



## The Role of Ombudsmen in Assuring Quality for Residents of Long-Term Care Facilities: Straining to Make Ends Meet

BACKGROUND  
PAPER NO. 71

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OVERVIEW — *Assuring quality of care for residents in long-term care facilities has been a serious and continuing concern of policymakers for decades. The Older Americans Act's long-term care ombudsman program is a consumer advocacy model intended to improve quality of care by helping the 2.5 million residents of almost 67,000 nursing and other residential care facilities resolve complaints about their care and protect their rights. Despite broad recognition of its value in assisting residents and its efforts to complement federal and state oversight of long-term care facilities, some observers are concerned about the program's ability to meet its legislative mandates. Limited funding affects the ability of many states to meet minimum staffing goals recommended by the Institute of Medicine (IOM). Also, in most states, ombudsmen do not conduct regular quarterly visits to long-term care facilities. This background paper discusses the role of long-term care ombudsmen and highlights selected issues regarding the capacity of the program to promote quality care and advance the rights of residents.*

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Unanswered calls for help, improper medication administration, discharge or eviction without proper notice, lack of respect for residents, unsafe buildings or equipment—these are complaints made by some of the 2.5 million residents of nursing and other residential care facilities to state and local long-term care ombudsmen across the nation. The long-term care ombudsman program is a consumer advocacy model intended to improve quality of care by helping residents of nursing homes and other residential care facilities resolve complaints about their care and rights. It was established as part of the Older Americans Act in 1978 and is administered by the U.S. Administration on Aging (AoA).

Despite significant public and private spending for care in nursing homes and other residential care facilities, assuring quality of care and resident rights has been a serious and continuing concern of long-term care consumers and policymakers for decades. Almost as soon as nursing facility care became a benefit under Medicare and Medicaid in 1965, Congress began to be concerned about the quality of care provided by these facilities. Between 1969 and 1976, it held 30 hearings on problems in the nursing home industry and in 1987 passed landmark nursing home reform legislation to address concerns about nursing home quality and resident rights. Oversight of implementation of the legislation continues today with frequent congressional reports and hearings, including a series of reports by the Government Accountability Office (GAO).<sup>1</sup> Policymakers have also been concerned about oversight of quality of care and resident rights in other residential care settings, such as assisted living facilities.<sup>2</sup>

The ombudsman program aims to improve the quality of life and care in facilities by assisting residents to resolve complaints about care they receive and assuring that their rights are protected. Ombudsmen complement efforts of federal and state staff who, under statute and/or regulation, are required to review and enforce nursing home quality of care. Many analysts and practitioners believe that the program's ability to meet its full potential as a robust consumer advocacy program is constrained by limited resources. Fiscal constraints affect the

### **Ombudsman Program History Under the Older Americans Act of 1965**

The long-term care ombudsman program began as a Public Health Service demonstration in 1972. It was given statutory authority in the Act's 1978 amendments that required all states to establish programs. In 1987, Congress added a specific authorization of funds for the program. And in 1992, Congress added a new title to the Act for vulnerable elder rights protection activities, which include ombudsman activities.

ability of many states to meet minimum staffing goals recommended by the Institute of Medicine (IOM) and of ombudsmen to conduct regular quarterly visits to long-term care facilities.

### TRENDS IN NURSING HOMES AND OTHER RESIDENTIAL CARE FACILITIES

About 1.5 million residents live in more than 16,000 nursing facilities.<sup>3</sup> The nation spends a substantial amount on nursing home care: about 6 percent (\$131.3 billion) of the more than \$2 trillion spent on health care in 2007 was for nursing home care. The federal-state Medicaid program accounted for over 42 percent of all nursing home spending; the next largest share (27 percent) was paid out-of-pocket by individuals and families.<sup>4</sup>

The nursing home population is exceedingly frail. According to the 2004 National Nursing Home Survey, over three-quarters of residents had four or more limitations in activities of daily living (ADLs), and more than half were either totally dependent or required extensive assistance in bathing, dressing, toileting, and transferring. Just under half of residents took nine or more medications. About 56 percent of nursing home residents resided in the facility for at least one year or more.<sup>5</sup> In June 2009, about 47 percent of residents had a diagnosis of dementia.<sup>6</sup>

In addition to traditional nursing homes, about 50,000 other residential care facilities provide room, board, and supportive services to about one million people who may not have sustained nursing needs but need some assistance with their ADLs.<sup>7</sup> Depending upon state policy and practice, these settings are referred to as assisted living facilities, adult foster care homes, group homes, supportive living arrangements, board and care homes, personal care homes, and community residential settings, among many others. (For purposes of this background paper, facilities that are not nursing homes will be referred to as residential care facilities.) Financing for care in residential care facilities comes from a host of sources, including out-of-pocket payments from individuals, state and local funds, and Medicaid.

In response to older consumers' preference for more home-like settings and privacy than are found in many traditional nursing homes, the residential care market has burgeoned with newer assisted living models in recent years. Between 1990 and 2002, the supply of licensed residential care beds increased by 97 percent; in comparison,

the number of licensed nursing home beds increased by 7 percent.<sup>8</sup> While residents of assisted living are, on average, less frail than those in nursing homes, a sizable proportion need substantial assistance; a recent survey of assisted living facilities showed that 42 percent of residents needed assistance with two or more ADLs.<sup>9</sup> The presence of cognitive disabilities is often one of the key factors leading to admission to an assisted living facility; estimates of the proportion of assisted living residents who have Alzheimer's disease or other dementia range from 45 percent to 67 percent.<sup>10</sup>

## ASSESSING QUALITY IN LONG-TERM CARE FACILITIES

Both federal and state governments have major responsibilities for oversight of care in nursing facilities. Nursing facility standards are established by federal law and regulation. State and local governments have responsibility for establishing standards for, and oversight of, residential care facilities.

### OBRA Requirements for Nursing Facilities

The primary way the federal government reviews quality of care in Medicare- and Medicaid-certified nursing facilities is by assessing facility compliance with federal conditions of participation required by the Omnibus Budget Reconciliation Act (OBRA) of 1987 and subsequent amendments. The OBRA survey and certification requirements for nursing facilities are focused on resident care, quality of life, nursing services, and transfer and discharge rights, among other things. The federal government contracts with states to perform surveys of facilities to determine their compliance with federal requirements. States are required to conduct surveys on each nursing facility at intervals of not more than 15 months, with the statewide average interval between surveys not to exceed 12 months (see text box).

