

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**Long Term Care Ombudsman Program:  
Overall Capacity**



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Inspector General**

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# EXECUTIVE SUMMARY

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## PURPOSE

To describe the overall capacity of State Long Term Care Ombudsman programs to promote and monitor quality of care in nursing homes.

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## BACKGROUND

While many studies indicate that changes in law and regulations may have had a positive effect on improving the environment and overall health care of nursing home patients, recent reports by the Health Care Financing Administration (HCFA) and the General Accounting Office have raised serious concerns about patients' care and well-being. The Senate Special Committee on Aging held hearings in the summer of 1998 on these results. Committee staff requested the Office of Inspector General (OIG) to examine the issue of nursing home quality of care. At the same time, we undertook additional studies aimed at assessing the quality of care in nursing homes. This report examines the capacity of the Ombudsman program to monitor and promote quality of care. Future OIG reports will address trends in reported abuse of nursing home residents, the nursing home survey and certification process, and the availability of survey results.

In response to growing concerns about poor quality care in nursing homes and to protect the interests of residents, the State Long Term Care Ombudsman program was established in the 1978 Older Americans Act. The ombudsmen advocate on behalf of residents of long term care facilities to ensure they have a strong voice in their own treatment and care. It operates in all fifty States and in hundreds of local communities, using both paid and volunteer staff.

We examined the Ombudsman program in the 10 States with the largest nursing home population. We analyzed 1997 program data from the National Ombudsman Reporting System (NORS), reviewed written program procedures, and conducted phone interviews with State and local ombudsmen, as well as State Unit on Aging Directors.

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## FINDINGS

### **The Ombudsman Approach is Distinct From and Complements Other Nursing Home Monitoring Programs**

Discussions with State and local ombudsmen, as well as State Aging Unit Directors, emphasize the uniqueness of the Ombudsman program. In contrast to other programs, ombudsmen lack enforcement and regulatory oversight authorities. As independent advocates, they work solely on behalf of residents and are able to mediate between these residents and nursing home staff on an informal level. Furthermore, a routine nursing

home presence is essential to the role of the ombudsman since it provides residents with the opportunity to develop personal and confidential relationships with ombudsmen staff and creates a comfortable environment for registering complaints. Finally, the program is also distinct in its reliance on volunteers.

### **The Program's Overall Capacity to Monitor and Promote Nursing Home Care Appears Limited**

A number of factors appear to limit the capacity of the Ombudsman program. First, the program is limited by staffing constraints. Staffing levels among the 10 States vary considerably, ranging from a ratio of 5,003 beds per paid staff person in Florida, to 1,115 beds per paid staff person in California. Also, a majority of State and local ombudsmen (six and seven respectively) identify insufficient program staffing as an obstacle which detracts from their program's effectiveness.

Insufficient program staffing is particularly evident in the limited extent to which ombudsmen make regular nursing home visits. In the nine States that make such visits, volunteers are generally assigned to just one home and are able to visit this home on a weekly basis. However, most nursing homes in the 10 States do not have volunteers assigned to them, and these homes are visited just once or twice a year for no longer than one to three hours. Furthermore, in four States there are nursing homes that never have regular visits by volunteers or by paid staff.

The capacity of the Ombudsman program is additionally limited by the lack of a common standard for responding to and resolving complaints; consequently, staff in some States are not consistently responding to and resolving complaints in a timely manner. Moreover, ombudsman advocacy and outreach efforts in the 10 States are inconsistent, and half of State and local ombudsmen say their program lacks adequate support. Finally, while the National Ombudsman Reporting System (NORS) developed in 1995 has improved the program's data reporting capacity, it lacks some important performance measurement data.

### **Collaboration With Other Monitoring Programs Enhances the Capacity of Ombudsmen**

Both State and local ombudsmen, as well as State Aging Unit Directors, believe that collaboration is crucial to enhancing their capacity to improve the life of nursing home residents. However, ombudsmen would like better collaboration with State surveyors. Despite the requirement that they be notified of inspection dates, two ombudsmen say they are not notified. Furthermore, ombudsman and survey and certification data for 1997 show that ombudsmen staff accompanied surveyors just 61 percent of the time.

