there was an increase of 47 paid program FTE staff between FY 1998 and FY 1999. Twenty-one (40%) state ombudsmen report an increase in paid full-time or full-time equivalent staff, most prominently in direct services, but also in administrative staff, legal assistance, and volunteer coordination. Numbers of volunteers have increased even more dramatically, from 6,795 in FY 1997 to 7,359 in FY 1998, to 8,451 in FY 1999. Twenty-seven (54%) state ombudsmen report an increase in the number of volunteers in the last two years. All volunteer increases occurred in direct services, but two state LTCOPs also experienced an increase in volunteers in community education and administrative staff. Reasons for volunteer increases include heightened recruitment and training efforts, additional funding and/or staff to develop the volunteer program, assistance from AARP, and change in state or local volunteer policy initiative.

Data from NORS for FY 1999 indicates that ombudsman program expenditures per LTC bed is significantly associated with the ratio of LTC beds per FTE ombudsman ($p < 0.001$), as displayed in Figure 4. In addition, the ratio of LTC beds per FTE ombudsman staff is significantly associated with the percentage of nursing facilities that are visited in a year ($p = 0.009$), and the ratio of volunteers per LTC bed is significantly associated with how ombudsmen rank the effectiveness of their programs' work with nursing facilities ($p = 0.003$; Appendix 1).

**Figure 4: Association Between Program Expenditures and the Ratio of LTC Beds per FTE Ombudsmen**




**LTCOP Expenditures per Bed**
($p < 0.001$, Spearman's Test of Rank Correlation)

**Department of Health & Human Services, AoA, National Ombudsman Reporting System, FY 1999**

In the large majority (93%) of state LTCOPs, volunteer ombudsmen and paid staff ombudsmen roles are differentiated. Role differentiation most frequently occurs in complaint investigation. In some programs volunteers refer complaints to staff (43%), while in other programs volunteers investigate complaints only under the supervision of staff (26%) or turn over the more complicated complaints to staff (19%). In addition some programs utilize volunteers to make unannounced or regular visits (not in response to a complaint), while staff take care of training, systemic advocacy, handling of medical records, legal matters, and interactions with outside agencies.

When asked to describe turnover of staff and volunteers in the last two years, thirty-six (69%) state ombudsmen report "very low" or "somewhat low" for paid staff, and twenty-four (56%) report "very low" or "somewhat low" for volunteers. Ombudsman-reported levels of turnover of paid staff and turnover of volunteers within individual states are significantly associated ($p = 0.001$; Appendix 1).

## Political Influences and Relationships with Other Organizations

The majority (76%) of ombudsmen report that the political and social climate in their state is supportive of the mission of the ombudsman program. Ombudsman reports of a supportive political and social climate are significantly associated with reports of sufficient program autonomy ($p = 0.004$) and ability to carry out federal mandates independently from other state agencies and parties ($p = 0.001$; Appendix 1).

Twenty-two (43%) state ombudsmen report that there is legislation currently being proposed in their state that will affect their state LTCOP. Six ombudsmen report a possible increase in funding for their program, which could allow them to develop or expand their volunteer programs and will help them better meet mandates, but may also require that they address the needs of new populations (such as home care and managed care clients). In five states, ombudsmen report legislation regarding assisted living and board and care facilities that will increase ombudsman responsibilities, create a need for more staff, and strengthen the penalties on providers when they violate requirements. Four ombudsmen report legislation that could potentially change the placement or structure of the LTCOP and thereby increase autonomy, allow ombudsmen to speak to legislators, and separate the ombudsman program from licensing and certification. Other pending legislation that will affect ombudsman programs in some states includes legislation regarding nursing home reform and changes in the role of the long term care ombudsman.

When asked if there are any barriers or impediments at the state or federal level that keep them from carrying out their jobs, twenty (39%) ombudsmen say barriers exist at the state level, six (12%) ombudsmen report that barriers exist at the federal level, and eleven (22%) ombudsmen report that barriers exist at both the state and federal level. Barriers at the state level include conflicts of interest with umbrella agencies at the state level, a strong nursing home industry lobby, lack of cooperation with other agencies, lack of autonomy in advocacy efforts and in legislative and media contacts, resource and funding issues, hierarchical and bureaucratic structure of state agencies, state mandates that require broad coverage, and a conservative political climate. Barriers at the federal level include inadequate monitoring and enforcement of laws by the AoA, budgetary issues, and inadequate notification about survey scheduling.

According to thirty-nine (78%) state ombudsmen, the strong nursing home industry lobby in their state influences the effectiveness of their political advocacy efforts. When asked to explain, ombudsmen state that the nursing home industry is very powerful due to large contributions to legislators' campaigns and full-time lobbying efforts. In some states the industry has blocked nursing home staffing legislation from passing. A number of ombudsmen report that they do not have the time, money, or autonomy to speak out and counter the actions of the nursing home industry.

Another factor that influences political advocacy efforts is the relationship between LTC ombudsmen and representatives of the SUA and AAA (47%). Strained relationships often relate to conflicts of interest and lack of autonomy within the SUA. Some ombudsmen report interference by SUAs and AAAs in both systemic advocacy efforts and at an individual case level. Other related problems include lack of support from AAAs for the program, lack of

continuity due to changes in the SUA director's position, lack of control or influence regarding contracts, and conflicts between the SUA and regional units. It should be noted that during the course of this study one ombudsman chose to resign due to feelings that conditions imposed by the State Unit on Aging limited the ombudsman's ability to act in the best interest of residents.

Difficulties with regulatory agencies (42%) also impact political advocacy, due to delayed responses to calls, collaboration with the provider industry, neglecting to notify ombudsmen about surveys, and general communication problems. The perception that the aging network is apathetic to the plight of the institutionalized aged (27%) is another barrier to political advocacy efforts, mostly because community-based services are replacing institutionalized long term care as the current priority of the aging network in many states. Finally, some ombudsmen report a lack of clear guidance on how to advocate for special populations (20%), stating that the ombudsman program needs to work with other agencies to learn how to work with residents with special needs, such as mental health patients, patients with dementia, the disabled population, and younger residents.

In terms of their program's relationship with citizen's advocacy groups (CAGs), 83% of state ombudsmen report that their relationship with CAGs in their state is "very effective" or "somewhat effective." Effective relationships with CAGs are significantly associated with effective legislative and administrative policy advocacy ($p < 0.001$; Appendix 1).

Factors that contribute to an effective relationship include regular communication, common goals, attendance at each other's meetings, the ability for CAGs to advocate when ombudsmen cannot speak out, working on legislative agendas together, sharing information, and mutual respect and support. State ombudsmen attribute ineffective relationships with CAGs to different priorities and focus, the need to build awareness among CAGs that ombudsmen are also advocates for LTC residents, turnover within CAGs, a lack of regular meetings among CAGs, and the need to spend more time building a relationship based on common goals.

# DISCUSSION OF KEY ISSUES

This nationwide survey of LTCOPs reveals that the majority of state ombudsmen rate their programs as effectively meeting the mandates specified in the Older Americans Act. A detailed analysis of survey responses, however, suggests that a number of barriers currently exist that limit the effectiveness of LTCOPs. The following section discusses prominent issues raised during this study, including the organizational placement and structure of ombudsman programs, adequacy of resources, efforts to improve quality of care in long term care facilities, and the LTCOP's relationship with other agencies.

## Organizational Placement and Structure of the State LTCOP

More than half of the state LTCOPs report that their organizational placement creates difficulties for service provision, including impaired ability to objectively and independently investigate and resolve complaints, and lack of autonomy to speak to legislators and the media. In some instances, constraints around organizational placement impede the efforts of ombudsmen to fulfill the requirements of legislative and administrative policy advocacy.

One of the primary concerns with the organizational placement of state LTCOPs is the potential for conflicts of interest. The 1995 IOM Report recommended that by FY 1998 no ombudsman program should be located in an entity of government or agency outside the government whose head is responsible for licensing and certification, provision of long-term care services, adult protective services, and Medicaid eligibility determination. (Harris-Wehling *et al.*, 1995) According to state ombudsmen, however, a number of programs remain in an umbrella agency with their state's licensing and certification agency, adult protective services and/or the programs administering Medicaid.

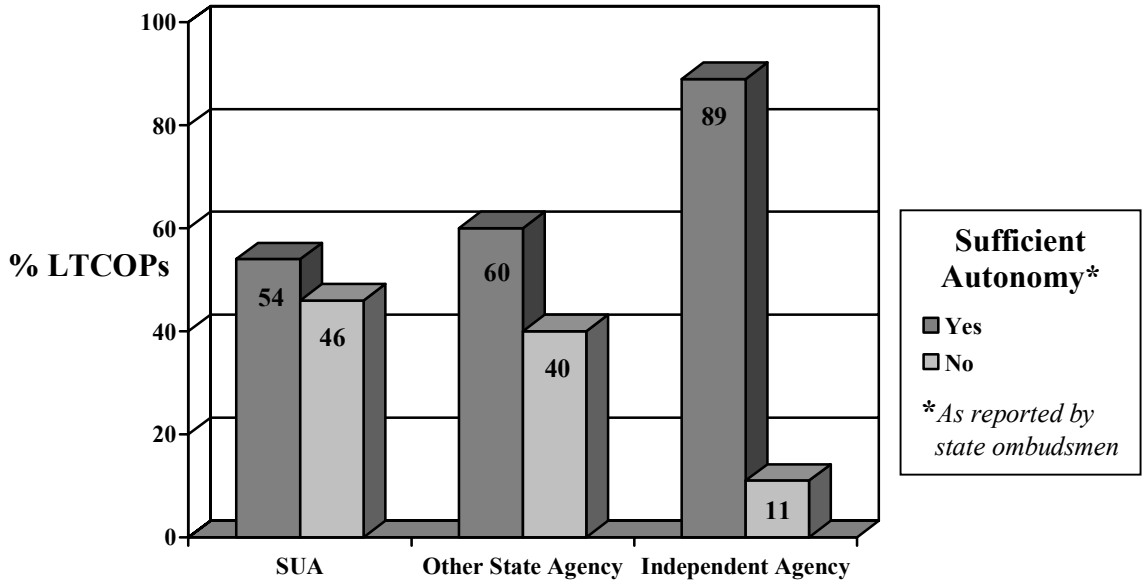
A second concern raised repeatedly in discussions with state ombudsmen is the issue of program autonomy. There is a significant association between ombudsman responses to the question of whether their program's placement allows for sufficient autonomy, and their responses to questions about: 1) freedom from excessive legislative or regulatory restrictions ($p = 0.002$), and 2) ability to carry out federal mandates independently from other state agencies and parties ($p < 0.001$). In addition, there is a significant association between ombudsman reports of "sufficient program autonomy" and ombudsman reports of effective legislative and administrative policy advocacy ($p = 0.038$; Appendix 1), but no association with any other statutorily mandated requirements (including complaint investigation, and community, family, and resident education).

Of the problems stemming from organizational placement of the program, lack of autonomy is mentioned most frequently. Eleven of the thirty-seven ombudsmen in SUAs report that their program's placement limits their freedom to speak with legislators and/or the media. In contrast only one of the fifteen ombudsmen in nonprofit agencies, legal agencies, or non-SUA state agencies report experiencing limitations on autonomy due to the placement of their program.

Also notable is the fact that of the nine ombudsmen reporting conflicts of interest due to program placement, all are located in SUAs.

State ombudsmen from programs within SUAs report several other problems stemming from their organizational placement. For example, of the twenty ombudsmen who state that their LTCOP's organizational placement does not allow for sufficient autonomy, seventeen are located in SUAs. Figure 5 displays the association between organizational placement of LTCOPs and ombudsman responses to a question regarding sufficient program autonomy. In addition, when asked about the effectiveness of their LTCOPs in meeting the statutorily mandated requirement to monitor federal, state, and local law, regulations, and other government policies and actions, all except seven ombudsmen rate their program as "very" or "somewhat effective," and these seven are all located in SUAs. Similarly, when asked about their effectiveness in meeting the requirement of legislative and administrative policy advocacy, all except fourteen respond "very" or "somewhat effective," and of the fourteen, twelve are in SUAs.

**Figure 5: Autonomy Associated with Placement of LTCOPs**




**State LTCOP Survey (Questions 2 & 5g), Institute for Health & Aging, UCSF, 2001**

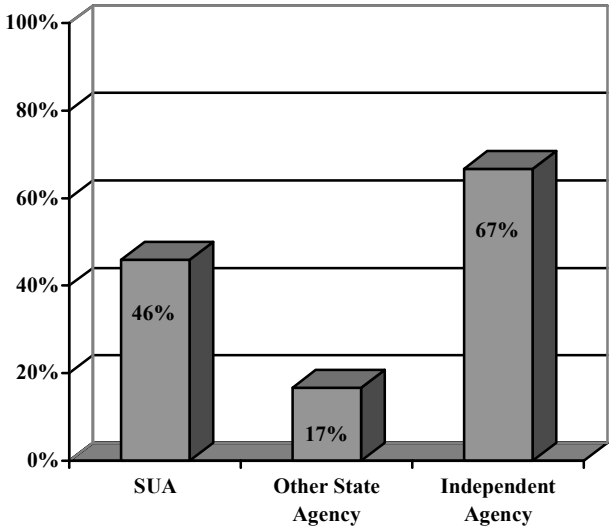
These findings suggest that being located in an SUA may hinder advocacy efforts and impede autonomy. Some ombudsmen who are in SUAs and are therefore state employees find that even though they are ostensibly free to speak to legislators and the media, the structure of their SUA imposes bureaucratic barriers (such as requiring that communication be pre-approved). Following are comments from three ombudsmen regarding the autonomy of their programs:

> "Sometimes it is a little awkward for me to lobby members of the state legislature. I am really not supposed to do that, but I think the OAA envisioned that I would lobby the legislators. For me to do that is impossible because I am a state employee. Also the climate of the governor makes a difference in our ability to influence systematic change."
>
> "There is a lack of autonomy because we are part of the state. Our biggest problem is that we are competing for the attention and interest of the director [of our state agency], and our program is often not contacted or considered. I believe if we were in a more autonomous setting we would be more effective, people would pay more attention to us, and our outcomes would matter more."
>
> "There is a potential conflict of interest simply being in state government, in the department. We are not necessarily able to speak freely on behalf of residents. If the department has a policy that the LTC ombudsman feels may be detrimental, the ombudsman might be instructed not to say anything in court."

SUAs can provide valuable support to ombudsman programs, including financial support, administrative and technical assistance, legal services, advocacy for the program, and the use of facilities and supplies. Being housed outside an SUA can diminish these types of support. Several ombudsmen in programs located outside SUAs report encountering their own difficulties due to placement, including a lack of access to state amenities (such as travel resources and supplies), budget vulnerability due to the lack of a protective umbrella agency, and limitations on autonomy by the umbrella nonprofit agency. In addition, thirteen ombudsmen in programs within SUAs report having no difficulties due to their placement. Statistical analysis of program placement, resources, and effectiveness did not demonstrate any significant relationship between the organizational placement of LTCOPs and their funding or staffing levels or ratings for effectiveness. This indicates that placement within a SUA does not necessarily have to be a problem in itself, if the potential conflicts of interest and limitations on autonomy are resolved to the satisfaction of all parties.

Figures 6 through 8 display the association between organizational placement of LTCOPs and funding and staffing levels, as well as facility visitation. Figure 9 displays the association between organizational placement and how ombudsmen respond to questions regarding the effectiveness of their legislative and administrative policy advocacy.