A host of investigations by GAO has documented many serious quality problems in nursing facilities as well as inadequate federal

### Medicare and Medicaid Nursing Facility Survey and Certification Requirements

OBRA 1987 and subsequent amendments and Centers for Medicare & Medicaid Services (CMS) regulations define quality standards that nursing facilities must meet in order to participate in Medicare and Medicaid. Nursing facilities are subject to surveys to determine their compliance with standards in 15 categories, such as resident care, quality of life, resident assessment, quality of care, transfer and discharge rights, resident behavior and facility protocols, and nursing services. Nursing facility surveys must be unannounced and must be conducted on each nursing facility at least every 15 months, with a statewide average interval between surveys not to exceed 12 months. Facilities with poor histories of compliance with quality standards may be surveyed more frequently. The survey process is conducted by a team that may include nurses, social workers, pharmacists, and others. Survey inspections are required to be resident-centered and outcome-oriented. CMS contracts with state agencies that conduct the surveys.

*Source: CMS, "Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities," State Operations Manual, chap. 7, rev. 1, May 21, 2004; available at [www.cms.hhs.gov/manuals/downloads/som107c07.pdf](http://www.cms.hhs.gov/manuals/downloads/som107c07.pdf).*

and state oversight of facility deficiencies.<sup>11</sup> GAO has found that a substantial proportion of surveys understate serious care problems in nursing facilities and miss deficiencies involving poor quality of care. Quality of care issues that come up between the 15-month visit cycles may not be picked up by surveyors, unless complaints come to their attention in the interim. GAO has pointed to weaknesses in state surveyors' investigative skills and their ability to integrate and analyze information to make a deficiency determination.<sup>12</sup> Federal funding and state staff surveyor shortages hamper investigations of facilities. GAO found that funding for surveys of all health care facilities, including nursing facilities, which comprise most of the survey workload, fell by 9 percent, in inflation-adjusted terms, from fiscal year (FY) 2002 through FY 2007.<sup>13</sup>

### State Oversight of Residential Care Facilities

Oversight of quality of care and resident rights in residential care facilities is the province of state and local governments, which are responsible for regulation, licensure and inspection. Federal oversight of state quality measures and enforcement activities is minimal.<sup>14</sup> Generally, there is variation among states, and sometimes within states, in the use of terminology that applies to residential care facilities. Some states have varying levels and types of residential care that may target multiple population groups, for example, the elderly and people with physical, cognitive, or intellectual disabilities. Requirements for assuring quality vary widely, and often oversight responsibilities are shared among multiple state and local agencies.

### LONG-TERM CARE OMBUDSMAN PROGRAM: A CONSUMER ADVOCACY MODEL

The Older Americans Act long-term care ombudsman program addresses quality of care and resident rights in nursing facilities and other residential care facilities through consumer advocacy. The long-term care ombudsman role grew out of the classic ombudsman model conceived by the Swedish parliament in the 19th century, in which a neutral party intercedes between a citizen and a governmental entity or other form of authority. Unlike the classic model, the long-term care ombudsman function stresses active advocacy and representation on behalf of long-term care facility residents. Ombudsmen may intercede



with providers on behalf of residents in areas related to the quality of life, care, and rights.<sup>15</sup>

Since 1978, the Older Americans Act has required states to establish long-term care ombudsman programs to advocate for and protect the rights of long-term care facility residents. Ombudsmen are charged with advocating for individual residents by identifying, investigating, and resolving complaints that adversely affect their health, safety, welfare, or rights—a function known as individual advocacy. They are also required to carry out broader functions through systems advocacy by representing the interests of residents before governmental agencies, seeking administrative and legal remedies to protect their rights, and monitoring the implementation of laws and regulations affecting residents. Examples of systems advocacy include efforts of state ombudsmen during discussions leading up to the OBRA 1987 nursing home reform requirements and subsequent implementation of the reforms by states; state activities to establish standards for assisted living facilities; and efforts to advocate for wider availability of community alternatives to divert people from nursing homes.<sup>16</sup> (See text box for a list of legislated functions of long-term care ombudsmen.)

The Older Americans Act charges ombudsmen with complaint investigation and resolution in nursing facilities as well as a vast array of other residential care facilities. In FY 2008, slightly more

### Functions of the State Ombudsman As Set Out in the Older Americans Act of 1965

“The state long-term care ombudsman shall serve on a full-time basis, and shall, personally or through representatives of the Office”:

- Identify, investigate, and resolve complaints made by residents that relate to action, inaction, or decisions by long-term care and health and social providers or public agencies that adversely affect resident health, safety, welfare, or rights
- Provide services to help residents protect their health, safety, welfare, and rights
- Inform residents about means of obtaining services provided by long-term care and health and social service providers or public agencies
- Ensure that residents have regular and timely access to ombudsman services and that residents and complainants receive timely responses to their complaints from ombudsman representatives
- Represent the interests of residents before governmental agencies and seek administrative, legal, and other remedies to protect residents’ health, safety, welfare, and rights
- Provide administrative and technical assistance to local ombudsman entities
- Analyze, comment on, and monitor the development and implementation of federal, state, and local laws, regulations, and other governmental policies and actions that pertain to residents’ health, safety, welfare, and rights, with respect to the adequacy of long-term care facilities and services in the state
- Recommend changes to, and facilitate public comment on, laws, regulations, policies, and actions affecting residents
- Train representatives of the ombudsman
- Promote development of citizen organizations and resident and family councils to protect the well-being and rights of residents

*Source: Adapted from the Older Americans Act of 1965, Title VII, Section 712(a)(3).*

than 1,300 ombudsmen (full-time equivalent, or FTE, staff) were responsible for working to resolve complaints of residents of 67,000 nursing and other residential care facilities that had over 2.5 million residents. The program operates in all states, the District of Columbia, and Puerto Rico. In most states, the program is administered by state agencies on aging; most of the 572 local ombudsman programs are administered by area agencies on aging under the direction of state ombudsmen.<sup>17</sup>

States are required to ensure that ombudsmen have access to residents and their medical and social records if the resident or his or her legal representative grants permission or if it is necessary to investigate a complaint when the resident is unable to grant permission, as well as access to facility administrative records and policies. To ensure that ombudsmen are independent and have the freedom to carry out their consumer advocacy role, programs must be separate from agencies that regulate, license, or certify long-term care services and from associations of long-term care facilities. States are required to prohibit long-term care facilities from retaliating or making reprisals in the event that residents, employees, or others file a complaint investigated by the program, and to prohibit any interference with ombudsmen who carry out their official duties. State agencies must provide ombudsmen with legal counsel to assist them in carrying out their official functions and in the event that legal actions are taken against them.