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## **RECOMMENDATIONS**

Ombudsmen, with their unique combination of functions-- visitation, complaint and crisis

response, and advocacy-- play an important role in assuring quality of care in nursing homes. We therefore believe that the program limitations we have identified in this inspection must be addressed.

We recommend that the Administration on Aging work with States to strengthen the Ombudsman program. In particular, we suggest they:

- ▶ develop guidelines for a minimum level of program visibility that include criteria for the frequency and length of regular visits, as well as a ratio of Ombudsman program staff to long term care beds;
- ▶ further highlight strategies for recruiting, training, and supervising more volunteers;
- ▶ develop guidelines for complaint response and resolution times;
- ▶ continue to strengthen the program's data reporting system, including ensuring that all State ombudsmen understand and use the definitions in the system and train local ombudsmen and volunteers in standard utilization; and
- ▶ establish ways in which Ombudsman programs can enhance collaboration with the survey and certification agency.

We recognize that in order to implement these recommendations, and to fulfill the Ombudsman program mission as outlined in the Older Americans Act, additional funding may be required. In particular, it may be necessary to find ways to increase the number of paid and volunteer ombudsmen. As noted earlier, the Institute of Medicine recommends one full-time equivalent ombudsman staff person for every 2,000 long term care facility beds in each State, a standard which not all States meet.

The President's recent nursing home initiative highlights the importance of improving the quality of care provided to vulnerable nursing home residents. We believe that strengthening the Ombudsman program will significantly contribute to this important effort.

## **AGENCY COMMENTS**

We received comments on the draft report from the Administration on Aging (AoA) and the Health Care Financing Administration (HCFA). They concur with our recommendations.

The AoA suggests two modifications to our recommendations. First, it points out its ongoing efforts through training and technical assistance to work with States in the effective use of volunteers. In acknowledgment of these efforts, we have changed the

recommendation to say that AoA should further highlight and promote strategies for volunteer programs. Second, the AoA reports that while they work closely with ombudsmen to understand NORS, more could be done to promote a better understanding of the system. We have therefore broadened our recommendation to include the need for a common understanding and use of NORS definitions. We also continue to believe that the system could be strengthened by adding performance-based data such as complaint response and resolution times.

Some parts of the report were additionally modified in response to AoA's technical comments. The full comments are presented in Appendix A.

# TABLE OF OF CONTENTS

	PAGE
<b>EXECUTIVE SUMMARY</b> .....	1
<b>INTRODUCTION</b> .....	6
<b>FINDINGS</b>	
Ombudsman Approach Distinct and Complementary .....	10
Overall Capacity of Program Appears Limited .....	10
Collaboration with Other Programs Enhances Capacity .....	15
<b>RECOMMENDATIONS</b> .....	17
<b>APPENDIX</b>	
Comments .....	19

# INTRODUCTION

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## PURPOSE

To describe the overall capacity of the State Long Term Care Ombudsman program to promote and monitor quality of care in nursing homes.

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## BACKGROUND

While many studies indicate that changes in law and regulations may have had a positive effect on improving the environment and overall health care of nursing home patients, recent reports by the Health Care Financing Administration (HCFA) and the General Accounting Office have raised serious concerns about patients' care and well-being. The Senate Special Committee on Aging held hearings in the summer of 1998 on these results. Committee staff requested the Office of Inspector General (OIG) to examine the issue of nursing home quality of care. At the same time, we undertook additional studies aimed at assessing the quality of care in nursing homes. This report examines the capacity of the Ombudsman program to monitor and promote quality of care. Future OIG reports will address the trend in reported abuse of nursing home residents, the nursing home survey and certification process, and the availability of survey results.

In 1987, Congress passed major nursing home reform legislation with the Omnibus Reconciliation Act of 1987 (OBRA 1987). This legislation required nursing homes with Medicare and Medicaid residents to comply with specific quality of care standards by providing "services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." More than a decade later, concerns still exist about the quality of care provided in nursing homes.