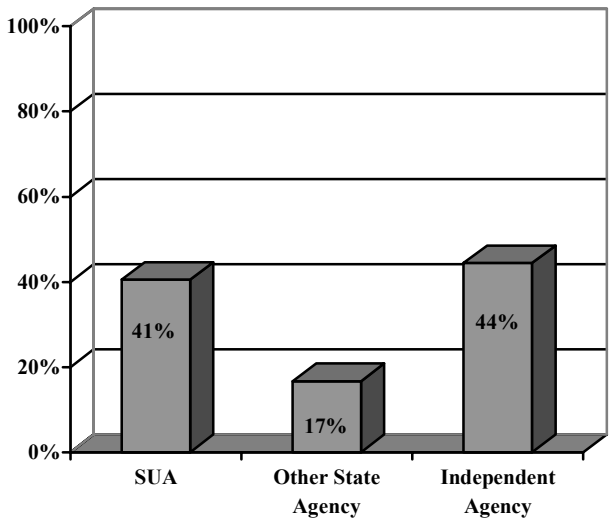
**Figure 6: Percent LTCOPs with Expenditures > $20 per LTC Bed, by Organizational Placement**




| LTCOP Placement | LTCOP Expenditures per LTC Bed (N = 52) | |
|---|---|---|
| | < $20 | > $20 |
| SUA | 20 | 17 |
| Other State Agency | 5 | 1 |
| Independent Agency | 3 | 6 |

State LTCOP Survey (Question 2), Institute for Health & Aging, UCSF, 2001
Department of Health & Human Services, AoA, National Ombudsman Reporting System, FY 1999

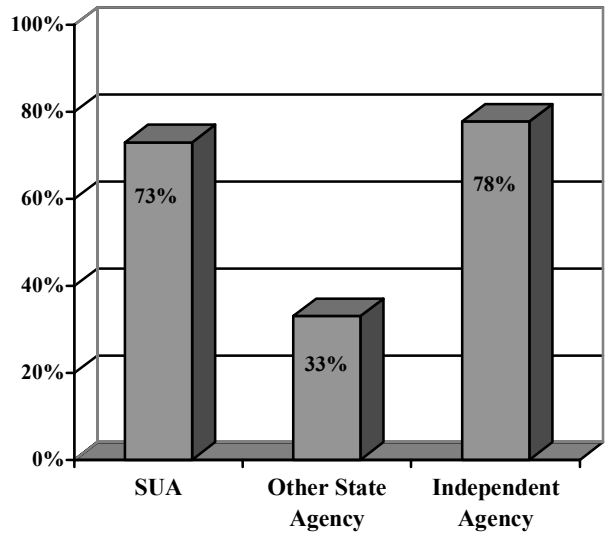
**Figure 7: Percent LTCOPs with IOM Recommended Ratio of < 2000 LTC Beds per FTE Staff, by Organizational Placement**




| | Funding per LTC Bed (N = 52) | |
|---|---|---|
| | < 2000 | > 2000 |
| SUA | 15 | 22 |
| Other State Agency | 1 | 5 |
| Independent Agency | 4 | 5 |

State LTCOP Survey (Question 2), Institute for Health & Aging, UCSF, 2001
Department of Health & Human Services, AoA, National Ombudsman Reporting System, FY 1999

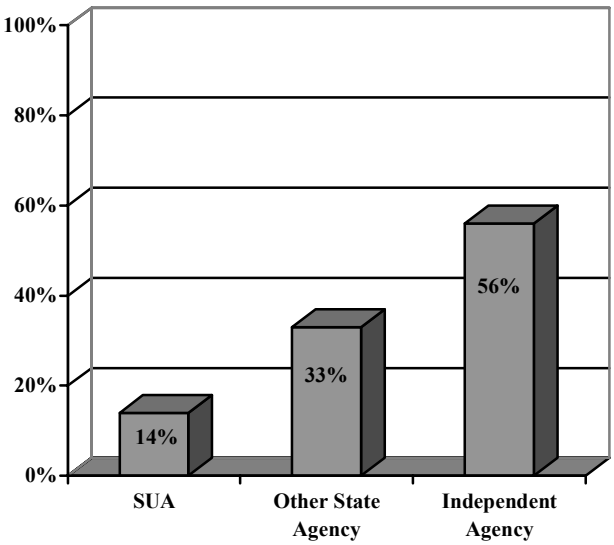
**Figure 8: Percent LTCOPs visiting 75-100% Nursing Facilities in FY 1999, by Organizational Placement**




| | Percent Nursing Facilities Visited (N = 52) | | | |
|---|---|---|---|---|
| | < 25% | 25.1-50% | 50.1-75% | 75.1-100% |
| **SUA** | 2 | 1 | 7 | 27 |
| **Other State Agency** | 0 | 3 | 1 | 2 |
| **Independent Agency** | 0 | 1 | 1 | 7 |

**State LTCOP Survey (Question 2), Institute for Health & Aging, UCSF, 2001**
**Department of Health & Human Services, AoA, National Ombudsman Reporting System, FY 1999**

**Figure 9: Percent LTCOPs Rated "Very Effective" at Systemic Advocacy Efforts, by Organizational Placement**




| | Effectiveness of Systemic Advocacy (N = 52) | | | | |
|---|---|---|---|---|---|
| | Very Effective | Somewhat Effective | Neutral | Somewhat Ineffective | Very Ineffective |
| **SUA** | 5 | 20 | 7 | 4 | 1 |
| **Other State Agency** | 2 | 3 | 1 | 0 | 0 |
| **Independent Agency** | 5 | 3 | 1 | 0 | 0 |

**State LTCOP Survey (Questions 2 and 6e), Institute for Health & Aging, UCSF, 2001**

## Adequacy of LTCOP Resources

Ombudsmen report that insufficient funding and inadequate levels of staff and volunteers are the greatest barriers to effectiveness. Financial shortages have a direct influence on effectiveness by limiting the number of staff available to visit facilities, investigate and resolve complaints, coordinate volunteer programs, focus on community education, advocate for long term care residents, and develop community, family, and resident education and councils. Lack of funding has also impeded the expansion of ombudsman programs into board and care and assisted living facilities.

A large majority of state ombudsmen report that their budget over the past three years was inadequate to fund federal requirements (67%) and state requirements (74%). One of the results of inadequate funding is that ombudsmen are prevented from carrying out unannounced friendly visits. These routine visits are crucial in order for ombudsmen to be accessible for residents who cannot place telephone calls to the LTCOP. Another result of inadequate funding is that LTCOPs must limit their focus to immediate concerns rather than trying to impact the systems that are producing the residents' complaints. While the majority of state ombudsmen rank their programs as "very effective" in resolving complaints, inadequate resources prevent them from effectively implementing other federal and state mandates (such as resident, family, and community education, and systemic advocacy). Until LTCOPs have adequate resources, their ability to influence systemic and long-term changes will be severely limited.

Obstacles to obtaining additional funding include the state political climate and perception of the ombudsman program, strong lobbying efforts on the part of the nursing home industry, and the state fiscal situation and legislative process. One ombudsman commented that the reason her program is not visible enough in the political realm is that positive outcomes resulting from ombudsman actions are not readily apparent. Another ombudsman stated that the current attitude is to do away with nursing homes rather than make them better, and to put money into building alternatives (such as community-based facilities) rather than improving the present system.

Adequate resources are essential to enable state LTCOPs to meet the standard set in the IOM evaluation report of a minimum of one FTE staff ombudsman per 2000 LTC beds. Analysis of NORS data for FY 1999 suggests that LTCOP expenditures per LTC bed are significantly associated with the ratio of LTC beds per ombudsman staff ($p < 0.001$; Appendix 1). Meeting this minimal staffing standard is crucial if ombudsmen are going to have a regular and strong presence in LTC facilities and on-going visibility to residents and families. While staffing levels have improved over the past few years, nationwide in FY 1999 there were 2,801 beds per paid FTE staff. However, the average state had 3,062 beds per paid FTE staff. This higher number accounts for the states that have very large ratios and thereby skew the nationwide ratio (i.e., FL 8,638; IA 13,135; NE 11,161; and OR 6,229). With the exception of Florida, these states with high ratios have relatively few LTC facility beds compared to some of the larger states. The residents of these states are therefore under-represented in the nationwide ratio (2,801), but over-represented in the average of state ratios (3,062).

Volunteers can also contribute immeasurably to ombudsman programs. Most ombudsmen (91.5%) report that the number of volunteers contributes to the effectiveness of their local

programs, but only 22% of ombudsmen believe they have a sufficient number of volunteers in their program. According to ombudsman responses, the ratio of volunteers per LTC bed is significantly and positively associated with how ombudsmen rank the effectiveness of their programs' work with nursing facilities ($p = 0.003$; Appendix 1).

In addition to the most basic resources of funding, staff, and volunteers, legal services provide essential support for ombudsmen. The majority of ombudsmen rate the advice from their legal counsel as "very effective" (58%) or "somewhat effective" (27%), but only 67% report that they have adequate legal services available. Ombudsman responses indicate that effectiveness of legal counsel is significantly associated with effectiveness of LTCOPs at the state level ($p < 0.001$) and effectiveness of work with nursing facilities ($p = 0.006$; Appendix 1).

## LTCOP Efforts to Improve Quality of Care

According to NORS data for FY 1999 ombudsmen in all states visited 83% of nursing homes but only 48% of all board and care facilities. Almost all ombudsmen (96%) rate their programs' work in nursing homes as effective, while 85% and 83% rate their programs' work as effective in board and care and assisted living facilities, respectively.

Detailed responses from ombudsmen, however, reflect that effectiveness of the program is limited by several critical factors, including: inadequate autonomy due to organizational structure and placement, inadequate resources (e.g., insufficient funding, insufficient numbers of paid staff, insufficient legal services), and inability to conduct systemic advocacy. According to ombudsmen, nursing home staffing issues, including sufficient levels of staff, recruitment, training, and supervision, are the most important advocacy issues to be addressed.

Given the scope of ombudsman responsibilities, the priorities of the program, and the structure and placement of various LTCOPs, many ombudsmen report not having the time, money, or autonomy to speak out and counter actions of the nursing home industry, advocate for key issues in long term care, and monitor and evaluate policy changes. In addition, lack of autonomy in advocacy efforts and in legislative and media contacts negatively affects the ombudsman's ability to educate public and facility staff on LTC issues, ombudsman programs, laws and regulations.

Ombudsmen utilize several approaches to address quality of care issues in long term care facilities. These include: 1) working closely with regulatory agencies, 2) collaborating with other state agencies and citizen's advocacy groups, 3) educating facility staff and providers about specific problem areas, 4) educating residents, families, and community members about quality of care issues, and 5) advocating for residents and providing testimony at the legislative level.

*1. Work With Regulatory Agencies.* Ombudsmen often register complaints of a severe nature (such as abuse or neglect, malnutrition, and pressure sores) with the state licensing and certification agency. Ombudsmen report working with the surveying agency to identify and increase the presence of volunteer ombudsmen at facilities where Medicare fraud was taking place.

*2. Collaborate with State Agencies and Citizen's Advocacy Groups.* In addition to working with licensing and certification agencies, collaborations with other state agencies and citizen's advocacy groups offer opportunities for stronger advocacy efforts in quality of care. One ombudsman reports working with AARP to raise awareness about improper medication administration. Another ombudsman participated in a task force with representatives from the Department of Justice to discuss pressure sores. A third ombudsman assisted in the development of an interagency committee on mental health issues. When asked about their relationship with citizen's advocacy groups, ombudsmen report working on legislative agendas together, attending each others' meetings and conferences, co-sponsoring joint training, and forming coalitions with resident councils and family councils to support lobbying efforts. These collaborations provide ombudsmen with an essential link to the community and strengthen the network of individuals and groups working toward the improvement of long term care facilities. State ombudsman responses to questions regarding systemic advocacy indicate that the effectiveness of their advocacy efforts is significantly associated with the effectiveness of their relationship with citizen's advocacy groups ($p < 0.001$; Appendix 1).

*3. Educate Facility Staff and Providers About Specific Problem Areas.* Many ombudsmen also work closely with facility staff and providers to raise awareness about quality of care issues. Ombudsmen report holding staff training sessions and meetings with administrators to address issues such as staffing levels, malnutrition, dementia care, depression, discharge procedures, and financial exploitation. In addition one ombudsman organizes regional meetings with providers to discuss how supportive and caring relationships may be cultivated between residents and staff.

*4. Educate Residents, Families, and Community About Quality of Care.* Community, family, and resident education is also emphasized by many ombudsman programs. Ombudsmen report organizing statewide conferences and training sessions around nutrition, hydration, staffing levels, quality of life issues, language barriers, fall prevention, and improper discharge procedures. One successful strategy is to distribute brochures with ombudsman contact information to residents so that they are aware of their rights and resources.

*5. Advocate for Residents and Providing Legislative Testimony.* Finally, in addition to focusing on community education and collaboration with other agencies, a number of ombudsman programs make systemic advocacy a priority. The issue of facility staffing levels is most prominent in the majority of states (69%). One ombudsman said, "Our whole campaign is staffing, staffing, staffing. We work with commissions, provide public testimony, and work with AARP on state-wide public broadcasting." Most ombudsmen (87%) agree there is a significant relationship between staffing levels and quality of care. While individual complaints may be resolved on a case-by-case basis, the problem of understaffing is so severe that many ombudsmen are concentrating their advocacy efforts at the legislative level.

Overall it is clear that the LTCOP fulfills a unique role, as noted by the 1995 IOM Report. The contributions to quality of care made by ombudsmen, through complaint investigation and resolution, coordination of resident and family councils, community outreach and education, and systemic advocacy, complement the contributions of regulatory agencies, community-based

organization, and providers. Enabling ombudsmen to fulfill their responsibilities as mandated by the OAA, however, will necessitate adequate resources and stronger support from policy-makers.

## The LTCOP's Relationship with Other Agencies

State LTCOPs report that uncooperative relationships with regulatory agencies negatively affect political advocacy while interagency coordination and collaboration (with SUAs, local LTCOP, AAAs, provider agencies, and citizen's advocacy groups) enhance advocacy efforts. Having little enforcement authority, state LTCOPs often find their observations ignored by regulators. The majority of state ombudsmen report needing additional financial support and assistance to increase visibility and support for their mission, acquire stronger legal support, and obtain autonomy from the state agency.

In terms of regulation of the ombudsman program, the 1995 IOM Report states that the AoA should play a stronger role in monitoring state LTCOPs and take action when states are not in compliance with the OAA. The IOM Report discusses the need to administer sanctions when states are out of compliance on significant performance measures. Several state ombudsmen report that there continues to be a need for the AoA to monitor LTCOPs and ensure that the programs are receiving adequate funding and support to fulfill their statutorily mandated requirements.

Ombudsmen report that their relationship with CAGs can greatly increase their effectiveness. Several ombudsmen, however, report that their relationship with certain CAGs has become antagonistic because of misunderstandings about the LTCOP's regulatory role and other capabilities. Ombudsmen discuss the need to clarify their role as one of mediation and conflict resolution, but not one in which they have the authority to take regulatory action against facilities. Other misunderstandings occasionally arise because CAGs perceive that ombudsmen are not doing all they can to advocate for the rights of residents when in fact they are prohibited from speaking out due to the placement and structure of their program.