### **Ombudsman Presence in Facilities: Heart of the Program**

Key to the ombudsman function is regular facility and resident visitation by paid and volunteer ombudsmen. The AoA has defined regular visitation as no less than quarterly.<sup>18</sup> Through their visits, ombudsmen can act as sentinels regarding quality of care and resident right issues. Their interactions and familiarity with residents can potentially alert facility staff to issues before they become actual complaints. Their visits to facilities may act as a deterrent to issues negatively affecting the quality of care and the lives of residents and prevent the need for costly interventions by state officials later. Ombudsman availability in facilities can assist residents and family members in knowing how and when to report concerns about quality and about abuse and neglect and in making reports promptly.



Ombudsmen stress the importance of their role as representatives of the community in facilities and the personal connection that they have with residents. Some describe the “watchdog” function of ombudsmen as crucial in assisting older people who are too frail or afraid to draw attention to problems with their care. Because many nursing home residents do not have informal support systems or families and friends who visit regularly, an independent advocate can play a critical role in helping residents with their care and rights.

Although investigation and resolution of complaints are their primary responsibilities, ombudsmen also play other roles, such as educating residents and families about resident rights and acting as mediators between residents and facility staff and government agencies.<sup>19</sup> They may also assist residents who are making the transition from nursing homes to home or to other nonfacility care and play a role in state programs that seek to prevent people from entering nursing homes. These efforts have taken on added significance with the Centers for Medicare & Medicaid Services’ (CMS’) national implementation of the Money Follows the Person Medicaid demonstration program, which is designed to transition nursing home residents from facilities to their own homes or other home and community-based settings, and with the establishment of AoA nursing home diversion, or community living, programs in several states.<sup>20</sup> As federal and state governments expand home and community-based services and nursing home transition efforts, ombudsmen may be expected to step up the intensity and scope of their activities in these areas in the future. Beyond facility complaint investigation and resolution, some state ombudsmen also extend services to home care recipients. However, these services are not among the ombudsman activities financed by the Older Americans Act; states that carry out these activities do so with funding from sources other than those designated for federally authorized ombudsman activities.<sup>21</sup>

## RESIDENT COMPLAINT INVESTIGATION

Both CMS, through state agencies, and AoA, through ombudsmen, have responsibilities for investigating and collecting information on resident complaints in nursing facilities, though the scope of their responsibilities differs. State ombudsmen have responsibilities for investigation of complaints in residential care facilities; this

information is reported to AoA, along with nursing facility complaint information.

### CMS Complaint Investigation Procedures

Medicare and Medicaid statutes require states, under contract with CMS, to maintain procedures and staff to investigate and report on nursing home complaints they receive about Medicare- or Medicaid-certified facilities.<sup>22</sup> Complaint investigations are intended to be a response system for health and safety concerns and allow states to evaluate the quality of care between survey and certification visits.<sup>23</sup> States are required to investigate complaints alleging immediate resident jeopardy within two business days and those alleging serious harm within 10 business days. State investigators must consult with ombudsmen to determine if they have substantiated any complaints similar to those reported to state investigators.<sup>24</sup>

A 1999 GAO report found that state complaint investigation procedures were inadequate. It indicated that states understated serious complaints and failed to investigate complaints promptly and that state reporting systems did not collect timely, consistent, or complete information.<sup>25</sup> In response to GAO recommendations for more timely state investigations of serious complaints and for stronger federal monitoring of state investigations, CMS has taken a series of steps to address complaint investigation procedures. These have included instructions to states to investigate complaints within 10 business days of receipt as well as requirements for in-facility complaint investigation. CMS has also instructed states to notify local law enforcement agencies and/or Medicaid Fraud Control Units of allegations or confirmation of abuse. In efforts to strengthen federal oversight of state investigation procedures, CMS implemented a national automated complaint tracking system in 2004.<sup>26</sup> Continuing reporting problems exist, according to a 2009 GAO review. Further, state officials say that inadequate funding hampers their complaint investigations.<sup>27</sup>

### Ombudsman Complaint Investigation: Reports to the AoA

The ombudsman role in investigating resident complaints is to advocate for residents regarding their care and rights. While their efforts may complement the role of federal and state surveyors, ombudsmen do not enforce the federal OBRA nursing home reform requirements and cannot sanction facilities for poor performance.

Ombudsmen are required to report complaint data to AoA as part of its National Ombudsman Reporting System (NORS).<sup>28</sup> AoA collects data on over 100 types of resident complaints. In FY 2008, ombudsmen investigated about 272,000 complaints.<sup>29</sup> Table 1 shows the complaint types that fall within about the top 25 percent of all complaints reported. The complaints shown are the most frequent types in recent years, although the frequency changes slightly from year to year.

Many of the complaints about both nursing homes and residential care facilities reported to AoA related to inadequate or unresponsive staff. Most frequent complaints were related to staff failure to respond to resident requests for assistance; food service lacking in quality, quantity or variation; failure to properly plan for discharge

**TABLE 1**  
**Top Six Complaints Reported to State Long-Term Care Ombudsmen by Residents of Nursing Homes and Other Residential Care Facilities, 2008**

| Rank | Nursing Homes   | Rank | Residential Care Facilities   |
|------|---|------|---|
| 1    | Failure to respond to resident requests for assistance*   | 1    | Food service lacking in quality, quantity, variation, choice; lack of timely delivery and removal of food trays |
| 2    | Failure to properly plan for resident discharge or eviction†  | 2    | Failure to properly administer medication§  |
| 3    | Lack of respect for residents‡  | 3    | Failure to properly plan for resident discharge or eviction†  |
| 4    | Food service lacking in quality, quantity, variation, choice; lack of timely delivery and removal of food trays | 4    | Equipment or building in disrepair or hazardous, inadequate safety procedures, including fire safety            |
| 5    | Failure to properly administer medication§  | 5    | Lack of respect for residents‡  |
| 6    | Failure to assist residents with personal hygiene, grooming, and dressing¶                                      | 6    | Cleanliness, pests, general housekeeping**  |

\*Includes, for example, requests unanswered or not answered in a timely manner.