### Ombudsman Program

A nursing home is a long term care residential facility for individuals with physical or mental impairments that prevent them from living independently. A nursing home provides its residents with a room, meals, assistance with daily living activities, and medical care. According to data provided in State ombudsman reports, in 1996 there were 18,066 nursing homes and 1,845,791 nursing home beds. Medicaid payments to nursing homes that year totaled \$29.6 billion, while Medicare payments totaled \$10.6 billion.

In response to growing concerns about poor quality care in nursing homes and to protect the interests of residents, the State Long Term Care Ombudsman program was established in 1978 in the Older Americans Act. The ombudsmen advocate on behalf of residents of all long term care facilities, including nursing homes, to ensure they have a strong voice in their own treatment and care.



The Ombudsman program operates in all fifty States, the District of Columbia, and Puerto Rico, and in hundreds of local communities, and uses both paid and volunteer staff. The program receives funding from Federal, State and local levels, and is overseen by the Administration on Aging (AoA). Most State ombudsmen operate within the State Unit on Aging (SUA), some of which are independent while others are part of a larger State umbrella agency. The remaining State Ombudsman programs are located organizationally outside of the SUA. These programs are operated by non-profit organizations or legal services agencies, or they are freestanding Ombudsman programs.

State Ombudsman programs have multiple functions that are mandated by law, many of which are closely tied to ensuring quality care for long term care residents. They include:

- identifying, investigating, and resolving complaints;
- protecting the legal rights of patients;
- advocating for systemic change;
- providing information and consultation to residents and their families; and,
- publicizing issues of importance to residents

Several national associations have been established to support State Ombudsman programs. One of these, the National Long Term Care Ombudsman Resource Center, was established in 1993. This Center is funded by AoA and is run by the National Citizens' Coalition for Nursing Home Reform (NCCNHR) in cooperation with the National Association of State Units on Aging (NASUA). It serves as a clearinghouse for information on the national Ombudsman program. One of its functions is to identify issues of significance to the Ombudsman program, including ways the ombudsman can improve quality of care in nursing homes; it also trains ombudsmen and provides technical assistance. Additionally, the National Association for Long Term Care Ombudsman Programs (NASOP) was established by State ombudsmen to provide a common voice for all State programs and promote the sharing of ideas and experience among ombudsmen.

## Ombudsman Data

States have recently started to collect and report data under a new system. In 1995, States began to systematically collect and report data under the National Ombudsman Reporting System (NORS). Prior to NORS, States reported data to AoA which was of limited use due to the lack of common definitions for key data elements. The NORS was created in response to earlier recommendations made by the General Accounting Office and the Office of Inspector General and was developed by the ombudsmen themselves. It includes more specific data elements than were reported before NORS. For example, it separates complaints by type and distinguishes between complaints and complainants. In 1995, 29 States reported under NORS, and all States did so annually beginning in 1996.

The first Long Term Care Ombudsman Program Annual Report was also published in 1995. This report utilizes NORS data for 29 programs and pre-NORS data for the other 23 programs, and describes the operation of Ombudsman programs nationwide. The report

also describes the broad range of ombudsman activities, including training and technical assistance programs, visitations, and community relations activities. The 1996 report, which provides complaint data for all states, was issued in January 1998.

## Prior Studies

Many studies have reported on the progress and impact of the Ombudsman program. One of the most recent, “Real People, Real Problems,” published in 1995 by the National Academy of Sciences’ Institute of Medicine, reported on State compliance, conflicts of interest, effectiveness, resources, and the need for future expansion of the program. It found that, overall, the Ombudsman program is effective. It also reported lack of access to ombudsman services by residents and their families, disparities in ombudsman visitation patterns and service provisions, and uneven availability of ombudsman legal services.

Additionally, the Inspector General issued several reports on the Ombudsman program in 1991 and 1992. First, “Successful Ombudsman Programs,” (OEI-02-90-02120), the main report in a series, found that successful programs are highly visible and obtain adequate funding and support. Furthermore, “State Implementation of the Ombudsman Requirements of the Older Americans Act,” (OEI-02-91-01516), found, among other things, that State program staffing and long term care facility visitation varies significantly, and that ombudsmen use many methods to increase their visibility.