# RECOMMENDATIONS

## Organizational Placement and Structure:

- *Study findings support the 1995 IOM Report's recommendation that: "No ombudsman program should be located in an entity of government (state or local) or agency outside government whose head is responsible for:*
  - *Licensure, certification, registration, or accreditation of long term care residential facilities;*
  - *Provision of long-term care services, including Medicaid waiver programs;*
  - *Long-term care case management;*
  - *Reimbursement rate setting for long-term care services;*
  - *Adult protective services;*
  - *Medicaid eligibility determination*
  - *Preadmission screening for long-term care residential placements;*
  - *Decisions regarding admission of elderly individuals to residential facilities." (Harris-Wehling et al., 1995; Recommendation 4.1, pg. 124)*

- *LTCOPs should have sufficient organizational autonomy from the state to ensure that ombudsmen may advocate for residents (in accord with their responsibilities as defined by law) without fear of political ramifications. As advised by the 1995 IOM Report: "Ombudsmen must be able to pursue independently all reasonable courses of action that are in the best interest of residents."(Harris-Wehling et al., 1995; pg. 125)*

## Adequacy of LTCOP Resources

- *Study findings support the need to increase funding to ensure that LTCOPs have adequate resources to fulfill their federal and state mandates. As stated in the 1995 IOM Report, appropriations for the state LTCOPs should be increased to ensure "that all state Offices of the Long-Term Care Ombudsman program are funded at a level that would permit them to perform their current functions adequately." (Harris-Wehling et al., 1995; Recommendation 6.1, pg. 193)*

- *Study findings support the need to ensure the availability of adequate legal services for LTCOPs. As stated in the 1995 IOM Report: "Legal resources are not an end in themselves but are an essential element of the ombudsman programs' infrastructure. Without such resources, the program is greatly hampered in its ability to comply with other mandated provisions in the OAA" (Harris-Wehling et al., 1995, pg. 96).*

- *As recommended by the 1999 report from the Office of Inspector General (OIG, 1999; OEI-02-98-00351), study findings support the need to continue to strengthen the LTCOP's reporting system and to develop a standard for measuring outcomes of ombudsman complaint investigation, education, and advocacy efforts.*

- *Study findings support the need to strengthen the commitment and support of policy makers for the ombudsman program through education, lobbying, publicity, and collaboration with individuals and agencies committed to long term care.*

**LTCOP Efforts to Improve Quality of Care**

- *Ombudsmen must continue to raise public awareness about the issue of nursing facility staffing ratios, and the need to improve recruitment, retention, training, and quality of staff, through advocacy efforts, education of providers and nursing facility staff, and collaboration with agencies committed to long term care.*

- *Study findings support the need for ombudsman visitation and monitoring of LTC facilities to be increased. As the LTC industry continues to shift towards non-traditional settings, policy-makers need to ensure that ombudsmen can meet the needs of increasing numbers of residents in board and care and assisted living facilities.*

- *Study findings support the continued need to promote advocacy efforts for improved quality of care through LTCOP work with citizen's advocacy groups and family and resident councils.*

- *Funding and staffing should be increased to allow ombudsmen to fulfill their role in systemic advocacy. Ombudsmen report that systemic advocacy is one of the activities most often neglected because of inadequate funding. Due to the immediate needs of complaint investigation, goals such as legislative advocacy and community education may be set aside. LTCOP funding must therefore be sufficient for ombudsmen to fulfill their roles not only as complaint mediators and investigators, but also educators and advocates for residents.*

- *Program visibility should be increased to ensure continued funding and support from policy makers.*

**Relationship Between LTCOPs and Other Agencies**

- *The Administration on Aging (AoA) should take a more active role in monitoring LTCOP compliance with regulations stipulated by the Older Americans Act.*

- *LTCOPs should continue to work to improve relationships with state agencies that have authority to enforce regulations.*

- *LTCOPs should increase communication between parties (e.g. SUA administration, licensing agencies, and CAGs) by setting up work groups and negotiating memoranda of understanding. Ensure that all parties are aware of the designated roles, responsibilities, and capabilities of ombudsmen.*

- *Relationships between state and local LTCOPs should be enhanced through increased training, supervision and technical assistance, provision of educational materials, and timely information on legislative and advocacy issues.*

- *State Unit on Aging support for the ombudsman program should be strengthened. Ombudsmen and AoA should actively encourage SUAs to increase financial, technical, administrative, and moral support, ensure adequate legal assistance, increase visibility, and support the mission and autonomy of the LTCOP.*

- *LTCOPs should enhance relationships with citizen's advocacy groups by collaborating on legislative agendas, taking part in each others meetings and conferences, co-sponsoring joint training, and forming coalitions with resident and family councils.*

**Future Research**

- *Given the extent of policy change, the increase of ombudsman responsibilities, the growth of alternative LTC settings, and the increasing elderly population, the IOM Report's recommended staff ratio of one FTE ombudsman per 2000 facility beds should be reevaluated. The following issues should be considered in future research:*

  - *The use of FTE staff in the ratio, given that one full-time equivalent staff may be composed of multiple part-time staff, each of whom require training, supervision, resources, and program coordination (and therefore result in increased time and cost).*

  - *LTCOPs require a minimum level of program management and supervision, and this minimum critical mass may increase for coordination of multiple part-time staff. Staff with these responsibilities may not be actively involved in complaint investigation, education and outreach, or advocacy efforts. Smaller LTCOPs are likely to have a higher proportion of staff involved in administrative tasks and not delivering direct services.*

  - *States that are largely rural face specific challenges (such as travel time) due to geographic dispersion and other issues which have historically been noted but not thoroughly examined.*

  - *The effect of turnover among state and local ombudsmen should be examined.*

- *Research should be conducted to help develop criteria for minimum levels of ombudsman program visits, as described in the 1999 report from the Office of Inspector General (OIG, 1999; OEI-02-98-00351).*

- *Develop criteria for regular and consistent reports on ombudsman complaints to applicable state regulatory agencies.*

- *Identify effective strategies/mechanisms through which ombudsmen may address the need for systems change on behalf of residents.*

- *Research should be conducted to support the development of outcome measures, such as those currently being prepared by NASUA, that will allow ombudsmen (both state and local) to evaluate the impact the effects of the program on residents and families. The development of performance measures for systemic advocacy, in addition to complaint investigation and education, will enable programs to evaluate themselves with respect to policy and long-term change.*

- *Research should be conducted on the issue of the organizational structure and placement of the LTCOP that will allow ombudsmen to best meet statutorily mandated requirements, including complaint investigation; resident, family, and community education; and systems level advocacy. Issues of program autonomy and conflicts of interest must be investigated.*

- *Research should be conducted on the assisted living facility industry, specifically on monitoring care and residents' rights.*

- *Research should be conducted on the implications of managed care. Monitor the effects of managed care on long term care services and increase advocacy efforts in the arena of managed care. Focus initially on concerns identified by ombudsmen, such as denial or reduction of services, premature discharges, and claim and payment denials.*

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# STATISTICALLY SIGNIFICANT ASSOCIATIONS
## Factors Involved in LTCOP Effectiveness

**State LTCOP Survey, Institute for Health & Aging, UCSF 2001**
**National Ombudsman Reporting System, Department of Health & Services, AoA, FY 1999**

| **FUNDING, STAFFING, AND VOLUNTEERS** | | | | |
|---|---|---|---|---|
| **Source** | **Question** | **Source** | **Question** | **p-value** |
| *NORS | Funding per LTC Bed | NORS | Ratio of LTC Beds per Ombudsman | $p < 0.001$[a] |
| NORS | Ratio of LTC Beds per Ombudsman | NORS | Percent Nursing Facilities Visited | $p = 0.009$[a] |
| 5a | Sufficient Funding | 5b | Sufficient Staff | $p < 0.001$, df= 1[b] |
| | | 5c | Sufficient Volunteers | $p = 0.008$, df= 1[b] |
| | | 5i | Adequate Methods of Communication | $p = 0.008$, df= 1[b] |
| | | 8a | Effectiveness of Work with Nursing Facilities | $p = 0.008$, df= 1[b] |
| NORS | Volunteers per LTC Bed | 8a | Effectiveness of Work with Nursing Facilities | $p = 0.003$[a] |
| 36a | Turnover of Paid Staff | 36b | Turnover of Volunteers | $p = 0.001$[a] |

| **AUTONOMY** | | | | |
|---|---|---|---|---|
| **Source** | **Question** | **Source** | **Question** | **p-value** |
| 5g | Sufficient Autonomy | 6e | Effectiveness of Legislative and Administrative Policy Advocacy | $p = 0.038$[c] |
| | | 5d | Freedom from Excessive Legislative or Regulatory Restrictions | $p = 0.002$, df= 1[b] |
| | | 5f | Ability to Carry Out Federal Mandates Independently From Other State Agencies and Parties | $p < 0.001$, df= 1[b] |
| | | 5o | Supportive Political and Social Climate | $p = 0.004$, df= 1[b] |
| | | 5e | Clearly Defined Lines of Authority and Accountability for State and Local Ombudsmen | $p = 0.001$, df= 1[b] |

| **FACILITY VISITS AND COMPLAINT RESOLUTION** | | | | |
|---|---|---|---|---|
| **Source** | **Question** | **Source** | **Question** | **p-value** |
| NORS | Percentage of Nursing Facilities Visited | NORS | Percentage of Board & Care Facilities Visited | $p = 0.009$[a] |
| | | 6b | Effectiveness of Community Education | $p < 0.001$[a] |
| | | 6c | Effectiveness of Resident and Family Education | $p = 0.001$[a] |
| NORS | Percentage of Nursing Facility Complaints Resolved to the Satisfaction of the Complainant | NORS | Percentage of Board & Care Complaints Resolved to the Satisfaction of the Complainant | $p < 0.001$[a] |
| 6a | Effectiveness of Complaint Investigation | 6b | Effectiveness of Community Education | $p = 0.009$[a] |
| | | 6c | Effectiveness of Resident and Family Education | $p = 0.005$[a] |
| | | 4 | Effectiveness of LTCOP at the State Level | $p = 0.002$[a] |

| OTHER MEASURES OF EFFECTIVENESS | | | | |
|---|---|---|---|---|
| **Source** | **Question** | **Source** | **Question** | **p-value** |
| 8a | Effectiveness of Work with Nursing Facilities | 5i | Adequate Methods of Communication | $p = 0.003$, $df = 1$[b] |
| | | 8b | Effectiveness of Work with Board & Care Facilities | $p = 0.001$, $df = 6$[b] |
| | | 8c | Effectiveness of Work with Assisted Living Facilities | $p = 0.003$, $df = 4$[b] |
| 8b | Effectiveness of Work with Board & Care Facilities | 8c | Effectiveness of Work with Assisted Living Facilities | $p < 0.001$, $df = 9$[b] |
| 4 | Effectiveness of LTCOP at the State Level | 6e | Effectiveness of Legislative and Administrative Policy Advocacy | $p < 0.001$[a] |
| | | 6d | Effectiveness of LTCOP's Monitoring of Federal, State, and Local Law, Regulations, and Other Government Policies and Actions | $p < 0.001$[a] |
| | | 10 | Effectiveness of Local LTCOPs | $p < 0.001$[a] |
| 6b | Effectiveness of Community Education | 6c | Effectiveness of Resident and Family Education | $p < 0.001$[a] |
| 6d | Effectiveness of LTCOP's Monitoring of Federal, State, and Local Law, Regulations, and Other Government Policies and Actions | 6e | Effectiveness of Legislative and Administrative Policy Advocacy | $p < 0.001$[a] |
| | | 8a | Effectiveness of Work with Nursing Facilities | $p = 0.003$[a] |
| | | 8b | Effectiveness of Work with Board & Care Facilities | $p = 0.002$[a] |
| 10 | Effectiveness of Local LTCOPs | 6d | Effectiveness of LTCOP's Monitoring of Federal, State, and Local Law, Regulations, and Other Government Policies and Actions | $p < 0.001$[a] |
| | | 6e | Effectiveness of Legislative and Administrative Policy Advocacy | $p < 0.001$[a] |
| | | 8a | Effectiveness of Work with Nursing Facilities | $p = 0.009$[a] |

| POLITICAL AND SOCIAL CLIMATE | | | | |
|---|---|---|---|---|
| **Source** | **Question** | **Source** | **Question** | **p-value** |
| 5o | Supportive Political and Social Climate | 5g | Sufficient Autonomy | $p = 0.004$, $df = 1$[b] |
| | | 5f | Ability to Carry Out Federal Mandates Independently From Other State Agencies and Parties | $p = 0.001$, $df = 1$[b] |

| LEGAL COUNSEL AND COLLABORATION WITH OTHER AGENCIES | | | | |
|---|---|---|---|---|
| **Source** | **Question** | **Source** | **Question** | **p-value** |
| 19a | Effectiveness of Legal Counsel | 4 | Effectiveness of LTCOP at the State Level | $p < 0.001$, $df = 12$[b] |
| | | 8a | Effectiveness of Work with Nursing Facilities | $p = 0.006$[a] |
| 42 | Effectiveness of Relationship with Citizen's Advocacy Groups | 6e | Effectiveness of Legislative and Administrative Policy Advocacy | $p < 0.001$[a] |

* NORS Data taken from the National Ombudsman Reporting System, DHHS, AoA, FY 1999

**Statistical Tests Used to Analyze Associations Between Responses to Quantitative, Five-Point, and Yes-No Questions**

[a] Spearman's Test of Rank Correlation — Analysis of Quantitative x Quantitative, Quantitative x Five-Point Scale, and Five-Point Scale x Five-Point Scale

[b] Chi-Squared Test of Association — Analysis of Yes-No x Yes-No

[c] Komolgorov-Smirnov Two-Sample Test — Analysis of Five-Point Scale x Yes-No

## 1. What is your current position?

46 State LTC Ombudsmen
6 Assistant or Co-State Ombudsman, or staff person within state office of the LTCOP

## 2. Which of the following organizational structures most accurately describes where your state LTCOP is placed:

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | SUA | 20 | 38.5 | 38.5 |
| | SUA in umbrella with L&C | 9 | 17.3 | 17.3 |
| | SUA in umbrella without L&C | 8 | 15.4 | 15.4 |
| | Legal Agency | 2 | 3.8 | 3.8 |
| | Nonprofit Agency | 7 | 13.5 | 13.5 |
| | Independent State Agency | 4 | 7.7 | 7.7 |
| | In Another State Agency | 2 | 3.8 | 3.8 |
| | Total | 52 | 100.0 | 100.0 |

## 2a. Has the organizational placement of your state LTCOP changed in the last 5 years?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes | 13 | 25.0 | 25.0 |
| | No | 39 | 75.0 | 75.0 |
| | Total | 52 | 100.0 | 100.0 |

## 2b. How has your organizational placement changed?
## AND
## 2c. Why was this change made?

| # | Changes in State LTCOP's Organizational Placement and Reasons for Change |
|---|---|
| 5 | Moved out of SUA<br>*To avoid conflict of interest*<br>*To place LTC ombudsmen with classical ombudsmen*<br>*Program is more effective without conflicts as a state agency*<br>*Budget change that transferred funds in order to make program more effective* |
| 3 | Change in placement within or incorporation into aging services<br>*Consolidation of resources*<br>*Consolidation of all programs dealing with APS*<br>*Consolidation of all senior services into new department* |
| 3 | Elevation of program, or elevation of state ombudsman's position within department<br>*Ombudsman program was made a priority in the agency* |
| 1 | SUA has begun doing Licensing and Certification<br>*SUA became the unit that licenses and certifies assisted living homes* |
| 1 | Obtained independence within SUA<br>*Advocates demanded more independence* |
| 1 | Change in placement from cabinet for families and children to health cabinet<br>*LTCOP requested change because the program was better suited for health cabinet* |