† Includes, for example, discharge or eviction to an inappropriate environment; notices not given to resident, representative, or ombudsman or not given on a timely basis; notices improperly documented; and level of care change made against resident's will.

‡ Includes, for example, resident being treated with rudeness, indifference or insensitivity.

§ Includes, for example, medications not given on time or not at all; medication administered improperly, not secured, or improperly labeled.

¶ Includes, for example, resident not bathed in a timely manner, not clean, not bathed at all, allowed to remain in soiled clothing, diaper, bed, chair; hands and face not washed after meals; teeth/dentures not cleaned.

\*\* Includes, for example, uncleanliness or pests (insects, vermin) in resident's room or other facility area; ant, snake, rat, or mosquito bites.

Source: Administration on Aging, "Top 20 Complaints by Category for Nursing Facilities" and "Top 20 Complaints by Category for Board and Care Facilities," 2008 National Ombudsman Reporting System Data Tables; available at [www.aoa.gov/AoARoot/AoA\\_Programs/Elder\\_Rights/Ombudsman/National\\_State\\_Data/2008/Index.aspx](http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/National_State_Data/2008/Index.aspx). AoA collects complaint types in over 100 categories; the complaints shown are the most frequent types in recent years, although the frequency has changed slightly from year to year. The table presents complaints in about the top 25 percent of all complaints made.

### EXAMPLE: Ombudsman Complaint Investigation Regarding Quality Care

When Mrs. Brown visited her husband in the nursing home, she discovered him sitting naked and unattended in the shower stall, while the aide was talking on her cell phone. Mrs. Brown was upset that Mr. Brown, who was confused due to Alzheimer's disease, was not receiving the assistance he needed. She noted there was a bruise on his back and no one had provided her with an explanation of its origin....When she didn't receive the response she needed from facility staff, Mrs. Brown asked the ombudsman for help. With Mrs. Brown's permission, the ombudsman reviewed Mrs. Brown's concerns with the Director of Nursing, who started investigating the unattended shower issue and the bruising. Later that week, the Office of Regulatory Services was conducting a standard survey, so the ombudsman and Mrs. Brown described their concerns to the surveyors. The surveyors substantiated Mrs. Brown's concerns, citing several violations of federal regulations by the nursing home. The facility took disciplinary actions with staff who had failed to meet Mr. Brown's needs.

*Source: Georgia Department of Human Resources, Office of the State Long-Term Care Ombudsman, "Ombudsmen Advocate for Quality Care," in Ombudsman Long-Term Residents' Advocate: 2008 Annual Report, p. 9; this and other examples available at [www.georgiaombudsman.org/docs/AnnualReport.pdf](http://www.georgiaombudsman.org/docs/AnnualReport.pdf).*

or eviction; failure to properly administer medications; and accidents or injuries of unknown cause. A recurring issue is the unplanned or improper discharge of residents. Ombudsmen report that discharge notices are not given on a timely basis or are improperly documented or that a level of care change is made against the resident's will. Ombudsmen interviewed for this paper indicated that, especially in the case of residential care facilities, discharges are frequently made because the person's care needs go beyond what the facility can provide.<sup>30</sup> In some cases, state law prohibits facilities from keeping residents whose needs cannot be met. (See text boxes on this and following pages for examples of ombudsman complaint investigations and assistance.)

## OMBUDSMAN PROGRAM CAPACITY

A consumer advocacy model in which ombudsmen have direct access to residents and maintain a regular presence in facilities has the potential to produce more immediate improvements in resident care than less frequent state surveys and inadequate complaint systems. Ombudsmen's interactions with residents may prevent quality issues from becoming serious complaints and can serve as an alarm system, alerting facility administrators and nursing staff to problems on a real-time basis. Some nursing home administrators work closely with ombudsmen to anticipate and resolve resident care and rights issues. Although ombudsmen are responsible for maintaining regular visits to facilities, the scope of their activities and implementation of their functions varies by state.

Ombudsman visits to nursing facilities and their access to residents have the potential to strengthen and complement efforts of federal

and state surveyors. State survey agencies are required to notify ombudsmen when surveyors will be in facilities and to obtain any information about facilities and complaints ombudsmen want to share with the survey team. After the survey is completed, state surveyors are required to notify ombudsmen of nursing facilities' noncompliance with survey and certification requirements and any adverse actions taken against facilities. State survey agencies must have a written policy that establishes a process for sharing information between the agencies and state ombudsmen.<sup>31</sup>

Despite broad recognition of the ombudsman program's potential to assist thousands of residents and to complement federal and state oversight of facilities, some observers indicate that its ability to meet its legislative mandates is severely restricted by its limited resources. The most extensive national evaluation of the program was conducted by the IOM in 1995. The report, which reviewed the extent of compliance with federal mandates, program effectiveness, and adequacy of resources to operate the program, concluded that that the program "serves a vital public purpose" and has improved the long-term care system. However, the report pointed out that not all long-term care facility residents had meaningful access to the program, the degree of implementation was uneven within and among states, and the program lacked sufficient resources to fulfill its basic mission.<sup>32</sup>

Other than the rather dated IOM study, there has not been another major national evaluation of the program. A 1998 study on ombudsman program capacity by the Office of the Inspector General (OIG) at the U.S. Department of Health and Human Services also pointed to the value of the program in promoting quality of care but echoed

#### **EXAMPLE: Ombudsman Assistance Regarding a Resident's Legal Rights**

In October 2007, the [North Dade, Florida] ombudsman office received a complaint from a resident of an assisted living facility with about 120 residents. Several months prior, Dade County's guardianship program had temporarily placed her in the facility for her safety. She stated that she was removed from her home under the allegation that she was unable to care for herself. The resident stated that all of her valuables...were removed from her home by the guardian and a social worker. According to the resident and the facility's administrator, the guardian never visited the facility. The case was assigned to an ombudsman who...contacted the resident and initiated the process to restore the resident's legal rights. The ombudsman guided the resident through the legal process, and they appeared in front of the probate judge to discuss the resident's request for restoration of her rights. Upon hearing the resident's story and corroborating testimony from a medical doctor, the judge restored all of the resident's rights and ordered the county guardianship program to return all of her belongings immediately...Upon contacting the resident for follow-up, the ombudsman confirmed that she had moved to a new apartment, but many of her belongings were still missing. The ombudsman helped her make arrangements to receive guidance from the local Legal Aid office on how to recoup the remainder of her personal items.