In July, 1998, the Secretary of the Department of Health and Human Services released a report to Congress on nursing home care. While the report found that some progress had been made in nursing home care, particularly in the more appropriate use of physical restraints and drugs, it also indicated that further improvements were needed. In conjunction with this report, the President announced a new nursing home initiative to provide enhanced protection to residents and target needed improvements in care.

Also in July, 1998, the General Accounting Office (GAO) released a report on California nursing homes. This report found that care problems still exist, despite Federal and State oversight. Among problems described are poor nutrition, dehydration, and pressure sores.

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## METHODOLOGY

We used three methods for this inspection. First, we analyzed 1997 data from the National Ombudsman Data Reporting System (NORS) in order to determine the extent of Ombudsman program staffing and activities. Second, we reviewed written Ombudsman program procedures to assess program processes and standards. Third, we conducted telephone interviews with State and local ombudsmen, as well as with State Unit on Aging Directors, to obtain their perspectives on program strengths and weaknesses.

## Sample Selection

We selected a purposive sample of 10 States for this inspection. These ten States are New

York, California, Texas, Ohio, Illinois, Pennsylvania, Massachusetts, Florida, New Jersey, and Tennessee. They represent 55.8 percent of total skilled nursing beds and 53 percent of all Ombudsman program complaints nationally for 1996. They also account for nearly half (43 percent) of all Ombudsman programs nationwide and half of all program funding.

## Procedures Review

We obtained and reviewed written procedures for all 10 State Ombudsman programs. Using a structured review guide, we examined these procedures to determine the different processes used by ombudsmen to monitor and promote quality of care in nursing homes. We also looked for any standards mandated for these processes, such as complaint response times, and discussions of linkages with other nursing home programs in the State.

## Interviews

We conducted a total of 30 structured interviews for this inspection. In each of the 10 States we spoke with the State ombudsman, one local program ombudsman, and the Director of the State Unit on Aging (except for one State, when we interviewed the Deputy Director). We selected these three groups of respondents to obtain their different perspectives of the program and looked for consensus among the groups in our analysis.

In selecting ombudsmen from local programs to interview, we chose individuals from a variety of local program structures. Five of the local programs represented are operated by Area Agencies on Aging (AAAs), while the other five are operated by non-profit or legal service agencies. Furthermore, five of the local programs are rural and five are urban.

During our interviews with the ombudsmen, we discussed the processes their programs use to impact quality of care in nursing homes, as well as their opinions on which processes are most effective. Additionally, we discussed the factors that either facilitate or hinder their effectiveness. In this report, to differentiate between respondent groups, we will refer to “State ombudsmen” and “local ombudsmen.” We will use the term “ombudsman” to refer to both the Ombudsman program and the individual.

During our interviews with the Directors of State Units on Aging, we discussed ways in which the Ombudsman program is linked to other nursing home programs. This discussion included both programs within the Aging Unit and programs outside the Unit.

## Data Analysis

We analyzed 1997 NORS data, looking specifically at data on program staffing, visitation rates, advocacy activities, and coordination with survey and certification agencies.

This inspection was conducted in accordance with the **Quality Standards for Inspections** issued by the President’s Council on Integrity and Efficiency.

# FINDINGS

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## The ombudsman approach is distinct from and complements other nursing home monitoring programs

The Ombudsman program has several functions to promote and monitor quality of care in nursing homes. First, ombudsman staff identify and resolve complaints, typically by contacting the complainant and informally mediating with residents and nursing home staff to reach some resolution. Second, ombudsmen also make regular visits to nursing homes, during which they speak with residents and make themselves available to answer questions and listen to concerns. Lastly, ombudsmen engage in a variety of different activities to advocate for improved nursing home care.