**3. Does the placement of your state LTCOP create any difficulties for your service provision (e.g. any conflicts or potential conflicts of interest; perception problems with local ombudsmen, nursing homes, residents, families)?**

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes | 28 | 53.8 | 54.9 |
| | No | 23 | 44.2 | 45.1 |
| | Total | 51 | 98.1 | 100.0 |
| Missing | Refuse to Answer | 1 | 1.9 | |
| Total | | 52 | 100.0 | |

**3a. What kind of difficulties does it create?**
**AND**
**3b. How have you dealt with these situations?**

| **State LTCOPs in an independent SUA** |
|---|
| Lack of autonomy to speak to legislators and the media (advocacy efforts hindered) |
| *Quietly work with other groups* |
| *Regional program association carries legislative issues* |
| *Volunteers do and say what state ombudsman cannot* |
| *Local ombudsman association can effectively lobby for funding since they are voters* |
| Conflicts of interest with SUA |
| *Developing protocol to address conflicts of interest and give ombudsmen more flexibility to deal with them* |
| *Encourage communication between all parties* |
| Ombudsmen prohibited from criticizing state agencies (executive director appointed by governor) |
| *Maintain good relationship with and work directly with licensure agency* |
| SUA is also responsible for Adult Protective Services |
| *Ombudsman and APS work is kept separate* |
| *Encourage communication between all parties* |
| No direct access to information about policy issues |
| *Regional program association carries legislative issues* |
| **State LTCOPs in a SUA within an Umbrella Agency with a Licensing and Certification Agency** |
| Lack of autonomy to speak to legislators and the media |
| *Work with citizen's advocacy groups* |
| *Participating in workgroup to determine whether placement of LTCOP is most effective* |
| *Education with leaders of agency about the need for independence in speaking out about legislative issues* |
| LTCOP is not considered or contacted about policy issues |
| *Try to be a neutral force with all agencies co-mingled together* |
| Conflicts of interest with SUA and/or umbrella organization |
| i.e. SUA involved in licensing, APS, Medicaid, nursing home eligibility, operation of facilities, etc.) |
| *Discuss conflict with SUA* |
| *Work with media to expose conflicts of interest* |
| *Participate in legislative audit* |
| *Conduct investigations* |
| *Negotiate memorandum of understanding that will apply in the case of a conflict of interest* |
| *Utilize memorandum of understanding to document what information is shared with ombudsmen to assure residents that ombudsman's job is not compromised by being housed with licensing agency* |
| Consumers confused because they think ombudsmen are licensing regulators |
| *Participating in workgroup to determine whether placement of LTCOP is most effective* |
| LTCOP must compete for the attention and interest of the director of the umbrella agency |
| *Try to be a neutral force with all agencies co-mingled together* |
| Cumbersome bureaucracy in terms of budget management and lines of authority |

| **State LTCOPs in a SUA within an Umbrella Agency without a Licensing/Certification Agency** |
|---|
| State ombudsman is required to keep the entire hierarchy informed of LTCOP activities<br>*Keep everyone informed, especially about press calls and legislative hearings*<br>Lack of autonomy to speak to legislators and the media<br>*Have local ombudsman staff talk to media since they have more autonomy*<br>Gap in legal services because LTCOP's legal advisor cannot represent residents<br>*Advise residents of their choices (i.e. go to legal aid or ask judge for a public defender)* |
| **State LTCOPs in a Nonprofit Agency** |
| Autonomy limited by parent organization<br>*Repeated meetings with director of nonprofit about the need for independence when it comes to legislative and policy issues*<br>No access to state amenities due to tight budget<br>*Wrote grants and approached general assembly for additional funding* |
| **State LTCOPs in an Independent State Agency** |
| Lack of protective umbrella agency allows for budget vulnerability<br>*Run a sound agency to ensure that levels of funding remain stable* |
| State LTCOPs in Another State Agency |
| Unable to advocate at state level as a state employee<br>*Have others advocate for residents and the program*<br>Conflict of interest as part of state government<br>*Work with grassroots organizations, AARP*<br>*Open communication about specific situations as they arise* |
| **State LTCOPs in a Legal Agency** |
| No specific difficulties due to placement were reported |

## 4. On a scale of 1 to 5 with 1 being "very effective" and 5 being "very ineffective," how would you rate the effectiveness of your LTCOP at the state level?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Very Effective | 16 | 30.8 | 30.8 |
| | Somewhat Effective | 33 | 63.5 | 63.5 |
| | Neutral | 1 | 1.9 | 1.9 |
| | Somewhat Ineffective | 2 | 3.8 | 3.8 |
| | Total | 52 | 100.0 | 100.0 |

## 5. Next we have some questions regarding factors that may or may not contribute to your state LTCOP's effectiveness.

| | Yes | No | DK | RTA | N/A | Total | % Yes |
|---|---|---|---|---|---|---|---|
| a) Does your state LTCOP have a sufficient amount of funding? | 11 | 39 | 2 | 0 | 0 | 50 | 22.0% |
| b) Does your state LTCOP have a sufficient number of paid staff? | 11 | 41 | 0 | 0 | 0 | 52 | 21.2% |
| c) Does your state LTCOP have a sufficient number of volunteers? | 10 | 35 | 0 | 0 | 7 | 45 | 22.2% |
| d) Are your state LTCOP's activities free from excessive legislative or regulatory restrictions? | 44 | 8 | 0 | 0 | 0 | 52 | 84.6% |
| e) Are lines of authority and accountability clearly defined for state and local ombudsmen? | 42 | 9 | 0 | 0 | 1 | 51 | 82.4% |
| f) Can your state LTCOP carry out federal mandates independently from other state agencies and parties? | 36 | 14 | 0 | 1 | 1 | 50 | 72.0% |
| g) Does your state LTCOP's organizational placement allow for sufficient autonomy? | 31 | 20 | 0 | 1 | 0 | 51 | 60.8% |
| h) Is your state LTCOP generally able to represent the interests of residents to most state agencies? | 52 | 0 | 0 | 0 | 0 | 52 | 100.0% |
| i) Does your state LTCOP have adequate communication methods to share information with local programs? | 33 | 15 | 0 | 0 | 4 | 48 | 68.8% |
| j) Does your state LTCOP have a uniform database? | 44 | 7 | 0 | 0 | 1 | 49 | 89.8% |
| k) Does your state LTCOP have a good working relationship with the long term care industry? | 45 | 6 | 0 | 0 | 1 | 51 | 88.2% |
| l) Is your state LTCOP in agreement with the position of employees' unions regarding staffing practices? | 22 | 4 | 10 | 1 | 15 | 26 | 84.6% |
| m) Does your state LTCOP have a good working relationship with the HCFA? | 41 | 3 | 0 | 0 | 8 | 44 | 93.2% |
| n) Does your state LTCOP have a good working relationship with the Licensing & Certification agency and/or survey agency? | 49 | 2 | 0 | 0 | 1 | 51 | 96.1% |
| o) Is the political and social climate in your state supportive of your state LTCOP? | 37 | 12 | 0 | 0 | 3 | 49 | 75.5% |
| p) Does your state LTCOP have sufficient legal service available? | 34 | 17 | 0 | 0 | 1 | 51 | 66.7% |

Other factors that influence effectiveness:

6 Independence of the program
5 Relationship with local programs (control and unity)
4 Turnover of state and local ombudsmen, and SUA directors
3 Support from legislature
3 Support from CAGs, aging advocacy network, and advisory councils
2 Public recognition of the program
2 Bureaucracy within AAAs
1 Diminished advocacy because local ombudsmen are stretched thin with too many responsibilities
1 Supportive director of Division of Aging
1 Outdated policy and procedure
1 Geographical factors (concentration of people in areas of state)
1 Environment surrounding LTC (i.e. Medicare, prescription drugs, private pay insurance, Medicaid)
1 Lenient regulations for community care licensing result in complaints not being addressed.

**6. On a scale of 1 to 5 with 1 being "very effective" and 5 being "very ineffective," how would you rate the effectiveness of LTCOPs in your state in meeting the statutorily mandated requirements, including:**

| | Very Effective | | Somewhat Effective | | Neutral | | Somewhat Ineffective | | Very Ineffective | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Statutorily Mandated Requirement** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** |
| Complaint investigation | 32 | 61.5% | 18 | 34.6% | 1 | 1.9% | 0 | 0.0% | 1 | 1.9% | 52 |
| Community education | 12 | 23.1% | 33 | 63.5% | 3 | 5.8% | 3 | 5.8% | 1 | 1.9% | 52 |
| Resident and family education | 9 | 17.3% | 35 | 67.3% | 5 | 9.6% | 1 | 1.9% | 2 | 3.8% | 52 |
| Monitoring federal, state, and local law, regulations, and other government policies and actions | 18 | 34.6% | 27 | 51.9% | 4 | 7.7% | 3 | 5.8% | 0 | 0.0% | 52 |
| Legislative and administrative policy advocacy | 12 | 23.1% | 26 | 50.0% | 9 | 17.3% | 4 | 7.7% | 1 | 1.9% | 52 |

**7. What is the percentage of time the LTCOPs in your state spend on nursing homes, board and care, assisted living facilities, home care, and other institutions?**

| | 0% | | 1-25% | | 26-50% | | 51-75% | | 76-99% | | 100% | | DK | N/A | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Facility** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **#** | **#** |
| Nursing Homes | 0 | 0.0% | 1 | 2.1% | 9 | 18.8% | 21 | 43.8% | 17 | 35.4% | 0 | 0.0% | 4 | 0 | 48 |
| Board & Care And/Or Assisted Living | 24 | 50.0% | 22 | 45.8% | 1 | 2.1% | 0 | 0.0% | 1 | 2.1% | 0 | 0.0% | 4 | 0 | 48 |
| Home Care | 41 | 80.4% | 10 | 19.6% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 0 | 51 |
| Other | 0 | 0.0% | 9 | 17.3% | 1 | 1.9% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0 | 52 |

Other: Anybody in the community over age 60, home health, hospice, hospitals… people who were previously in a facility or who want to move to a facility, state Medicaid agency, complaints that were not against the provider, mental health, disabilities and special needs, psychiatric hospitals, transitional care units at hospitals, state veterans homes, homeless.

**7a. What percentage of your state's nursing homes, board and care, and assisted living facilities are visited each year?**

| | 0% | | 1-25% | | 26-50% | | 51-75% | | 76-99% | | 100% | | DK | N/A | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Facility** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **%** | **#** | **#** | **#** |
| Nursing Homes | 0 | 0.0% | 2 | 3.9% | 4 | 7.8% | 5 | 9.8% | 13 | 25.5% | 27 | 56.3% | 1 | 0 | 51 |
| Board & Care | 0 | 0.0% | 10 | 24.4% | 8 | 19.5% | 5 | 12.2% | 4 | 9.8% | 14 | 29.2% | 1 | 10 | 41 |
| Assisted Living | 0 | 0.0% | 12 | 33.3% | 7 | 19.4% | 2 | 5.6% | 7 | 19.4% | 8 | 16.7% | 1 | 15 | 36 |

**8. On a scale of 1 to 5 with 1 being "very effective" and 5 being "very ineffective," how would you rate your state LTCOP work with the following facilities?**

| | Very Effective | | Somewhat Effective | | Neutral | | Somewhat Ineffective | | Very Ineffective | | DK | A | N/A | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Facility** | # | % | # | % | # | % | # | % | # | % | # | # | # | # |
| Nursing Homes | 24 | 47.1% | 25 | 49.0% | 2 | 3.9% | 0 | 0.0% | 0 | 0.0% | 1 | 0 | 0 | 51 |
| Board & Care | 12 | 29.3% | 23 | 56.1% | 3 | 7.3% | 3 | 7.3% | 0 | 0.0% | 2 | 0 | 9 | 41 |
| Assisted Living | 10 | 28.6% | 19 | 54.3% | 2 | 5.7% | 2 | 5.7% | 2 | 5.7% | 2 | 0 | 15 | 35 |

| Other: | | |
|---|---|---|
| | Community | Very Effective |
| | Hospital | Neutral |
| | Home health, hospice, hospitals | Neutral |
| | Home care | Very Effective, Neutral, Somewhat Ineffective |
| | Transitional Care Units at hospitals | Somewhat Ineffective |
| | Mental Health | Very Effective, Very Ineffective |
| | Homeless | Very Effective |

**9. Have the organizational placements of any of your local Ombudsman programs changed in the past 5 years?**

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes | 15 | 28.8 | 32.6 |
| | No | 31 | 59.6 | 67.4 |
| | Total | 46 | 88.5 | 100.0 |
| Missing | Not Applicable | 6 | 11.5 | |
| Total | | 52 | 100.0 | |

**9a. What changes have occurred in local program placement?**
**AND**
**9b. Why were these changes made?**

| # | Changes in Local Program Placement and Reasons for Change |
|---|---|
| 5 | Increase in local ombudsmen; new local programs<br>*Received state funding*<br>*To increase coverage and accessibility*<br>*More effective to move ombudsman from state to community* |
| 4 | Subcontracting of ombudsman program by Area Agency on Aging (AAA)<br>*Because the AAA was not capable of doing the ombudsman work*<br>*Trouble finding qualified workers in rural community*<br>*For effectiveness of the program, and the person who was running the in-house program retired*<br>*AAA was also administering Medicaid home care program and felt this was a conflict of interest* |
| 2 | Subcontracted programs brought back under AAA umbrella<br>*AAAs have had trouble with contractors and have taken them in-house*<br>*Poor performance/administrative problems on the part of the agency (not the ombudsman)* |
| 2 | Move from one AAA to another, or from one outside agency to another<br>*Individual issues within agencies* |
| 1 | Change in umbrella agency<br>*Umbrella agency had financial irregularities so the LTCOP was moved to another agency* |
| 1 | Local councils were made accountable to state ombudsman<br>*To increase accountability* |
| 1 | Increased staff time<br>*Availability of additional employees* |
| 1 | Change in headquarters of local programs<br>*Better organization and service* |
| 1 | New local programs created<br>*Better organization and service* |
| 1 | Local program abolished<br>*AAA board decided to dissolve* |
| 1 | AAA middle-man removed, and state office will now contract directly with not-for-profit locally<br>*Allows ombudsmen more control of the program to effect change; more effective for residents* |

**10. Overall, on a scale of 1 to 5 with 1 being "very effective" and 5 being "very ineffective," how would you rate the effectiveness of your local LTCOPs?**

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Very Effective | 18 | 34.6 | 40.9 |
| | Somewhat Effective | 24 | 46.2 | 54.5 |
| | Neutral | 2 | 3.8 | 4.5 |
| | Total | 44 | 84.6 | 100.0 |
| Missing | Not Applicable | 8 | 15.4 | |
| Total | | 52 | 100.0 | |