*Source: "Florida's Long-Term Care Ombudsman Program: Our Two Cents Is No Small Change," Annual Report 2007–2008, p. 18; this and other examples available at [www.ltombudsman.org/sites/default/files/norc/FL-0708-AnnualReport.pdf](http://www.ltombudsman.org/sites/default/files/norc/FL-0708-AnnualReport.pdf).*

the IOM concerns about program capacity and funding. The OIG recommended that AoA develop guidelines for a minimum level of program visibility that include criteria for frequency and length of visits and highlight strategies for recruiting, training, and supervising additional volunteers.<sup>33</sup> Another study that interviewed ombudsmen about their perceived effectiveness also pointed to concerns about program capacity.<sup>34</sup>

### Federal Funding

In FY 2008, total program support was \$86.4 million (see Figure 1, next page). State and local sources provide 42 percent of this funding, well over the amount required by federal law to receive federal matching funds.<sup>35</sup> Because of the significant contributions of unpaid ombudsman volunteers, the program's effective resources are higher.

#### **EXAMPLE: Ombudsman Complaint Investigation Regarding Involuntary Resident Discharge or Transfer**

In FY 2008, the Washington State Ombudsman Program received over 700 complaints regarding nursing home or assisted living residents' discharges or transfers. This was a 47 percent increase from the previous year. Included in those complaints were reports of death, diminished quality of life caused from losing connections with friends and family, depression, anxiety, anger, fearfulness, confusion, sleep disturbance, weight loss, unexplained seizures and increased hospitalization. Residents were involuntarily discharged from assisted living facilities, primarily as a result of assisted living facilities' decisions to no longer accept Medicaid payment for personal care services provided to residents, even though the residents' needs had not changed. The program had some legislative success in helping to enact a state law that now prevents assisted living facilities from involuntarily discharging their current residents on Medicaid when the facility chooses to terminate their Medicaid contracts. The state ombudsman program was also successful in securing nursing home residents' return to facilities by prevailing at hearings before an administrative law judge.

*Source: Louise Ryan, Washington State Ombudsman Program, e-mail communication with author, November 6, 2009.*

The program receives Older Americans Act funds from two sources:

- Separate federal appropriations under Title VII—one for ombudsman services and one for elder abuse prevention, from which a small percentage is used for ombudsman services. These sources represented 21 percent of all funds for the ombudsman program in FY 2008.
- A portion of Title III supportive services appropriations designated by state and area agencies on aging for use by the ombudsman program. (The Title III supportive services appropriation funds many different services, including information and assistance, and home and community-based services; with a few exceptions, states have wide discretion in determining how to spend Title III funds.) Title III represented 31 percent of funds for the ombudsman program in FY 2008.

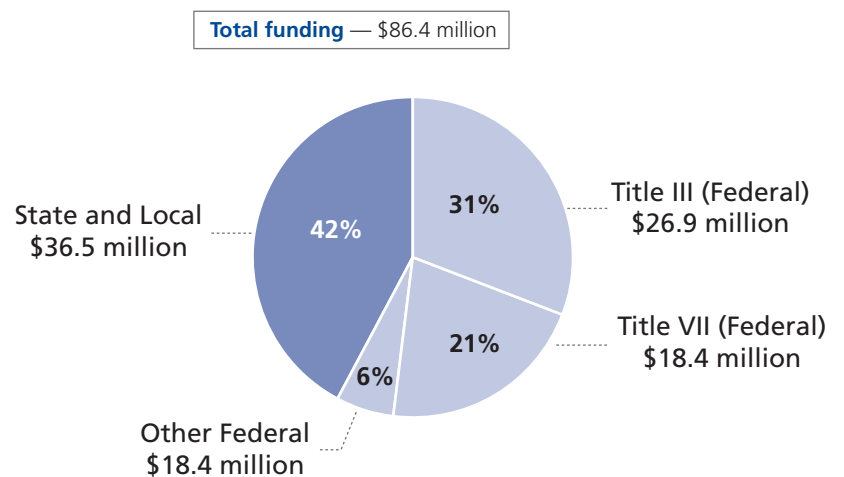


### Wide State Variation in Funding

The amount spent by the program nationally from both federal and state sources is the equivalent of about \$30 per bed annually. Twenty-nine states and the District of Columbia spent the same as or more than the national average of \$30 per bed. But per bed spending across all states varies widely, ranging from \$6.27 per bed in Nebraska to \$131.61 in Alaska. The variation in per bed spending is strongly affected by how much each state supplements the federal funds. Variation in per bed spending also is affected by the number of beds each state has.

The formula for distributing Older Americans Act funds is based on a state's proportionate share of the population age 60 and older, not on the number of beds.<sup>36</sup> Some state officials have suggested that the formula allocation method be reviewed when the Older Americans Act is considered for reauthorization by Congress in 2011.<sup>37</sup> Other formula factors have been considered in the past. The 1995 IOM report suggested that the formula be revised to account for the number, size, and type of long-term care facilities across states and for variations in state economic factors.<sup>38</sup> A formula factor based on the number of beds in each state could pose implementation difficulties because of a potential lack of accurate data, especially for residential care facilities, and variations in facility occupancy levels across states.

**FIGURE 1** Long-Term Care Ombudsman Program Funding Sources, FY 2008



Source: Administration on Aging, "2008 National Ombudsman Reporting System Data Tables," Table A-9; available at [www.aoa.gov/AoARoot/AoA\\_Programs/Elder\\_Rights/Ombudsman/National\\_State\\_Data/2008/Index.aspx](http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/National_State_Data/2008/Index.aspx).

### Staffing Goals and Regular Visitation

The 1995 IOM study recommended that the ombudsman program's staffing ratio be at least one paid FTE staff member to every 2,000 beds.<sup>39</sup> This staffing level is still the recommended measure used to assess program performance and to determine the amount of resources needed. In FY 2008, the program had 1,300 paid FTE staff. On

average, across all states, there was one paid FTE staff member for every 2,200 beds, a level approaching the IOM-recommended minimum staffing guideline. Twenty-three states, the District of Columbia, and Puerto Rico met the recommended paid-staff-to-bed ratio in FY 2008. (See Figure 2 on next page and Appendix). Nevertheless, wide variation in the ratio of paid ombudsmen to beds exists across states. The ratio ranged from one paid FTE staff member per 791 beds in the District of Columbia to one per 6,692 beds in Oregon.