Discussions with State and local ombudsmen, as well as State Aging Unit Directors, emphasize the uniqueness of the Ombudsman program. In contrast to other programs, ombudsmen lack enforcement and regulatory oversight authorities. As independent advocates, they work solely on behalf of residents and are often the only voice these residents have in their own care. Says one State ombudsman, her program is the “only certified, unrestricted organization” that can go into a nursing home on a resident’s behalf. Furthermore, by taking the concerns and complaints of residents directly to nursing home staff, they are able to mediate between both parties on an informal and amicable level.

Unlike many other programs, an ongoing, routine nursing home presence is essential to the role of the ombudsman. In fact, most State ombudsmen (six) believe this presence is the most important part of their program. This presence provides residents with the opportunity to develop personal and confidential relationships with ombudsmen. It also gives ombudsmen the chance to identify and address individual issues before they become larger, systemic problems and creates a comfortable environment for registering complaints. The Ombudsman program is also distinct from other programs in its reliance on volunteers, who are needed to achieve an ongoing presence in nursing homes.

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## The program’s overall capacity to monitor and promote nursing home care appears limited

### The program is limited by staffing constraints

Staffing levels among the 10 States vary considerably, as shown in Table 1 below. Ombudsman staff cover from as many as 5,003 nursing home beds per paid staff person in Florida, to as few as 1,115 beds in California (these numbers do not include licensed board and care and similar facilities for which the Ombudsman programs are also responsible). Due to its relatively high number of volunteers, California also has the lowest ratio of beds

per volunteer (79 to 1) among the 10 States. These numbers do not reflect actual nursing home coverage, however, since most State programs assign each volunteer to just one nursing home or one board and care home; therefore, not all nursing home beds are covered by volunteers.

Table 1  
**Ombudsman Program Staffing, 1997**

State	# Nursing Homes	# Paid Staff	Beds per Paid Staff	# Volunteers*	Beds per Volunteer
CA	1,468	121	1,115	1,691	79
FL	716	16	5,003	214	374
IL	1,102	33	3,344	314	325
MA	579	37	1,566	328	177
NJ	354	18	2,752	64	774
NY	668	25	4,618	600	192
OH	1,456	59	2,173	200	641
PA	807	50	1,946	276	354
TN	352	12	3,301	211	184
TX	1,161	46	2,753	761	166

\*Includes both certified and other volunteers

Source: 1997 NORS data

No minimum staffing ratios are required by law. However, a 1995 Institute of Medicine study on the Ombudsman program recommends a standard staffing ratio of 1 paid ombudsman staff person per 2,000 long term care facility beds (including both nursing home and board and care home beds). Only 1 of the 10 sample States, Massachusetts, meets this standard when counting both nursing home and board and care beds.

A majority of State and local ombudsmen identify insufficient program staffing as an obstacle which detracts from their program's effectiveness. Six State and seven local ombudsmen believe their program does not have enough paid staff. Similarly, seven of each say they have an insufficient number of volunteers. Finally, many ombudsmen also say they would like better supervision and training of the volunteers they have.

**Extent of regular visits is limited**

Insufficient program staffing is particularly evident in the limited extent to which ombudsmen make regular nursing home visits, as illustrated in Table 2 below. First, while

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9 of the 10 States make regular visits, in 4 States there are nursing homes that are never visited by paid staff or volunteers. Second, despite AoA instructions which define regular visits as weekly, monthly, or quarterly, most nursing homes in these 9 States are usually visited only once or twice a year and for no longer than 1 to 3 hours. While volunteers do visit homes more frequently since they are generally assigned to just one nursing home and visit this home on a weekly basis, there are not enough volunteers to cover all nursing homes.

It is notable that Florida, which has the highest number of beds per paid staff, also has the lowest percentage of regular nursing home visits. Additionally, Florida has the lowest program funding among the 10 States, with approximately five dollars spent per long-term care bed (compared to the 10 State average of almost 18 dollars).

Table 2  
**Nursing Homes Visited Annually,  
 Not in Response to a Complaint, 1997**

State	% Nursing Homes Visited At Least Once a Year*
CA	100%
FL	65 %
IL	88%
MA	94%
NJ**	0%
NY	100%
OH	100%
PA	100%
TN	100%
TX	80%

- Most visits last from 1 to 3 hours
- \*\* While New Jersey does not make regular nursing home visits, staff do make periodic, surprise visits when warranted.