## 11. Which of the following factors contribute to the effectiveness of local LTCOPs in your state?

| | Yes | No | DK | RTA | N/A | Total | % Yes |
|---|---|---|---|---|---|---|---|
| Staff and volunteer training | 47 | 1 | 0 | 0 | 4 | 48 | 97.9% |
| Response time to complaints | 46 | 1 | 2 | 0 | 3 | 47 | 97.9% |
| Quality of working relationship with other local programs dealing with LTC | 44 | 2 | 2 | 0 | 4 | 46 | 95.7% |
| Amount of funding | 47 | 3 | 0 | 0 | 2 | 50 | 94.0% |
| Number of paid staff | 47 | 3 | 0 | 0 | 2 | 50 | 94.0% |
| Ability to obtain needed assistance to deal with complaints | 46 | 3 | 0 | 0 | 3 | 49 | 93.9% |
| Degree of collaboration/cooperation with the local nursing home providers | 45 | 3 | 1 | 0 | 3 | 48 | 93.8% |
| Number of visits to nursing home residents | 44 | 3 | 2 | 0 | 3 | 47 | 93.6% |
| Number of volunteers | 43 | 4 | 1 | 0 | 4 | 47 | 91.5% |
| Organizational placement of local LTCOPs. | 41 | 4 | 0 | 0 | 7 | 45 | 91.1% |
| Quality of working relationship with L&C agency and/or survey agency | 44 | 5 | 0 | 0 | 3 | 49 | 89.8% |
| Ability to obtain legal services | 43 | 6 | 0 | 0 | 3 | 49 | 87.8% |
| Employee consistency (rate of turnover) | 42 | 6 | 0 | 0 | 4 | 48 | 87.5% |
| Convenience of travel to facilities | 35 | 11 | 3 | 0 | 3 | 46 | 76.1% |
| Agency policies or protocol that allow for contact with the media or legislators | 34 | 12 | 2 | 1 | 3 | 46 | 73.9% |
| Quality of working relationship with HCFA | 21 | 20 | 8 | 0 | 3 | 41 | 51.2% |
| Other (see below) | 9 | | | | | | |

Other:
- 4 Communication and supervision between state ombudsman, local ombudsmen, and volunteers
- 1 Advocacy skills of local ombudsmen
- 1 Past experience of ombudsmen in LTC facilities and in social work
- 1 Communication with providers
- 1 Full-time vs. part-time employees
- 1 Commitment to the mission of the ombudsman program at the local level
- 1 Well-established (and older) ombudsman programs are more effective

## 12. What do you see as the most important advocacy issues for local LTCOPs to address right now?

**36 Staffing**
- Minimum staffing ratios
- Training and quality of staff
- Public's perception about understaffing of nursing facilities
- Recruitment and retention of staff
- Ombudsman involvement in dealing with the staffing crisis so that they remain a key component of the system

**8 Quality of Care issues**
- In relation to staffing shortages
- Need to reduce disparities in level of care

**7 Training**
- Focus on: residents' rights, best practices, ESL, medication administration, special care units
- Need to improve the quality of staff training
- Quality of staff directly affects quality of care, quality of life, and continuity of care for residents

**6 Ensure and protect residents' rights**
- Train staff about resident rights
- Enhance legal services available for residents
- Expand legal services for residents to those in adult family homes and Board and Care facilities
- Protect the rights of residents to make choices.

**5 Provision of appropriate services for special populations**
- Mental health and mental retardation services

Ensure appropriate placement of residents with behavioral problems
Alternative placements for younger residents
Residents with dementia should be placed in special care units
Develop better standards and training for dementia care

**5 Develop better relocation plans and procedures**
Provide better community alternatives
Prevent involuntary transfers and discharge from LTC facilities

**5 Expansion into Assisted Living**
Provide quality services to Assisted Living residents
Focus on education and training of staff and managers in Assisted Living facilities

**4 Working with Licensure to get stricter enforcement**
Ensure support for the ombudsman program
Encourage the use of sanctions for facilities and individuals who are mistreating residents
Improve monitoring of Assisted Living and Board and Care

**3 Abuse and neglect**
Enforce kaws that protect seniors from elder abuse

**3 Funding**
Ensure that state program has financial capacity to support at least one full-time ombudsman in each region

**2 Quality of life**
Improve nonmedical transportation for residents
Increase personal needs allowance

**2 Managed care issues**
Address issue of ill-spent Medicaid money
Resolve problems with prospective payment system

**3 Placement and organization of the LTC ombudsman program**
Placement of program must allow ombudsmen to advocate for residents
Placement of program must allow for sufficient autonomy
Address program's dual role as ombudsman program and Adult Protective Services

**2 Laws that protect seniors from financial exploitation**
Financial exploitation should be viewed as a form of abuse

**2 Inappropriate guardianships being forced on people**

**2 Eliminate the hiring of convicted criminals as nursing facility staff**
Criminal background checks should be required of facility staff

**1 Annual inspections**
Inspections by the Department of Health should be unannounced

**1 Family and resident education about availability of ombudsman services**

**1 Systemic advocacy for LTC resources in general**
Develop plans for the future; consider the role of nursing facilities in the future

**1 Expand the ombudsman program to cover all nursing facilities**

**1 Monitor facilities in financial difficulty**

**1 Weak protections in new regulations governing residential care/BC services**

**1 Poor/low-income elders face barriers to access residential care services**

**1 Some administrators of facilities refuse to acknowledge the ombudsman role**

**1 Development of family councils**

## 13. On a scale of 1 to 5, with 1 being "very effective" and 5 being "very ineffective," how would you rate the relationship between your state LTCOP and local programs?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Very Effective | 35 | 67.3 | 76.1 |
| | Somewhat Effective | 10 | 19.2 | 21.7 |
| | Somewhat Ineffective | 1 | 1.9 | 2.2 |
| | Total | 46 | 88.5 | 100.0 |
| Missing | Not Applicable | 6 | 11.5 | |
| Total | | 52 | 100.0 | |

## 14. What type of support does your state LTCOP provide to its local programs? (N=45)

| # | % | Support for Local Programs |
|---|---|---|
| 33 | 73.3% | Training and supervision |
| 29 | 64.4% | Technical assistance |
| 21 | 46.7% | Written materials, info from our national organization, current events regarding LTC, info about current legislation, community education materials, materials from NCCNHR to disseminate, info on broad advocacy issues |
| 16 | 35.6% | Support and consultation with any specific complaints, with problems with L&C |
| 12 | 26.7% | Development of policies and procedures, program manuals |
| 10 | 22.2% | Advocacy w/ legislature, other agencies, statewide advocacy, advocacy w/ media |
| 8 | 17.8% | Volunteer training or materials for volunteer trainings |
| 8 | 17.8% | Legal support and representation when necessary |
| 7 | 15.6% | N/A |
| 6 | 13.3% | Financial support, funding for special projects, conferences |
| 4 | 8.9% | Data analysis, tracking of complaints, system for statewide database |
| 2 | 4.4% | Moral and emotional support |
| 2 | 4.4% | Administrative assistance |
| 1 | 2.2% | Travel |
| 1 | 2.2% | Regional visits |
| 1 | 2.2% | NH visits |
| 1 | 2.2% | Buddy system to relieve ombudsmen when they take vacation time |
| 1 | 2.2% | Assistance in forming association of local programs- As a result, the local programs have advocated as a group for increased funding and were successful. The association can deal with all issues in a much more efficient manner, especially with repsect to advocacy. |
| 1 | 2.2% | "They're my employees. They're my team members. I make everything provided to the state ombudsman accessible to them." |

## 15. Do you have regular contact with local ombudsman programs to discuss advocacy issues and ombudsman policies and procedures?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes | 44 | 84.6 | 100.0 |
| Missing | Not Applicable | 8 | 15.4 | |
| Total | | 52 | 100.0 | |

## 15a. What types of communication? (Circle all that apply)

| Type of Communication | # | % |
|---|---|---|
| Meetings | 42 | 80.8 |
| Mailings | 42 | 80.8 |
| Visits | 40 | 76.9 |
| E-mails | 39 | 75.0 |
| Tele-conference calls | 28 | 53.8 |
| Newsletters | 17 | 32.7 |
| Other | 16 | 30.8 |

Other: Training, conferences, faxed advocacy alerts, volunteer training and recognition, individual phone calls, on-site job shadowing, communication with the head of the local ombudsman association, participation in groups of local ombudsmen that address quality of care issues, legislative alert system via fax and e-mail.

## 16. What types of assistance, if any, do you receive from your State Unit on Aging?

17 Financial support, assistance with grants, assistance with securing funding
10 Administrative support; development of policies and procedures
10 Moral support/belief in the program; support for the mission of the LTCOP
10 None, no comment, refuse to answer
9 Technical assistance
9 Legal assistance and services and support with legislative matters
8 Supervisory support; leadership/management support from director
7 Training and conferences (both outside training and training of ombudsmen), training materials, travel costs
7 Use of facilities (housed in SUA)
6 Advocacy for the program (both legislative and within larger department); solicit local support and funding
5 Supplies, resources
5 Clerical support, personnel
3 Budget assistance; fiscal and accounting support
2 Independence; support of the independence of the ombudsman prgram
2 Direction
1 Link with AoA
1 Data analysis
1 Communications unit assists with outreach
1 Communication with AAAs
1 Alerts about issues we should pay attention to

## 17. Are there any types of assistance you would like to receive from your SUA that you are not currently receiving?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes | 27 | 51.9 | 54.0 |
| | No | 23 | 44.2 | 46.0 |
| | Total | 50 | 96.2 | 100.0 |
| Missing | Don't Know | 1 | 1.9 | |
| | Refuse to Answer | 1 | 1.9 | |
| | Total | 2 | 3.8 | |
| Total | | 52 | 100.0 | |

## 17b. What types of assistance would you like to receive?

**15 Financial assistance and support in requests for additional funding from the state**
Funding for additional staff, expansion of volunteer program, conferences and meetings, materials, computers, and technical support

**7 Consistent support for our mission**
Respect, more visibility; support to advocate even if it's not politically popular

**4 Independence**
"They need to relocate the ombudsman program. They're out of compliance with federal laws. They need to understand that and resolve the issues surrounding that."
Support for the autonomy of the office
Less control over interactions with the media

**4 Legal support**

**3 Information**
Make information on resources available for ombudsmen and overall aging network

**3 More communication, a better relationship, a mutually supportive relationship, less adversarial**
Collaboration and assistance in problem solving

**2 Less conditions on receipt of funding**
Funding should not be funneled through an agency that ombudsmen may be compelled to criticize in fulfilling the responsibilities of their jobs.

## 18. Where does your state LTCOP get legal counsel?

| Legal Counsel | # | % (N = 52) |
|---|---|---|
| Attorney General's Office | 24 | 46.2 |
| In-house counsel | 14 | 26.9 |
| State department or agency | 13 | 25.0 |
| Contract with outside agency or attorney | 10 | 19.2 |
| Legal Assistance Developer | 5 | 9.6 |
| Title III-B Legal Services | 4 | 7.7 |
| Legal Aid (Nonprofit) | 2 | 3.8 |
| Pro bono agency | 1 | 1.9 |
| Independent legal counsel | 1 | 1.9 |

## 18a. What is the scope of this legal assistance? (Circle all that apply.)

| Scope of Legal Assistance | # | % (N = 52) |
|---|---|---|
| Resident advocacy | 30 | 57.7 |
| Benefits rights advocacy | 29 | 55.8 |
| Entitlements | 27 | 51.9 |
| Civil Remedies | 22 | 42.3 |
| Don't Know | 1 | — |
| Refuse to Answer | 1 | — |
| Other | 27 | 51.9 |

Other:
Interpretation of laws, policies, procedures, regulations
Consultation in the case of administrative hearings and lawsuits, subpoenas, testimony
Legal intervention for residents, guardianship, resident rights
General legal advice
Release of and access to records
Autonomy of ombudsman program
Review policies and documents
Representation in committees
Lobbying assistance
Financial matters
Criminal investigations
Advice to counsel

## 19. Approximately how often did your state office seek legal advice last year?

| Legal Advice Sessions at State Level | # | % (N = 50) |
|---|---|---|
| 5 or less | 16 | 32.0 |
| 6-10 | 6 | 12.0 |
| 11-20 | 11 | 22.0 |
| 21-50 | 8 | 16.0 |
| 51-100 | 2 | 4.0 |
| More than 100 | 7 | 14.0 |
| Don't Know | 2 | — |

## 19a. On a scale of 1 to 5 with 1 being "very effective" and 5 being "very ineffective," how effective is the response of your legal advisor?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Very Effective | 28 | 53.8 | 58.3 |
| | Somewhat Effective | 13 | 25.0 | 27.1 |
| | Neutral | 2 | 3.8 | 4.2 |
| | Somewhat Ineffective | 4 | 7.7 | 8.3 |
| | Very Ineffective | 1 | 1.9 | 2.1 |
| | Total | 48 | 92.3 | 100.0 |
| Missing | Don't Know | 1 | 1.9 | |
| | Refuse to Answer | 1 | 1.9 | |
| | Not Applicable | 2 | 3.8 | |
| | Total | 4 | 7.7 | |
| Total | | 52 | 100.0 | |

## 20. Where do local LTCOPs get their legal counsel? (Circle all that apply)

| Legal Counsel for Local LTCOPs | # | % (N = 52) |
|---|---|---|
| Attorney General | 14 | 26.9 |
| Legal Services Attorney | 24 | 46.2 |
| Private Attorney | 14 | 26.9 |
| SUA | 15 | 28.8 |
| Non-SUA Umbrella | 3 | 5.8 |
| Title III-B Legal Services | 22 | 42.3 |
| Legal Assistance Developer | 11 | 21.2 |

Other: In-house attorney, nonprofit legal aid, AAA legal services, legal services for disabled residents, legal division of umbrella agency, insurance attorneys, county attorney

## 21. Approximately how many times did your state office receive calls from local ombudsman programs requesting legal assistance in the last year?

| Number of Requests for Legal Assistance | # | % (N = 40) |
|---|---|---|
| 5 or less | 10 | 25.0 |
| 6-10 | 6 | 15.0 |
| 11-20 | 7 | 17.5 |
| 21-50 | 9 | 22.5 |
| 51-100 | 4 | 10.0 |
| More than 100 | 4 | 10.0 |
| N/A | 8 | — |
| Don't Know | 4 | — |

## 22. Who is/are the target population(s) for your services? (Circle all that apply.)

| Target Population | # | % (N = 52) |
|---|---|---|
| Nursing facility residents | 52 | 25.0 |
| Board and Care residents | 39 | 15.0 |
| Assisted Living | 36 | 17.5 |
| Home Care beneficiaries | 11 | 22.5 |
| Managed Care clients | 6 | 10.0 |

Other: Mental health, community care, individuals over the age of 60, rehabilitation patients, homeless, family members of residents, and individuals in potential need of LTC services (including hospital patients)

## 23. At the state level, what quality of care issues do you think are currently the most important for the ombudsman programs to address?