AoA data show that the amount spent on the ombudsman program is partially related to whether or not states meet the IOM-recommended paid staff-to-bed ratio of one to 2,000. Of the 29 states plus the District of Columbia whose combined federal and state per bed spending equaled or exceeded the national average of \$30 per bed in FY 2008, 21 states and the District of Columbia met the IOM goal. Seven of the remaining states approached the goal, with a paid staff-to-bed ratio of one to 2,500 or less. Meeting the recommended staff-to-bed ratio depends largely on the dollar amounts states allocate to the program. State contributions averaged about \$13 per bed in FY 2008. Twenty-five states and the District of Columbia spent more than the average of \$13 and, of those, 19 states and the District of Columbia met the recommended staff-to-bed ratio goal.<sup>40</sup>

The level of paid staffing is only one factor in effective ombudsman programs, which rely primarily on volunteers to maintain a presence in facilities. Volunteers visit residents, assist them with complaints about care or rights, and take the first steps in complaint investigation. In FY 2008, about 12,000 part-time volunteers worked in the program and, of these, about 73 percent were certified to investigate complaints.

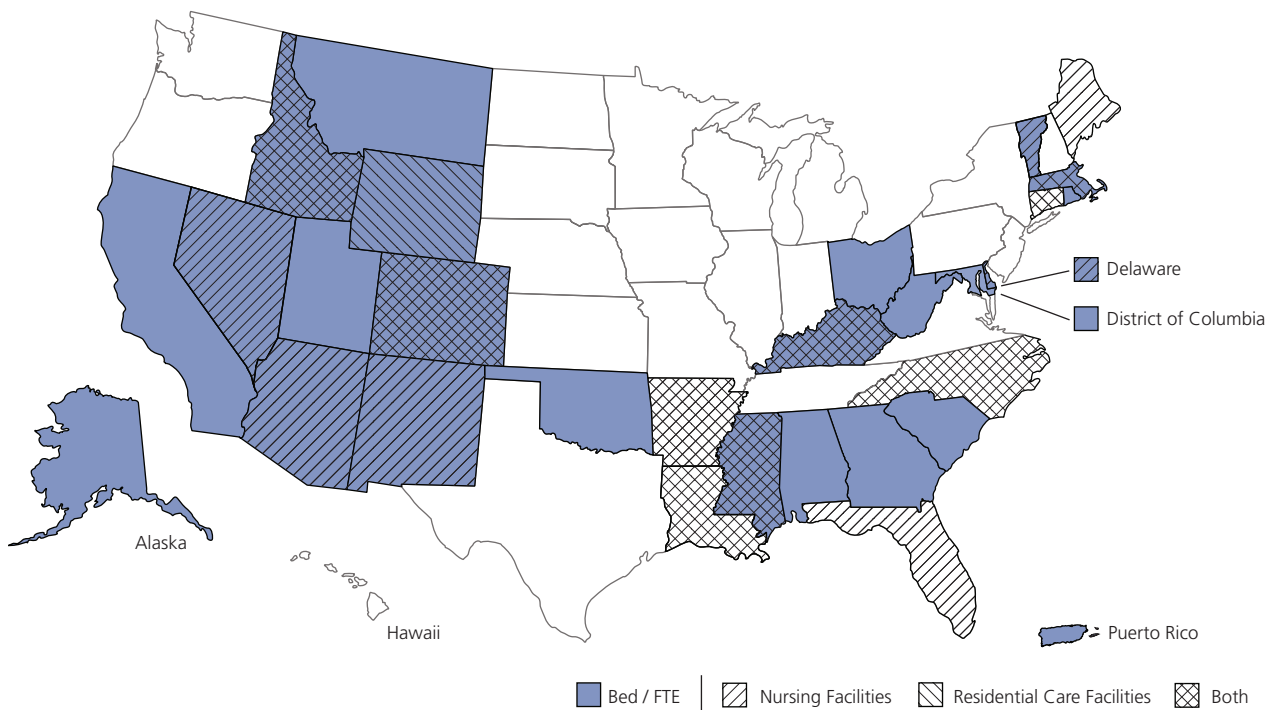
Ombudsman resources in most states do not appear to support the paid staff and volunteers necessary to perform regular (that is, quarterly) and timely visits to facilities and residents. (Visits made in response to complaints are not counted as quarterly visits.) Nationwide, ombudsmen visited about 80 percent of nursing facilities at least quarterly in FY 2008. Visits were much less regular in residential care facilities, only about 46 percent of which were visited quarterly.

Wide variation in meeting the federal quarterly visitation reporting measure exists across states. Ombudsmen in only nine states reported that they performed quarterly visits for 100 percent of both nursing facilities and residential care facilities. More states met the

## FIGURE 2 States Meeting Goal for One Full-time Ombudsman per 2,000 Beds, and Quarterly Facility Visitation Measure, Fiscal Year 2008

The Institute of Medicine (IOM) recommended that the ombudsman-to-bed ratio be at least one full-time paid ombudsman (FTE) for every 2,000 beds. According to data from the U.S. Administration on Aging (AoA), 23 states, the District of Columbia, and Puerto Rico met this FTE goal in fiscal year (FY) 2008 (■).

The AoA has set a measure that ombudsmen or representative volunteers visit all nursing facilities and other residential care facilities at least quarterly. According to AoA data, only nine states met the quarterly visitation measure for 100 percent of both types of facilities in FY 2008. Shown below are states in which ombudsmen met the quarterly visitation measure for 100 percent of the nursing facilities (▨), residential care facilities (▩), or both (⊠).



Source: Prepared by the National Health Policy Forum based on AoA, 2007 National Ombudsman Reporting System (NORS) Data Tables, updated July 21, 2009; available at [www.aoa.gov/AoARoot/AoA\\_Programs/Elder\\_Rights/Ombudsman/National\\_State\\_Data/2008/Index.aspx](http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/National_State_Data/2008/Index.aspx).

Note: In addition to the states in which ombudsmen visit 100 percent of nursing facilities quarterly, AoA data show that, in nine states, between 90 percent and 99 percent of nursing facilities were visited by ombudsmen quarterly. In one state, ombudsmen visited 99 percent of residential care facilities quarterly.