Source: 1997 NORS data

Ombudsman programs in the sample States rely on volunteers primarily to make regular nursing home visits. Due to this reliance on volunteers, ombudsmen generally agree that a strong volunteer component is crucial to their program's success; one says that volunteers

act as her “eyes and ears” in nursing homes.

In all 10 States, ombudsman staff make more frequent visits to nursing homes that are chronically substandard, where residents are routinely poorly treated. Several ombudsmen mention that an ongoing presence in substandard homes is particularly important since problems in these homes are often cyclical; they tend to fall in and out of compliance.

### **Ombudsman programs lack a common standard for response and resolution times**

Only 2 States’ procedures specify any kind of standard at all. Without such a standard, ombudsman staff in some States are not consistently responding to complaints in a timely manner. Typically, once a complaint is received, ombudsman staff initially respond by contacting the complainant. Two ombudsmen say it takes them an average of five days to respond to a complaint, two say they take four days, and another five say they respond to complaints in just one or two days. In contrast, the remaining ombudsman says that it takes an average of 30 days for her program staff to respond to complaints.

All States, however, use a separate process for handling life-threatening complaints such as physical abuse. Ombudsmen do not investigate these complaints but instead usually refer them directly to the adult protective services and/or the survey and certification agencies. Most States’ procedures mandate that this referral take no more than 24 hours.

Complaint resolution time also varies somewhat among the 10 States. In most States, ombudsmen resolve complaints by working informally with the resident and nursing home staff to reach an agreement between both parties. While 6 State ombudsmen report that complaints are typically resolved in a week or less, 2 State ombudsmen say they take an average of 90 days to resolve complaints. (The two remaining State ombudsmen are unable to specify an average resolution time). Only one State’s written procedures mandate a standard resolution time, saying that all cases should be closed within 60 days. In four States, ombudsmen report that certain complaints are eventually closed without a resolution being reached.

### **Outreach and advocacy efforts are inconsistent**

As Table 3 below shows, ombudsman staff devote varying amounts of time to outreach and advocacy activities, with some spending relatively little time on community education, work with the media, work on laws and policy, and nursing home staff training. Overall, California appears to be the most active of the ten States in outreach and advocacy, and New Jersey and Tennessee the least active. Despite the variation in time devoted these activities, all 10 ombudsmen stress the importance of advocating for systemic change in order to improve nursing home care.

Table 3  
**Other Ombudsman Program Staff Activities, 1997**

State	# Community Education Sessions	Work w/ Media (# Interviews & Press Releases)	Work on Laws & Govt. Policy <sup>1</sup>	# Nursing Home Staff Training Sessions
CA	1,621	661	10%	484
FL	176	143	27%	134
IL	177	890	10%	114
MA	621	15	30%	94
NJ	0	20	20%	170
NY	313	665	25%	204
OH	791	580	20%	437
PA	313	152	20%	602
TN	69	55	10%	64
TX	537	599	10%	631

<sup>1</sup>Percent of State-level efforts of total paid staff time only.

Source: 1997 NORS data

**Ombudsmen say their program lacks adequate support**

Half of State and local ombudsmen believe their program’s lack of support in the State diminishes its capacity and limits their ability to influence nursing home policies. One State ombudsman believes that the limited visibility of her program curtails her regulatory ability and impacts her overall effectiveness to resolve complaints; another believes that restrictions from her umbrella agency on activities such as publishing statements and serving on committees limit her overall effectiveness. On the local level, one ombudsman, expressing the opinion of others, notes that due to changing priorities within the Area Agency on Aging (AAA), “there are multiple demands at the regional level that distract from the effectiveness of the program.” Another relate’s her program’s lack of support to a diminished impact on the survey and certification process, because the surveyors are not sure how much weight to place on the information provided by the ombudsman.

**Ombudsman data reporting systems are still being improved**

The Administration on Aging (AoA) and State ombudsmen are working to improve the Ombudsman data reporting system. Prior to 1995, the reporting system consisted of only 30 data elements and lacked common definitions. The new system, called the National Ombudsman Reporting System (NORS), has over 200 data elements and standard



definitions.