## AND

## 23b. How are you addressing the issue(s)?

**Inadequate staffing levels and training (24)**

*Communicating with regulatory agency*
*State ombudsmen speak at conferences to publicize the issue*
*Established panel on workforce issues in long term care*
*Providing public testimony*
*Working with AARP on state-wide public broadcasting*
*Legislative advocacy*
*Collaborating with other state agencies*
*Participate in training of facility staff*
*Using the HCFA staffing study to raise awareness*
*Staffing ratios committee will be making legislative recommendations at next session*
*Volunteer program and staff will be monitoring how facilities use funds for staffing*
*Working to pass bills to increase Medicaid reimbursement for direct care staff*
*Trying to improve the training requirements for staff*
*Working with large coalition of advocates and providers to improve wages of caregivers*

**Malnutrition/dehydration and weight loss (20)**

*Meeting with nursing home staff about concerns*
*Discussing malnutrition/dehydration at quarterly meeting*
*Registering complaints with state licensing agency*
*Informing residents and family members about issues regarding poor care*
*Systemic advocacy*
*Examining the single task worker concept*
*Researching into prevalence of problems*
*Organizing statewide conference on nutrition and hydration*
*Educating public about malnutrition and dehydration issues*

| |
|---|
| **Bedsores/pressure ulcers (8)**<br>*Registering complaints with state licensing agency*<br>*Informing residents and family members about issues regarding poor care*<br>*Systemic advocacy*<br>*Participating in task force with Department of Justice*<br>*Participating in quality initiative with providers, families, physicians, advocates, and regulatory agencies* |
| **Incidence and prevalence of falls (7)**<br>*Statewide training discussion about identifying when unnecessary risks are taken*<br>*Community and family education about fall prevention and risk assessment*<br>*Working closely with survey units to identify high-risk facilities and increase volunteer presence* |
| **Dementia care (7)**<br>*Working with assisted living facilities to train personnel about dementia care*<br>*Formed interagency committee on mental health issues*<br>*Offering assistance and training for staff*<br>*Additional training for ombudsmen to recognize and deal with dementia problems appropriately* |
| **Behavioral issues (7)**<br>*Discussing problem of "shipping behavior problem patients to psychiatry units" with psychiatry facilities and nursing home industry* |
| **Abuse and neglect (7)**<br>*State agency looking into changing the abuse statute*<br>*Participating in legislative testimony*<br>*Educating public about abuse and neglect issues*<br>*Sharing information with citizen's advocacy groups* |
| **Symptoms of depression (6)**<br>*Looking into getting funds to address depression issue*<br>*Monitoring Department of Health deficiencies of nursing homes*<br>*Educating public about depression issues*<br>*Developing presentations for LTC nurses and social workers* |
| **Quality of life (5)**<br>*Educating public about quality of life issues*<br>*Increasing staff awareness*<br>*Organizing department and regional meetings with providers about how to develop supportive and caring relationships between residents and staff*<br>*Making complaint investigations and recommendations on an individual basis* |
| **Mental health services (5)**<br>*Formed interagency committee on mental health issues*<br>*Researching into prevalence of problems*<br>*Educating providers about problems in mental health services*<br>*Additional training for ombudsmen on mental illness issues* |
| **Restraint use (4)**<br>*Staff training about the difference between physical restraints and appropriate restraints*<br>*Educating public about reduction of bed-rail use* |
| **Personal care and hygiene (4)**<br>*Advocacy at local level*<br>*Committee working on hygiene issues*<br>*Regular visits to check on basic hygiene, dress, and oral hygiene* |
| **Medication administration (4)**<br>*Advocacy at local level*<br>*Educating community about the consequences of errors in medication*<br>*Increasing staff awareness; training about interactions of medications*<br>*Taking legislative action*<br>*Educating AARP and CAGs about this issue* |
| **Requests for assistance (2)**<br>*Advocacy at local level*<br>*Ongoing advocacy at facilities* |
| **Inadequate resident assessments (2)**<br>*Training on resident assessments at next conference*<br>*Advocacy at local level*<br>*Offering assistance on case-by-case basis* |

| |
|---|
| **Discharge procedures (2)**<br>*Educating community about improper discharge procedures*<br>*Educating providers about discharge procedures*<br>*Distributing forms with ombudsman program contact information so that residents are aware of their right and ability to appeal* |
| **Accidents and improper handling (2)**<br>*Trying to enforce law that nursing homes must report accidents and improper handling to LTCOP* |
| **Language barrier (1)**<br>*Educating community about language barrier problem*<br>*Increasing staff awareness* |
| **Inappropriate placements (1)**<br>*Educating AARP and CAGs about inappropriate placements* |
| **Criminal background checks (1)**<br>*Lobbying for registry of unlicensed personnel to eliminate people with criminal backgrounds* |
| **Exploitation (1)**<br>*Working with investigation and referrals regarding Medicaid fraud*<br>*Presentations in facilities about exploitation* |
| **Access to home care (1)**<br>*Developing home-care advocacy program to address increasing number of home care complaints*<br>*Print home care brochure to send out to all providers in state*<br>*Developing regulation that will require home care providers to inform consumers about LTCOP* |

**State LTCOP Survey (Question 23), Institute for Health & Aging, UCSF, 2001**

## 23a. Is your program currently addressing (this/these) issue(s)?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes | 50 | 96.2 | 98.0 |
| | No | 1 | 1.9 | 2.0 |
| | Total | 51 | 98.1 | 100.0 |
| Missing | Don't Know | 1 | 1.9 | |
| Total | | 52 | 100.0 | |

## 24. Are reports of complaints related to managed care coming to the attention of the state LTCOP?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes | 14 | 26.9 | 27.5 |
| | No | 37 | 71.2 | 72.5 |
| | Total | 51 | 98.1 | 100.0 |
| Missing | Don't Know | 1 | 1.9 | |
| Total | | 52 | 100.0 | |

## 24a. What are the major complaints regarding managed care?

5 Denial or reduction of services
4 Premature discharge; premature cut-off of rehabilitation
4 Managed care pulling out of rural areas and leaving seniors without insurance
3 Denial of payment; facilities not certain about what procedures are covered
2 Inadequate services available
2 Claim denial
1 Problems getting transportation to appointments
1 Problems getting dental care
1 Poor home care
1 Not getting care or payments
1 Need for living allowances
1 Hospital complaints

## 24b. Is the current tracking system of managed care complaints adequate?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes | 4 | 7.7 | 30.8 |
| | No | 9 | 17.3 | 69.2 |
| | Total | 13 | 25.0 | 100.0 |
| Missing | Don't Know | 1 | 1.9 | |
| | Not Applicable | 38 | 73.1 | |
| | Total | 39 | 75.0 | |
| Total | | 52 | 100.0 | |

## 25. Is your state LTCOP advocating in the arena of managed care?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes | 8 | 15.4 | 15.7 |
| | No | 43 | 82.7 | 84.3 |
| | Total | 51 | 98.1 | 100.0 |
| Missing | Don't Know | 1 | 1.9 | |
| Total | | 52 | 100.0 | |

## 26. Do you anticipate that managed care will affect your state LTCOP in the future?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes | 31 | 59.6 | 70.5 |
| | No | 13 | 25.0 | 29.5 |
| | Total | 44 | 84.6 | 100.0 |
| Missing | Don't Know | 8 | 15.4 | |
| Total | | 52 | 100.0 | |

## 26a. What kind of effects do you anticipate?

7 Increased complaints regarding access to or quality of services, and choices of services, medication, and facilities
3 Premature discharges
3 Advocacy to ensure that sufficient services and care are available and that care is not compromised to save costs.
3 Problems with insurance reimbursements
2 May be asked to develop an ombudsman program for managed care
1 Residents' rights issues (i.e. restrictions on where residents can live)
1 Decreases in quality of life due to managed care putting a cap on care
1 Ombudsman program should be included in dealing with managed care complaints
1 More complaints as managed care has a bigger impact
1 More attention to managed care will detract from the attention to residents of nursing facilities
1 Inappropriate placement and care
1 HMOs will pull out of poor states

## 27. Based on the experience of your state agency, what is your opinion about the relationship, if any, between LTC facility staffing levels and overall quality of care?

31 Direct, causal relationship; low levels of staffing lead to poor quality of care for residents.
14 Significant relationship
1 Staffing levels are not directly proportional to quality of care; quality of staffing is just as important as quantity
1 Most important factor by far
1 Lack of staffing has caused major problems with care
1 If we have facilities with inadequate staffing levels, quality of care is a day-to-day issue
1 "Staff increases and staffing levels are a good start but not the total solution. You can throw money at the problem but if it's not effectively used, if [the staff] are not respected... you're not going to have a workforce that cares."
1 "If we required administrators to be C.N.A.s for just one day, we'd have ratios imposed immediately."

## 28. Based on the experience of your state agency, what is your opinion about the relationship, if any, between supervision in nursing facilities and overall quality of care?

46 Direct, strong relationship; without proper supervision staff can make mistakes.
4 Turnover is also a factor, eliminating continuity of care and compromising quality of care
3 Supervisors set the standard, ensure accountability, and have a direct impact on recruitment and retention
"Good supervision and good management seems to make for longevity of the staff. When they get to know residents and they are happy with their job, everything works out better."
2 Training is also key
2 Poor supervision can lead to ignored symptoms and problems; patients not recognized by staff
1 "[There is a] huge relationship. In fact, some of the things that are attributed to short staffing are really failures in the system to have good supervision and training. The problem is just as much that as a lack of numbers."
1 "When we see lots of turnover in administrators and directors of nursing, we see quality of care go down the toilet... And also lots of facilities have poor supervision because the staff is becoming more paper-centered, less people-centered."
1 Depends on the quality of supervision; a nursing assistant can be more effective than a R.N. because the supervision comes from the peer level.
1 Need to have adequate training and supervision
1 "Because there's a shortage of supervisory staff and CNAs, the supervisory staff have to fill in for CNAs and they can't do their job as supervisors. As a result, facilities lose good supervisory staff because it's too frustrating a job."
1 "[Supervision is] very important but also facilities where there is staff empowerment show better quality of care. It's supervision versus micromanagement. Aides should have some decision-making power."
1 "There needs to be more nurse's aids, but there also needs to be more supervision of supervisors to provide motivation for better supervision. Overall, the nurse's aide's attitude is only going to be as good as the administrator's and the owner's."

## 29. Over the past three years (FY1997-98; 1998-99; 1999-2000) was your agency's budget for its LTCOP:

| | Yes (#) | Yes (%) | No (#) | No (%) | DK | RTA | Total |
|---|---|---|---|---|---|---|---|
| **Adequate to fund the *federal* requirements for the LTCOP?** | 17 | 33.3% | 34 | 66.7% | 0 | 1 | 51 |
| **Adequate to fund the *state* requirements for the LTCOP?** | 13 | 26.5% | 36 | 73.5% | 2 | 1 | 49 |

## 29c. Which activities were neglected or partially carried out because of lack of funds?

18 Routine visits to facilities
14 Community education and outreach
13 Complaint investigation and resolution; response time to complaints
11 Developing and working with resident and family councils
6 Systemic advocacy
5 Volunteer recruitment and supervision
4 Monitoring Board and Care/residential care facilities
4 Monitoring and complaint investigation in Assisted Living
3 Working with survey/certification
3 Training
3 Proactive work, data analysis, identifying trends
3 Necessary staff (support, bilingual)
2 Home care
1 Working on regulations
1 Setting up a toll-free hotline
1 Elder abuse investigations
1 Attendance at exit interviews

## 29d. How much additional funding would your state LTCOP need to carry out these requirements?

| Additional Funding Needed | # | % (N = 31) |
|---|---|---|
| $200,000 or Less | 12 | 38.7 |
| $250,000 to $500,000 | 7 | 22.6 |
| $550,000 to $700,000 | 3 | 9.7 |
| $750,000 to $1,000,000 | 5 | 16.1 |
| More than $1,000,000 | 4 | 12.9 |
| Don't Know | 5 | — |

## 29e. What are the major obstacles to getting the funding you need?

18 Political climate; perception of Ombudsman program
- LTCOP is not visible enough; not viewed as important; the positive outcomes of program are not obvious
- Political focus is currently on kids
- General lack of knowledge about what program does
- Emphasis on eliminating nursing facilities for alternative LTC setting rather than improving them

14 State fiscal situation and legislative process
6 LTCOP is not a priority within state agency/ SUA (emphasis is on developing community care instead)
5 Nursing home industry lobby opposes the services provided by ombudsmen
3 Federal funding formula and the budget process; OAA dollars haven't increased substantially over the years
1 LTCOPs and AoA have not made enough of a national effort to lobby for more money for the ombudsmen
1 LTC residents are not able to lobby for themselves
1 LTCOP is not a budget item for the state

## 30. Are there any additional state mandates (either funded or unfunded) that increase cost to the ombudsman program? (e.g. home care ombudsmen, etc.)

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes | 20 | 38.5 | 40.0 |
| | No | 30 | 57.7 | 60.0 |
| | Total | 50 | 96.2 | 100.0 |
| Missing | Don't Know | 2 | 3.8 | |
| Total | | 52 | 100.0 | |

## 30a. What are these state mandates?

5 Mental health patients
5 Home care patients
3 Fulfilling the APS role of elder abuse investigations
2 Managed care patients
2 Developmentally disabled patients
2 All LTC residents (not only > 60)
1 Required, massive paperwork when recording any legal confrontation
1 Prison system patients
1 Only paid ombudmen (not volunteers) can investigate complaints
1 Community elderly
1 Any individual over 60
1 Any older adult receiving home care services for a fee or living in a facility.
1 Adult day care participants
1 Staffing a toll-free hotline

## 31. Is your current year's budget more, less, or about the same as last year's budget?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | More | 19 | 36.5 | 38.8 |
| | About the Same | 30 | 57.7 | 61.2 |
| | Total | 49 | 94.2 | 100.0 |
| Missing | Don't Know | 2 | 3.8 | |
| | Refuse To Answer | 1 | 1.9 | |
| | Total | 3 | 5.8 | |
| Total | | 52 | 100.0 | |

## 31a. What effect has this budget increase had on your program?

9 Increased resources for ombudsmen (increased salaries, purchased educational materials, developed training)
8 Increased staff
5 Increased services for residents (closer monitoring of facilities, more frequent visits to facilities, toll-free service)
4 Nothing, only enough to cover increased expenses
3 Purchased or revised computer system; upgraded or purchased equipment
3 Expanded volunteer program
1 Additional local programs

## 31b. What effect has this budget decrease had on your program?

No responses

## 32. Has the composition of your state LTCOP funding sources changed significantly in the last 3 years?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes | 15 | 28.8 | 28.8 |
| | No | 37 | 71.2 | 71.2 |
| | Total | 52 | 100.0 | 100.0 |

## 32a. How has it changed?

10 Increased funds from state
1 Increased private funds

## 32b. What caused the change in funding sources?

4 Legislative activity; commitment by policymakers
4 Advocacy by local ombudsmen, AAAs, AARP, or other agency
2 Used IOM study to obtain more funding
1 Report from study of quality of care in LTC by task force
1 Obtained previously unused funds from SUA
1 Medicaid funding
1 Don't Know
1 Deficit in budget
1 Change in departmental budget

## 32c. What effect, if any, have funding source changes had on your state LTCOP?

10 Increased staff (resulting in increased visibility and coverage, and more complaints surfacing)
3 Increased volunteers
1 Increased training
1 Materials for staff or volunteers
1 None
1 More services, better access for consumers, expanded coverage

## 33. Has the number of paid full-time or full-time equivalent staff in your state program increased, remained the same, or decreased in the last 2 years?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Increased | 21 | 40.4 | 40.4 |
| | Remained the Same | 27 | 51.9 | 51.9 |
| | Decreased | 4 | 7.7 | 7.7 |
| | Total | 52 | 100.0 | 100.0 |

## 33a. In what areas did staff increases occur?

21 Direct services
3 Administrative
1 Legal Assistance
1 Volunteer Coordinator

## 33b. What was the reason for the increase?

13 Increased funding
4 Positive response to work by governor/legislature
4 Need for specific staff position or general staff increase to address increase in beds
1 Title VII

## 33c. In what areas of staffing did reductions occur?

2 Administrative
2 Direct services
1 Volunteer coordinator

## 33d. What was the reason for the decrease?

1 Funding
1 Changes in responsibilities of ombudsman program
1 Increasing costs of personnel with no increase in budget
1 Budget deficit

## 34. Has the number of volunteers in your state LTCOP increased, remained the same, or decreased in the last 2 years?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Increased | 27 | 51.9 | 54.0 |
| | Remained the Same | 21 | 40.4 | 42.0 |
| | Decreased | 2 | 3.8 | 4.0 |
| | Total | 50 | 96.2 | 100.0 |
| Missing | Don't Know | 1 | 1.9 | |
| | Not Applicable | 1 | 1.9 | |
| | Total | 2 | 3.8 | |
| Total | | 52 | 100.0 | |