AoA NORS data identify "board and care" facilities. For purposes of this paper, the term "residential care" facilities is used. Data on quarterly visits to residential care facilities in Iowa and Rhode Island are not available.

visitation measure for nursing facilities than for residential care facilities: ombudsmen in 16 states reported that they regularly visited 100 percent of nursing facilities quarterly, while in only 10 states ombudsmen reported regularly visiting 100 percent of residential care facilities (Figure 2 and Appendix). In 10 states, ombudsmen visited less than half of nursing facilities quarterly; in 24 states, less than half of residential care facilities received quarterly visits.

### SOME UNFINISHED BUSINESS

Ombudsmen in many states face a number of challenges in implementing the full range of their responsibilities, especially with respect to visitation and complaint investigation in residential care facilities. In some areas of the country, the continual need for volunteer recruitment and training can strain paid staff resources.

#### Role of Ombudsmen in Residential Care Facilities

The recent growth in the number and types of residential care facilities, especially assisted living facilities, is presenting challenges to the program. Ombudsmen interviewed for this paper indicated that the resources available do not allow them to maintain a regular visitation schedule to these facilities. Some indicate that maintaining regular visitation schedules to nursing facilities claims most of their time, leaving them with insufficient staff or volunteers to visit both residential care facilities and nursing facilities.<sup>41</sup> Some ombudsmen report that their programs have no assigned volunteers for residential care facilities.

In theory, residents of assisted living facilities are, on average, less frail than most people in nursing homes. However, there is a fuzzy line between nursing homes and some types of residential care facilities;<sup>42</sup> the levels of impairment of some residents in assisted living facilities are similar to those of people living in nursing homes,<sup>43</sup> and dementia is common in both settings. Residents of assisted living facilities who receive services paid by Medicaid home and community-based waiver funds must meet the state's definition for nursing home functional eligibility, but because these settings are not subject to federal regulatory requirements, the involvement of ombudsmen may be even more essential to the well-being of their residents. Most states establish and monitor requirements for quality of care, but

oversight can be spotty, making it important to have a consumer advocacy voice for residents to assist state quality inspectors.

Experience in several ombudsman programs has shown the benefits of helping assisted living residents understand some of the complex policies of these facilities, such as conditions under which they may be discharged and costs of supplemental services they may receive.<sup>44</sup> The tasks of ombudsmen in assisted living facilities may be quite different from those in nursing homes. Unlike nursing homes, assisted living facilities stress resident privacy and autonomy. Developing a way to establish ombudsman interaction with these residents may pose challenges. Also, many assisted living residents have individualized contracts with facilities specifying what specific services, beyond room and board, residents will receive from the facility and the cost of those services. In order to help residents resolve complaints, ombudsmen may need access to information contained in resident contracts. These and other tasks that are specific to assisted living facilities may necessitate specialized ombudsman training.

Because of the paucity of full-time staff and thin volunteer coverage for assisted living facilities in some states, some ombudsman programs tend to be “complaint-driven” rather than playing the sentinel or “watchdog” role envisioned by a consumer advocacy model. That is, they are responsive to complaints when they are made but may be not as effective in identifying resident issues before they generate a complaint. In areas with insufficient paid staff or volunteer coverage, marketing of the program to residents may be weak to avoid creating demand for services that cannot be met.<sup>45</sup> In addition, some report that the demands of complaint investigation mean that systems advocacy, a legislatively required activity, may not be effective or complete.

### Role of Volunteers

Beyond issues of adequate numbers of volunteers to visit facilities, a program based on volunteer capacity faces issues of recruitment, training, and retention. For example, a study of the California ombudsman program by the California Health Care Foundation found that the annual turnover rate among volunteers was about 30 percent and that as many as 50 percent of volunteers who signed up did not complete the state-mandated 36-hour training certification.<sup>46</sup> Turnover of volunteers places burdens on paid program staff who

must continually recruit and train new volunteers. Maintaining a stable pool of volunteers may be affected by the socioeconomic status of volunteers; some ombudsmen report that periods of economic downturns may cause some volunteers to turn to paid jobs. Recruitment of volunteers may also vary across geographic areas and be affected by program management strategies.

Ombudsmen strongly support the volunteer model as a way to involve the community in long-term care facilities and as a source of support that cannot be met by existing resources. At the same time, some question the viability of a model that relies so heavily on volunteers who must master the complexities of complaint investigation and requirements of federal and state law. Volunteers may leave the program if they receive insufficient support from paid staff, necessitating a constant cycle of recruitment and training. Recruitment, training, and supervision of volunteers may require an increased paid staff-to-volunteer ratio.<sup>47</sup>

## CONCLUSION

Significant federal, state, and out-of-pocket funds are devoted to caring for residents in nursing homes and other residential facilities, but the ability of federal and state governments to provide sufficient oversight of facilities continues to be a serious problem. Ombudsmen are required to serve as advocates for residents and have the potential to play an important role in assisting them with complaints about the quality of their care. They can also complement the federally required survey and certification process for nursing homes and state oversight of residential care facilities. Yet the ability of the program to fulfill its role as a consumer advocate is constrained by limited resources. In many states, the program does not meet recommended staffing goals; in most states, ombudsmen do not conduct regular quarterly visits to nursing and residential care facilities, leaving many consumers without access to ombudsman services.

## ENDNOTES

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(endnote 1, continued)

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7. Reports from long-term care ombudsman to the Administration on Aging (AoA) estimate about 50,000 "licensed board and care and similar facilities" with slightly more than 1 million beds. See AOA, "2008 National Ombudsman Reporting System Data Tables," Table A-1; available at [www.aoa.gov/AoARoot/AoA\\_Programs/Elder\\_Rights/Ombudsman/National\\_State\\_Data/2008/Index.aspx](http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/National_State_Data/2008/Index.aspx). Another study estimated about 55,000 licensed residential care facilities with slightly more than 1 million beds. See Charlene Harrington et al., "Trends in the Supply of Long-Term Care Facilities and Beds in the United States," *Journal of Applied Gerontology*, 24, no. 4 (August 2005): pp 265–282.

8. Harrington et al., "Trends in the Supply of Long-Term Care Facilities."

9. American Association of Homes and Services for the Aging, American Seniors Housing Association, Assisted Living Federation of America, National Center for Assisted Living, and National Investment Center for the Seniors Housing and Care Industry, *2009 Overview of Assisted Living*, 2009; available at the Web sites of each of the sponsoring organizations. Participating in this survey were 500 facilities, each of which is defined as a long-term care option that combines housing, supportive services, personalized assistance with activities of daily living, and health care and is licensed, certified, or registered by states.