Ombudsmen in the 10 sample States are still getting accustomed to the new reporting format. However, ombudsmen generally evaluate NORS highly: six rate it excellent or good for comprehensiveness, accuracy, and usefulness. Two in particular say that “there are still grey areas” and that they are not always sure how to report certain data. Exemplifying this concern, we found that the 10 ombudsmen still do not all count complaints the same way. Half say they count a complaint when it is completely resolved, and another half when it is first received.

While NORS appears to have improved the data reporting capacity of the Ombudsman program and includes comprehensive data on complaints, it does lack other important performance measurement data. For example, no data are collected on response and resolution times. Furthermore, despite the decision of Ombudsmen to collect data on cases only after they are closed, the number of cases that remain open at the close of one year are not reported into the next, making it difficult to determine the number of cases that are currently open.

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## **Collaboration with other monitoring programs enhances the capacity of ombudsmen**

### **Collaboration with other programs is seen as important**

Both State and local ombudsmen, as well as State Aging Unit Directors, believe that collaboration is crucial to enhancing their capacity to improve the life of nursing home residents. In fact, several of the States’ written program procedures have charts and/or descriptions of how the ombudsman is linked with other long term care programs. Four State ombudsmen specifically cite collaboration with and support from other agencies as one of the main strengths of their program. Similarly, State Aging Unit directors believe that while different programs may have different perspectives, all share the same agenda of ensuring good nursing home care.

All State and local ombudsmen report collaborating with a number of organizations on a regular basis to promote quality care in nursing homes. First, all work with their State’s survey and certification agency to identify and eliminate nursing home problems. Ombudsmen also collaborate with legal support groups for advice on complaint cases. Additionally, all have an ongoing relationship with Adult Protective Services, who they work with on abuse cases. Most also report working with senior citizen groups to advocate for resident rights, as well as with Medicaid and Medicare program representatives, to ensure residents get the benefits that they’re entitled to have. Finally, in six States ombudsmen refer cases where they suspect health care fraud to the Attorney General.

### **However, ombudsmen would like better collaboration with State surveyors**

While ombudsmen in all 10 States believe collaboration with State surveyors is important, many believe this collaboration can be improved. One of the main ways ombudsmen work with surveyors is to participate in annual nursing home inspections. However, despite the requirement that they be notified of inspection dates, two ombudsmen say they are not consistently notified. Furthermore, ombudsman data for 1997 show that they participated in a total of approximately 5,100 surveys in that year; survey and certification data, however, indicate that in 1997 around 8,400 surveys were conducted in the 10 States. Thus, ombudsmen accompanied surveyors just 61 percent of the time.

Ombudsmen say their relationship with survey and certification staff is most productive when they are routinely given advance notice about upcoming inspections, and when they are asked for their input about the quality of care being provided at facilities. They also believe it is important to work with the surveyors during their inspection and to attend exit conferences held with facility administrators at the end of the inspection.

Ombudsmen characterize their relationship with State survey and certification staff in different ways. Four say this relationship is one in which they are currently working out problems. Four others indicate that the relationship is basically a good one. Furthermore, some ombudsmen also say that there is a healthy tension and mutual respect between the two functions.

# RECOMMENDATIONS

Ombudsmen, with their unique combination of functions-- visitation, complaint and crisis response, and advocacy-- play an important role in assuring quality of care in nursing homes. We therefore believe that the program limitations we have identified in this inspection must be addressed.

We recommend that the Administration on Aging work with States to strengthen the Ombudsman program. In particular, we suggest they:

- ▶ develop guidelines for a minimum level of program visibility that include criteria for the frequency and length of regular visits, as well as a ratio of Ombudsman program staff to long term care beds;
- ▶ further highlight and promote strategies for recruiting, training, and supervising more volunteers;
- ▶ develop guidelines for complaint response and resolution times;
- ▶ continue to strengthen the program's data reporting system, including ensuring that all State ombudsmen understand and use the definitions in the reporting system and train local ombudsmen and volunteers in standard utilization; and
- ▶ establish ways in which Ombudsman programs can enhance collaboration with the survey and certification agency.