## 34a. In what areas did volunteer staff increases occur?

27 Direct services
1 Community education
1 Administrative

## 34b. What was the reason for the increase?

16 Increased recruitment and training efforts
3 Assistance from AARP
7 Additional funding and/or staff to develop volunteer program
2 Change in state or local volunteer policy initiative

## 34c. In what areas did volunteer staff reductions occur?

2 Direct services

## 34d. What was the reason for the decrease?

1 Illness/age of volunteers
1 Lack of time to recruit
1 Reached saturation point

## 35. Are volunteer ombudsmen and paid staff ombudsmen roles differentiated?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes | 42 | 80.8 | 93.3 |
| | No | 3 | 5.8 | 6.7 |
| | Total | 45 | 86.5 | 100.0 |
| Missing | Not Applicable | 7 | 13.5 | |
| Total | | 52 | 100.0 | |

## 35a. How are the volunteer and staff ombudsmen roles differentiated?

18 Volunteers mainly serve as friendly visitors, referring complaints to staff
11 Volunteers investigate complaints only under supervision of staff
8 Staff handle more complex complaints
5 Volunteers visit regularly and build relationships with residents and facility administrators
5 Staff do training, statistics, reporting, systemic advocacy
5 Degree of certification/training distinguishes between various volunteer responsibilities
4 Only staff have access to medical records or confidential information
1 Volunteers only handle home care complaints while staff handle complaints in all facilities
1 Volunteers have more frequent interaction with residents and facility staff
1 Volunteers handle residents' complaints while staff handle complaints that come to the office
1 Staff serves as contact person with outside agencies (i.e. Medicaid)
1 Only staff handle court cases

## 36. On a scale of 1 to 5 with 1 being "very low" and 5 being "very high," please describe the turnover of the following groups in the last two years:

| | Very Low | | Somewhat Low | | Neutral | | Somewhat High | | Very High | | DK | NA | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | # | % | # | % | # | % | # | % | # | % | # | # | # |
| **Paid Staff** | 25 | 48.1% | 11 | 21.2% | 7 | 13.5% | 8 | 15.4% | 1 | 1.9% | 0 | 0 | 52 |
| **Volunteers** | 10 | 23.3% | 14 | 32.6% | 13 | 30.2% | 3 | 7.0% | 3 | 7.0% | 1 | 8 | 43 |

## 37. Does your program meet the 1995 Institute of Medicine recommendation of one paid full-time equivalent staff member for each 2000 nursing facility beds?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes | 21 | 40.4 | 41.2 |
| | No | 30 | 57.7 | 58.8 |
| | Total | 51 | 98.1 | 100.0 |
| Missing | Don't Know | 1 | 1.9 | |
| Total | | 52 | 100.0 | |

## 37a. Why was this recommendation not met?

19 Lack of funding
3 Formula does not work in rural areas (i.e. one part-time person covers three counties even though the ratio might be 1:2000, not every bed is visited. In addition, some regional programs might not meet the recommended ratio even if the state meets it overall.)
3 Freeze in hiring at state or department level
2 Lack of support at state level, political will
1 Don't Know

## 38. What is the ratio of full-time equivalent staff to beds? _____staff/ _____beds

| Additional Funding Needed | # | % (N = 52) |
|---|---|---|
| < 1:1000 | 1 | 1.9 |
| 1:1000 to 1:2000 | 17 | 32.7 |
| 1:2000 to 1:3000 | 13 | 25.0 |
| 1:3000 to 1:5000 | 14 | 26.9 |
| 1:5000 to 1:8000 | 5 | 9.6 |
| >1:8000 | 2 | 3.8 |

NOTE: These are the ratios as reported by state ombudsmen during interviews.
Please see FY 1999 NORS data in Research Findings for exact ratios by state.

## 39. Is there any legislation currently being proposed in your state that will affect your state LTCOP?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes | 22 | 42.3 | 43.1 |
| | No | 29 | 55.8 | 56.9 |
| | Total | 51 | 98.1 | 100.0 |
| Missing | Don't Know | 1 | 1.9 | |
| Total | | 52 | 100.0 | |

## 39a. What is that legislation? AND 39b. In what ways will it affect your program?

| | Legislation | How Legislation Will Affect the LTCOP |
|---|---|---|
| 6 | Increase in LTCOP funding | • Will allow for development/expansion of volunteer program<br>• Will allow LTCOP to better meet mandates<br>• LTCOP will have to redesign program to address needs of new populations (home care, managed care) |
| 5 | Legislation addressing Assisted Living and Board and Care facilities | • Will strengthen the penalties on providers when they violate requirements<br>• May increase ombudsman responsibilities/clientele<br>• Will increase need for staff<br>• Will increase resources for Assisted Living |
| 4 | Change in location and/or structure of LTCOP | • Ombudsman program may be relocated<br>• Will strengthen program by making it more independent and visible<br>• Will separate program from Licensing/Certification<br>• Will allow ombudsmen to speak to legislature |
| 3 | Legislation on nursing home reform | • Will lead to improvements in quality of care<br>• Will address issue of elder abuse<br>• Will address staffing shortages in nursing facilities |
| 2 | Ombudsman will serve on LTC review committee | • Will require state ombudsman to participate in committee |
| 2 | Change in role of ombudsman | • Ombudsmen may face conflict of interest in complaint procedures<br>• Will affect how program deals with abuse/neglect complaints<br>• Will increase workload for ombudsman staff |

## 40. Are there any barriers (or impediments) at the state *or* federal level that keep you from carrying out your job as you think it should be done?

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Yes, State | 20 | 38.5 | 39.2 |
| | Yes, Federal | 6 | 11.5 | 11.8 |
| | No | 14 | 26.9 | 27.5 |
| | Yes, State and Federal | 11 | 21.2 | 21.6 |
| | Total | 51 | 98.1 | 100.0 |
| Missing | Don't Know | 1 | 1.9 | |
| Total | | 52 | 100.0 | |

## 41. Please indicate whether the following factors influence the effectiveness of political advocacy in your state:

| | Yes | | No | | | RTA | Total |
|---|---|---|---|---|---|---|---|
| | # | % | # | % | | | |
| **Problems with Strong Industry Lobby** | 39 | 78.0% | 11 | 22.0% | 1 | 1 | 50 |
| Problems with either State Unit on Aging | 24 | 48.0% | 27 | 54.0% | 0 | 2 | 50 |
| Problems with regulatory agencies | 22 | 42.3% | 30 | 57.7% | 0 | 0 | 52 |
| Perception that aging network is apathetic to the plight of the institutionalized aged | 14 | 26.9% | 38 | 73.1% | 0 | 0 | 52 |
| Lack of clear guidance on how to advocate for special populations (e.g., persons w/ disabilities, dementia clients) | 10 | 19.2% | 41 | 78.8% | 1 | 0 | 52 |

**42. On a scale of 1 to 5 with 1 being "very effective" and 5 being "very ineffective," how would you rate your relationship with citizen's advocacy groups?**

| | | Frequency | Percent | Valid Percent |
|---|---|---|---|---|
| Valid | Very Effective | 17 | 32.7 | 35.4 |
| | Somewhat Effective | 23 | 44.2 | 47.9 |
| | Neutral | 5 | 9.6 | 10.4 |
| | Somewhat Ineffective | 3 | 5.8 | 6.3 |
| | Total | 48 | 92.3 | 100.0 |
| Missing | Don't Know | 1 | 1.9 | |
| | Not Applicable | 3 | 5.8 | |
| | Total | 4 | 7.7 | |
| Total | | 52 | 100.0 | |

**42a. What makes your relationship with advocacy groups [answer from #42]?**

| **Factors contributing to effectiveness** | **Factors contributing to ineffectiveness** |
|---|---|
| 19 Work closely together, communicate regularly | 3 Need more time to build a relationship |
| 7 Common goals and common obstacles | 2 Ombudsman program isn't as visible as CAGs, so the CAGs are not aware that ombudsmen are also advocates |
| 6 Attend CAG meetings/conferences | 2 Different focus (i.e. employee unions or families rather than residents) |
| 5 CAGs can advocate for residents when ombudsmen can't speak out about the issues | 2 CAG is disappointed with changes ombudsman program has been able to accomplish |
| 4 Work on legislative agendas together | 1 LTCOP has not given CAGs a clear agenda for the ombudsman program |
| 4 Share information | 1 Turnover in CAGs |
| 3 Mutual respect and support | 1 CAGs don't meet regularly |
| 2 Ombudsmen have been part of CAGs in the past | 1 Advocacy groups are very effective on their own |
| 2 Formed coalitions with resident councils and family councils (both important lobbying groups) | |
| 2 Co-sponsor joint training | |
| 1 Understanding of each other's roles and limitations | |
| 1 CAG's assist by providing people | |
| 1 Identify problems the other wasn't aware of | |

## APPENDIX 3

State code _____ Date_____

### State Long Term Care Ombudsmen Program
### *Interview Protocol*

Hello, my name is _____, and I am calling from the University of California, San Francisco. As you know, we are conducting a study on the role and responsibilities of the state Long Term Care Ombudsman Program (LTCOP). The study's aim is to identify factors that contribute to effective LTCOPs as well any barriers to effectiveness. This research is funded by the Henry J. Kaiser Family Foundation and is directed by Carroll Estes, Ph.D. from the Institute for Health & Aging.

The interview will require about 45 minutes of your time. You may refuse to answer any question and may withdraw from the interview at any point.

[With regards to confidentiality: Participation in research may involve a loss of privacy; however your records will be handled as confidentially as possible. No individual or organizational identities will be used in any reports or publications resulting from this study. No information will be released to any employer, regulator, policymaker, media representative or individual associates with your agency. Study information will be coded and kept in locked files at all times. Only study personnel will have access to the files. Once the data are analyzed and the evaluation is completed, all original data will be destroyed.]

Did you sign and return your consent form?

Before we begin, please let me know if you have any questions.

**RESPONDENT INFORMATION**

*I'd like to begin by asking you a few questions about your position and your relationship to the Long Term Care Ombudsman Program (LTCOP) in your state.*

(1) What is your current position? _____

(1a) How long have you been working in this position? _____ (# years)

**ORGANIZATIONAL STRUCTURE – STATE PROGRAM**

*Next I'd like to discuss the organizational structure of your LTCOP at the state level.*

(2) Which of the following organizational structures most accurately describes where your state LTC ombudsman program is placed:

1. In an independent State Unit on Aging (SUA)
2. In an independent SUA in an umbrella agency with Licensing & Certification
3. In an independent SUA in an umbrella agency without Licensing & Certification
4. In a legal agency
5. In a nonprofit agency
6. In another state agency (Please specify): _____
7. In another arrangement (Please specify): _____
8. Don't Know (DK)
9. Refuse to Answer (RTA)

(2a) Has the organizational placement of your state LTCOP changed in the last 5 years?

1. Yes (Ask Q. 2b-c)
2. No (Skip to Q. 3)
8. DK ( " " " )
9. RTA ( " " " )

(2b) How has your organizational placement changed?

(2c) Why was this change made?

(3) Does the placement of your state LTCOP create any difficulties for your service provision (e.g. any conflicts or potential conflicts of interest; perception problems with local ombudsmen, nursing homes, residents, families)?

1. Yes (Ask Q. 3a-b)
2. No (Skip to Q. 4)
8. DK ( " " " )
9. RTA ( " " " )

(3a) What kind of difficulties does it create?

(3b) How have you dealt with these situations?

(4) On a scale of 1 to 5 with 1 being "very effective" and 5 being "very ineffective," how would you rate the effectiveness of your LTCOP at the state level?

1. Very effective
2. Somewhat effective
3. Neutral
4. Somewhat ineffective
5. Very ineffective
8. DK
9. RTA

(5) Next we have some questions regarding factors that may or may not contribute to your **state** LTCOP's effectiveness. For each factor, please respond to the yes/no question and then indicate the degree to which this factor influences the effectiveness of your LTCOP at the state level (on a scale of 1 to 5 with 1 being "positive effect" and 5 being "negative effect.")

| | Yes/No (1/2) | Positive Effect | Somewhat Positive Effect | Neutral | Somewhat Negative Effect | Negative Effect | DK | RTA |
|---|---|---|---|---|---|---|---|---|
| **Resources and Staffing:** | | | | | | | | |
| a. Does your state LTCOP have a sufficient amount of funding? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| b. Does your state LTCOP have a sufficient number of paid staff? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| c. Does your state LTCOP have a sufficient number of volunteers? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| **Autonomy:** | | | | | | | | |
| d. Are your state LTCOP's activities free from excessive legislative or regulatory restrictions? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| e. Are lines of authority and accountability clearly defined for state and local ombudsmen? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| f. Can your state LTCOP carry out federal mandates independently from other state agencies and parties? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| g. Does your state LTCOP's organizational placement allow for sufficient autonomy? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| h. Is your state LTCOP generally able to represent the interests of residents to most state agencies? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| **Communication:** | | | | | | | | |
| i. Does your state LTCOP have adequate communication methods (such as computer networks or teleconferencing) to share information with local programs? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |

| | Yes/No (1/2) | Positive Effect | Somewhat Positive Effect | Neutral | Somewhat Negative Effect | Negative Effect | DK | RTA |
|---|---|---|---|---|---|---|---|---|
| j. Does your state LTCOP have a uniform database? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| **Relationship with Other Agencies:** | | | | | | | | |
| k. Does your state LTCOP have a good working relationship with the long term care industry? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| l. Is your state LTCOP in agreement with the position of employees' unions regarding staffing practices? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| m. Does your state LTCOP have a good working relationship with the HCFA? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| n. Does your state LTCOP have a good relationship with the Licensing and Certification agency and/or survey agency? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| o. Is the political and social climate in your state supportive of your state LTCOP? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| p. Does your state LTCOP have sufficient legal service available? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| q. Are there other factors that influence your state LTCOP's effectiveness? | 1/2 | 1 | 2 | 3 | 4 | 5 | 8 | 9 |

If yes, please explain:

(6) On a scale of 1 to 5 with 1 being "very effective" and 5 being "very ineffective," how would you rate the effectiveness of LTCOPs in your state in meeting the statutorily mandated requirements, including:

| | Very Effective | Somewhat Effective | Neutral | Somewhat Ineffective | Very Ineffective | DK | RTA |
|---|---|---|---|---|---|---|---|
| a. Complaint investigation | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| b. Community education | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| c. Resident and family education | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| d. Monitoring federal, state, and local law, regulations, and other government policies and actions | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| e. Legislative and administrative policy advocacy | 1 | 2 | 3 | 4 | 5 | 8 | 9 |

(7) What is the percentage of time the LTCOPs in your state spend on nursing homes, board and care, assisted living facilities, home care, and other institutions?

| | % Time | DK | RTA |
|---|---|---|---|
| a. Nursing Homes | _____ | 8 | 9 |
| b. Board and Care facilities | _____ | 8 | 9 |
| c. Assisted Living facilities | _____ | 8 | 9 |
| d. Home Care | _____ | 8 | 9 |
| e. Other _____ | _____ | | |

(7a) What percentage of your state's nursing homes, board and care, and assisted living facilities are visited each year?

| | % Time | DK | RTA |
|---|---|---|---|
| a. Nursing Homes | _____ | 8 | 9 |
| b. Board and Care | _____ | 8 | 9 |
| c. Assisted Living | _____ | 8 | 9 |

(8) On a scale of 1 to 5 with 1 being "very effective" and 5 being "very ineffective," how would you rate your **state** LTCOP work with the following facilities?

| | Very Effective | Somewhat Effective | Neutral | Somewhat Ineffective | Very Ineffective | DK | RTA |
|---|---|---|---|---|---|---|---|
| a. Nursing Homes | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| b. Board and Care | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| c. Assisted Living | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| d. Other _____ | 1 | 2 | 3 | 4 | 5 | 8 | 9 |

**ORGANIZATIONAL STRUCTURE – LOCAL PROGRAMS**

*Next, I would like to ask you a few questions about the organizational structure of the local LTCOPs in your state.*

(9) Have the organizational placements of any of your **local** Ombudsman programs changed in the past 5 years?