10. Data are from the Medicare Current Beneficiary Survey and from Joan Hyde, Rosa Perez, and Brent Forester, "Dementia and Assisted Living," *The Gerontologist*, 47, special issue III (2007): p. 53; available at [http://gerontologist.gerontologyjournals.org/cgi/reprint/47/suppl\\_1/51](http://gerontologist.gerontologyjournals.org/cgi/reprint/47/suppl_1/51).

11. See, for example, GAO, *Nursing Homes: Federal Monitoring Surveys*. See also other related GAO reports cited in this paper, as well as U.S. Department of Health and Human Services, Office of the Inspector General (OIG), *Nursing Home Complaint Investigations*, OEI-01-04-00340, July 2006; available at <http://oig.hhs.gov/oei/reports/oei-01-04-00340.pdf>.
12. GAO, *Nursing Homes: Federal Monitoring Surveys*.
13. GAO, *Medicare and Medicaid Participating Facilities: CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities*, GAO-09-64, February 2009; available at [www.gao.gov/new.items/d0964.pdf](http://www.gao.gov/new.items/d0964.pdf).
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18. AoA, "Instructions for Completing the State Long Term Care Ombudsman Program Reporting Form for the National Ombudsman Reporting System (NORS)," p. 10; available at [www.aoa.gov/AoARoot/AoA\\_Programs/Elder\\_Rights/Ombudsman/docs/Instructions\\_Final.doc](http://www.aoa.gov/AoARoot/AoA_Programs/Elder_Rights/Ombudsman/docs/Instructions_Final.doc).
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**APPENDIX**

**Long-Term Care (LTC) Facility Beds per Paid Ombudsman Staff and Percentage of LTC Facilities Visited at Least Quarterly, FY 2008**

|                      | No. of LTC Facility Beds per Paid Ombudsman Staff (FTEs) | Percent of Facilities Visited at Least Quarterly* |                  |
|----------------------|--|---|------------------|
|                      |  | Nursing   | Residential Care |
| U.S. Average         | 2,200  | 79.7%   | 45.8%            |
| Alabama              | 1,712  | 95%   | 87%              |
| Alaska               | 1,286  | 7%  | 22%              |
| Arizona              | 1,989  | 100%  | 65%              |
| Arkansas             | 2,799  | 100%  | 100%             |
| California           | 1,494  | 93%   | 88%              |
| Colorado             | 1,160  | 100%  | 100%             |
| Connecticut          | 3,772  | 100%  | 100%             |
| Delaware             | 1,223  | 100%  | 83%              |
| District of Columbia | 791  | 44%   | 2%               |
| Florida              | 2,364  | 100%  | 40%              |
| Georgia              | 1,169  | 96%   | 61%              |
| Hawaii               | 2,716  | 94%   | 2%               |
| Idaho                | 1,054  | 100%  | 100%             |
| Illinois             | 2,927  | 88%   | 85%              |
| Indiana              | 3,674  | 36%   | 12%              |
| Iowa                 | 6,442  | 1%  | NA†              |
| Kansas               | 3,154  | 90%   | 60%              |
| Kentucky             | 900  | 100%  | 100%             |
| Louisiana            | 2,207  | 100%  | 100%             |
| Maine                | 2,505  | 100%  | 32%              |
| Maryland             | 1,212  | 89%   | 33%              |
| Massachusetts        | 1,437  | 100%  | 100%             |
| Michigan             | 5,130  | 71%   | 1%               |
| Minnesota            | 5,030  | 53%   | 17%              |
| Mississippi          | 1,371  | 100%  | 100%             |
| Missouri             | 4,260  | 77%   | 41%              |
| Montana              | 832  | 44%   | 84%              |
| Nebraska             | 4,449  | 31%   | 3%               |

|                | No. of LTC Facility Beds per Paid Ombudsman Staff (FTEs) | Percent of Facilities Visited at Least Quarterly* |                  |
|----------------|--|---|------------------|
|                |  | Nursing   | Residential Care |
| Nevada         | 1,515  | 100%  | 10%              |
| New Hampshire  | 2,019  | 26%   | 9%               |
| New Jersey     | 4,052  | 43%   | 36%              |
| New Mexico     | 1,361  | 100%  | 83%              |
| New York       | 4,114  | 75%   | 33%              |
| North Carolina | 2,310  | 100%  | 100%             |
| North Dakota   | 2,134  | 83%   | 85%              |
| Ohio           | 1,694  | 65%   | 14%              |
| Oklahoma       | 1,559  | 94%   | 89%              |
| Oregon         | 6,692  | 68%   | 20%              |
| Pennsylvania   | 2,724  | 94%   | 80%              |
| Puerto Rico    | 1,318  | 17%   | 28%              |
| Rhode Island   | 1,137  | 29%   | NA†              |
| South Carolina | 1,589  | 35%   | 12%              |
| South Dakota   | 4,011  | 67%   | 42%              |
| Tennessee      | 4,299  | 86%   | 60%              |
| Texas          | 3,041  | 99%   | 14%              |
| Utah           | 1,113  | 69%   | 54%              |
| Vermont        | 893  | 100%  | 99%              |
| Virginia       | 2,410  | 73%   | 34%              |
| Washington     | 2,438  | 81%   | 62%              |
| West Virginia  | 1,287  | 72%   | 8%               |
| Wisconsin      | 2,732  | 70%   | 8%               |
| Wyoming        | 890  | 97%   | 100%             |

\* Facilities (unduplicated) visited on a regular basis; not in response to a complaint. "Regular basis" is defined as at least quarterly. Represents visits by local projects, except for those states in which the state office does more visiting. Percentages are based on the local numbers reported and may slightly underrepresent the actual number of facilities visited for some states.

† Data not available.

Source: Administration on Aging, National Ombudsman Reporting System FY 2008; available at [www.aoa.gov/AoARoot/Aoa\\_Programs/Elder\\_Rights/Ombudsman/National\\_State\\_Data/2008/Index.aspx](http://www.aoa.gov/AoARoot/Aoa_Programs/Elder_Rights/Ombudsman/National_State_Data/2008/Index.aspx).