1. Yes (Ask Q. 9a-b)
2. No (Skip to Q. 10)
8. DK ( " " " )
9. RTA ( " " " )

(9a) What changes have occurred in **local** program placement?

(9b) Why were these changes made?

(10) Overall, on a scale of 1 to 5 with 1 being "very effective" and 5 being "very ineffective," how would you rate the effectiveness of your **local** LTCOPs?

1. Very effective
2. Somewhat effective
3. Neutral
4. Somewhat ineffective
5. Very ineffective
8. DK
9. RTA

(11) Which of the following factors contribute to the effectiveness of **local** LTCOPs in your state?

| | Yes | No | DK | RTA |
|---|---|---|---|---|
| **Resources and Staffing:** | | | | |
| a. Amount of funding | 1 | 2 | 8 | 9 |
| b. Number of paid staff | 1 | 2 | 8 | 9 |
| c. Number of volunteers | 1 | 2 | 8 | 9 |

| | | | | |
|---|---|---|---|---|
| d. Staff and volunteer training | 1 | 2 | 8 | 9 |
| e. Employee consistency (rate of turnover) | 1 | 2 | 8 | 9 |
| f. Ability to obtain legal services | 1 | 2 | 8 | 9 |

**Relationships with Other Agencies:**

| | | | | |
|---|---|---|---|---|
| g. Organizational placement of local LTCOPs. | 1 | 2 | 8 | 9 |
| h. Quality of working relationship with Licensing and Certification agency and/or survey agency | 1 | 2 | 8 | 9 |
| i. Quality of working relationship with HCFA | 1 | 2 | 8 | 9 |
| j. Degree of collaboration/cooperation with the local nursing home providers | 1 | 2 | 8 | 9 |

**Other:**

| | | | | |
|---|---|---|---|---|
| k. Quality of working relationship with other local programs dealing with LTC | 1 | 2 | 8 | 9 |
| l. Response time to complaints | 1 | 2 | 8 | 9 |
| m. Ability to obtain needed assistance to deal with complaints | 1 | 2 | 8 | 9 |
| n. Number of visits to nursing home residents | 1 | 2 | 8 | 9 |
| o. Convenience of travel to facilities | 1 | 2 | 8 | 9 |
| p. Agency policies or protocol that allow for contact with the media or legislators | 1 | 2 | 8 | 9 |
| q. Other, please specify: | | | | |

(12) What do you see as the most important advocacy issues for **local** LTCOPs to address right now?

**INTERAGENCY COORDINATION**

*Now I would like to ask you some questions about your relationship with other organizations.*

(13) On a scale of 1 to 5, with 1 being "very effective" and 5 being "very ineffective," how would you rate the relationship between your state LTCOP and local programs?

1. Very effective
2. Somewhat effective
3. Neutral
4. Somewhat ineffective
5. Very ineffective
8. DK
9. RTA

(14) What type of support does your state LTCOP provide to its local programs? (Probe: with respect to specific complaints, broader advocacy issues, ombudsman program policies and procedures.)

(15) Do you have regular contact with local ombudsman programs to discuss advocacy issues and ombudsman policies and procedures?

1. Yes (Ans. Q. 15a)
2. No (Skip to Q. 16)
8. DK ( " " " )
9. RTA ( " " " )

(15a) What types of communication? (Circle all that apply)

1. Meetings
2. Visits
3. Newsletters
4. E-mails
5. Tele-conference calls
6. Mailings
7. Other (specify):
8. DK
9. RTA

(16) What types of assistance, if any, do you receive from your State Unit on Aging?

(17) Are there any types of assistance you would like to receive from your SUA that you are not currently receiving?

1. Yes (Ask Q. 17b)
2. No (Skip to Q. 18)
8. DK ( " " " )
9. RTA ( " " " )

(17b) What types of assistance would you like to receive?

**LEGAL ASSISTANCE**

*Next, I would like to ask you about the legal assistance your program receives.*

(18) Where does your state LTCOP get legal counsel?

(18a) What is the scope of this legal assistance? (Circle all that apply.)

1. Benefits rights advocacy
2. Entitlements
3. Civil Remedies
4. Resident advocacy
5. Other (specify): _____
8. DK
9. RTA

(19) Approximately how often did your state office seek legal advice last year?

_____times per year (Ask Q. 19a)
8. DK (Skip to Q. 20)
9. RTA (Skip to Q. 20)

(19a) On a scale of 1 to 5 with 1 being “very effective” and 5 being "very ineffective," how effective is the response of your legal advisor?

1. Very effective
2. Somewhat effective
3. Neutral
4. Somewhat ineffective
5. Very ineffective
8. DK
9. RTA

(20) Where do local LTCOPs get their legal counsel? (Circle all that apply)

1. Attorney General
2. Legal Services Attorney
3. Private Attorney
4. SUA
5. Non-SUA Umbrella
6. Title III-B Legal Services Program
7. Legal Assistance Developer
8. DK
9. RTA
10. Other: _____

(21) Approximately how many times did your state office receive calls from local ombudsman programs requesting legal assistance in the last year?

_____ times per year
8. DK
9. RTA

**CLIENTELE**
*Next I would like to ask you about your clientele.*

(22) Who is/are the target population(s) for your services? (Circle all that apply.)

1. Nursing facility residents
2. Board and Care residents
3. Assisted Living Arrangements
4. Home Care beneficiaries
5. Managed Care clients
6. Other (specify): _____
8. DK
9. RTA

**QUALITY OF CARE**

*Next, I would like to ask you some questions related to quality of care.*

(23) At the state level, what quality of care issues do you think are currently the most important for the ombudsman programs to address? (For example, incidence of new fractures, prevalence of falls, prevalence of symptoms of depression, etc. )

(23a) Is your program currently addressing (this/these) issue(s)?

1. Yes (Ask Q. 23b)
2. No (Skip to Q. 24)
8. DK ( " " " )
9. RTA ( " " " )

(23b) How are you addressing the issue(s)?

(24) Are reports of complaints related to managed care coming to the attention of the state LTCOP? (e.g., Medicare enrollees in managed care experiencing delay problems, quality of care complaints regarding Medicare, Medicaid complaints, etc.)

1. Yes (Ask Q. 24a-b)
2. No (Skip to Q. 25)
8. DK ( " " " )
9. RTA ( " " " )

(24a) What are the major complaints regarding managed care?

(24b) Is the current tracking system of managed care complaints adequate?

1. Yes
2. No
8. DK
9. RTA

(25) Is your state LTCOP advocating in the arena of managed care?

1. Yes
2. No
8. DK
9. RTA

(26) Do you anticipate that managed care will affect your state LTCOP in the future?

1. Yes (Ask Q. 26a)
2. No (Skip to Q. 27)
8. DK ( " " " )
9. RTA ( " " " )

(26a) What kind of effects do you anticipate?

(27) Based on the experience of your state agency, what is your opinion about the relationship, if any, between LTC facility staffing levels and overall quality of care?

(28) Based on the experience of your state agency, what is your opinion about the relationship, if any, between supervision in nursing facilities and overall quality of care?

**FUNDING**

*Next, I would like to ask you a few questions about your program's funding.*

(29) Over the past three years (FY1997-98; 1998-99; 1999-2000) was your agency's budget for its LTCOP:

| | Yes | No | DK | RTA |
|---|---|---|---|---|
| a. Adequate to fund the *federal* requirements for the LTCOP? | 1 | 2 | 8 | 9 |
| b. Adequate to fund the *state* requirements for the LTCOP? | 1 | 2 | 8 | 9 |

(If no to either a or b, ask Q. 29c-e)
(If yes/DK/RTA to both a &b, skip to Q. 30)

(29c) Which activities were neglected or partially carried out because of lack of funds?

(29d) How much additional funding would your state LTCOP need to carry out these requirements?

(29e) What are the major obstacles to getting the funding you need?

(30) Are there any additional state mandates (either funded or unfunded) that increase cost to the ombudsman program? (e.g. home care ombudsmen, etc.)

1. Yes (Ask Q. 30a)
2. No (Skip to Q. 31)
8. DK ( " " " )
9. RTA ( " " " )

(30a) What are these state mandates?

(31) Is your current year's budget more, less, or about the same as last year's budget?

1. More (Ask Q. 31a)
2. Less (Ask Q. 31b)
3. About same (Skip to Q. 32)
8. DK ( " " " )
9. RTA ( " " " )

(31a) What effect has this budget increase had on your program? (Skip to 32)

(31b) What effect has this budget decrease had on your program?

(32) Has the composition of your state LTCOP funding sources changed significantly in the last 3 years?

1. Yes (Ask Q. 32a-c)
2. No (Skip to Q. 33)
8. DK ( " " " )
9. RTA ( " " " )

(32a) How has it changed?

(32b) What caused the change in funding sources?

(32c) What effect, if any, have funding source changes had on your state LTCOP?

**STAFFING**

*Next I would like to ask you a few questions about staffing.*

(33) Has the number of paid full-time or full-time equivalent staff in your state program increased, remained the same, or decreased in the last 2 years?

1. Increased (Ask Q. 33a-b)
2. Remained the same (Skip to Q. 34)
3. Decreased (Ask Q. 33c-d)
8. DK (Skip to Q. 34)
9. RTA (Skip to Q. 34)

(33a) In what areas did staff increases occur? (e.g., administrative, direct services, etc.)

(33b) What was the reason for the increase? (Skip to Q. 34)

(33c) In what areas of staffing did reductions occur? (e.g., administrative, direct services, etc.)

(33d) What was the reason for the decrease?

(34) Has the number of volunteers in your state LTCOP increased, remained the same, or decreased in the last 2 years?

1. Increased (Ask Q. 34a-b)
2. Remained the same (Skip to Q. 35)
3. Decreased (Ask Q. 34c-d)
8. DK (Skip to Q. 35)
9. RTA (Skip to Q. 35)

(34a) In what areas did volunteer staff increases occur? (e.g., administrative, direct services, etc.)

(34b) What was the reason for the increase? (Skip to Q. 35)

(34c) In what areas did volunteer staff reductions occur? (e.g., administrative, direct services, etc.)

(34d) What was the reason for the decrease?

(35) Are volunteer ombudsmen and paid staff ombudsmen roles differentiated?

1. Yes (Ask Q. 35a)
2. No (Skip to Q. 36)
8. DK (Skip to Q. 36)
9. RTA (Skip to Q. 36)

(35a) How are the volunteer and staff ombudsmen roles differentiated?

1. On a scale of 1 to 5 with 1 being "very low" and 5 being "very high," please describe the turnover of the following groups in the last two years:

| | Very Low | Somewhat Low | Neutral | Somewhat High | Very High | DK | RTA |
|---|---|---|---|---|---|---|---|
| a. Paid staff | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| b. Volunteers | 1 | 2 | 3 | 4 | 5 | 8 | 9 |
| c. Other_____ | 1 | 2 | 3 | 4 | 5 | 8 | 9 |

(37) Does your program meet the 1995 Institute of Medicine recommendation of one paid full-time equivalent staff member for each 2000 nursing facility beds?

1. Yes (Skip to Q. 38)
2. No (Ask Q. 37a)
8. DK (Skip to Q. 38)
9. RTA ( " " " )

(37a) Why was this recommendation not met?

(38) What is the ratio of full-time equivalent staff to beds? _____staff/ _____beds

**POLITICAL INFLUENCES**

*I would like to ask you a few questions about political influences on your state LTCOP.*

(39) Is there any legislation currently being proposed in your state that will affect your state LTCOP?

1. Yes (Ask Q. 39a-b)
2. No (Skip to Q. 40)
8. DK ( " " " )
9. RTA ( " " " )

(39a) What is that legislation?

(39b) In what ways will it affect your program?

(40) Are there any barriers (or impediments) at the state *or* federal level that keep you from carrying out your job as you think it should be done?

1. Yes, **state**
2. Yes, **federal**
3. No
8. DK
9. RTA

(41) Please indicate whether the following factors influence the effectiveness of political advocacy in your state:

| | Yes | No | DK | RTA |
|---|---|---|---|---|
| a) Problems with strong industry lobby<br>If yes, please explain: | 1 | 2 | 8 | 9 |
| b) Problems with either State Unit on Aging or Area Agency on Aging<br>If yes, please explain: | 1 | 2 | 8 | 9 |
| c) Problems with regulatory agencies<br>If yes, please explain: | 1 | 2 | 8 | 9 |

| | Yes | No | DK | RTA |
|---|---|---|---|---|
| d) Perception that aging network is apathetic to the plight of the institutionalized aged | 1 | 2 | 8 | 9 |
| If yes, please explain: | | | | |
| e) Lack of clear guidance on how to advocate for special populations (e.g., persons with disabilities, dementia clients) | 1 | 2 | 8 | 9 |
| If yes, please explain: | | | | |

Other, please explain:

(42) On a scale of 1 to 5 with 1 being "very effective" and 5 being "very ineffective," how would you rate your relationship with citizen's advocacy groups?

1. Very effective
2. Somewhat effective
3. Neutral
4. Somewhat ineffective
5. Very ineffective
8. DK (Skip to Q. 43)
9. RTA ( " " " )

(42a) What makes your relationship with advocacy groups [answer from above] ?

(43) In regard to the recent Supreme Court decision Olmstead v. L. C., which state agency or individual agent oversees how the decision is implemented by your state LTCOP?

_____

(43a) What kind of influence or effect has the Olmstead decision had on your state LTCOP?

**OTHER ISSUES**
*I have two final questions to ask you.*

(44) What influence, if any, has the 1995 Institute of Medicine report had on your state or local ombudsman programs?

(45) Can you suggest anyone else from your state or local programs we should contact to give us a more complete understanding of the Ombudsman issues in your state?

***Thank you very much for taking the time and effort to complete this important survey. We appreciate your participation.***

(46) *Do you have any recommendations of state reports that should be reviewed for this study?*

(47) *May we be in contact with you to receive further clarification of your responses?*

1. Yes
2. No

(48) *Would you be interested in reviewing our draft analysis?*

1. Yes
2. No

(49) *Finally, would you like to receive a copy of the summary report when it is complete?*

1. Yes
2. No

# GLOSSARY OF TERMS

| | |
|---|---|
| AAA | Area Agency on Aging |
| AARP | American Association of Retired Persons |
| AoA | Administration on Aging |
| APS | Adult Protective Services |
| CAG | Citizen's Advocacy Group |
| CNA | Certified Nurse Assistant |
| FTE | Full-Time Equivalent |
| HCFA | Health Care Financing Administration |
| IHA | Institute for Health & Aging |
| IOM | Institute of Medicine |
| LTC | Long Term Care |
| LTCOP | Long Term Care Ombudsman Program |
| NALLTCO | National Association of Local Long Term Care Ombudsman |
| NASOP | National Association of State Long Term Care Ombudsman Programs |
| NASUA | National Association of State Units on Aging |
| NCCNHR | National Citizens' Coalition for Nursing Home Reform |
| NORS | National Ombudsman Reporting System |
| OAA | Older Americans Act |
| OIG | Office of Inspector General |
| SUA | State Unit on Aging |