We recognize that in order to implement these recommendations, and to fulfill the Ombudsman program mission as outlined in the Older Americans Act, additional funding may be required. In particular, it may be necessary to find ways to increase the number of paid and volunteer ombudsmen. As noted earlier, the Institute of Medicine recommends one full-time equivalent ombudsman staff person for every 2,000 long term care facility beds in each State, a standard which not all States meet.

The President's recent nursing home initiative highlights the importance of improving the quality of care provided to vulnerable nursing home residents. We believe that strengthening the Ombudsman program will significantly contribute to this important effort.

## AGENCY COMMENTS

We received comments on the draft report from the Administration on Aging (AoA) and the Health Care Financing Administration (HCFA). They concur with our recommendations.

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The AoA suggests two modifications to our recommendations. First, it points out its ongoing efforts through training and technical assistance to work with States in the effective use of volunteers. In acknowledgment of these efforts, we have changed the recommendation to say that AoA should further highlight and promote strategies for volunteer programs. Second, the AoA reports that while they work closely with ombudsmen to understand NORS, more could be done to promote a better understanding of the system. We have therefore broadened our recommendation to include the need for a common understanding and use of NORS definitions. We also continue to believe that the system could be strengthened by adding performance-based data such as complaint response and resolution times.

Some parts of the report were additionally modified in response to AoA's technical comments. The full comments are presented in Appendix A.

# APPENDIX A

In this appendix, we present in full the comments from the Administration on Aging and the Health Care Financing Administration.



MAR 5 1999

TO: June Gibbs Brown  
Inspector General

FROM: Assistant Secretary for Aging

SUBJECT: Comment on Draft Reports "Long-Term Care Ombudsman Program: Overall Capacity," OEI-02-02-98-00351 and "Long-Term Care Ombudsman Program: Complaint Trends," OEI-02-00350

Thank you for the opportunity to comment on the above-referenced reports, which we found informative and instructive.

**Report on Overall Capacity**

We agree that the state and local ombudsman programs need guidelines and other forms of assistance on program visibility; number and length of visits to facilities (not in response to a complaint); ratio of staff to beds; and recruitment, training, placement and supervision of volunteers. We plan to work with the states to develop such guidelines.

A national definition for *number of visits to facilities, not in response to a complaint*, is included in the ombudsman reporting instructions, which are attached. *Regular basis* for facility visitation is defined on page 12 as "weekly, bi-weekly, monthly or quarterly."

Most states would need significant increases in state and local ombudsman staff to reach targets which might be set through guidelines in these areas. Even if there were increased reliance upon volunteers for visibility and increased facility coverage, successful volunteer programs tend to require paid staff. We were pleased to see that the reports acknowledge that increased resources are necessary. While Congress provided \$3 million in new funding for the Ombudsman Program this year, further additional resources would be necessary to attain the Institute of Medicine's (IOM) recommended ratio of one paid full-time-equivalent ombudsman staff person to every 2,000 long-term care beds. The nationwide ratio for FY 1996, the latest year for which national data has been compiled, was one staff person for every 2,973 long-term care facility beds, including nursing homes, board and care, and similar homes.

The AoA has widely publicized the IOM staffing recommendation and the need for additional funding for ombudsman programs to carry out the functions assigned to them under the Older Americans Act.

Information about how to recruit, train, place and supervise volunteers is provided annually to ombudsmen through training and technical assistance by the AoA-funded National Long-Term Care Ombudsman Resource Center. In addition, the American Association of Retired Persons'

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(AARP) Legal Counsel for the Elderly, Inc., (LCE) has produced and disseminated an exemplary manual entitled "Developing and Managing Long-Term Care Ombudsman Volunteer Programs," which was developed with substantial input from ombudsmen. LCE also has assisted some ombudsman programs to recruit large numbers of needed volunteers through the AARP in targeted areas.

We believe that the elements in NORS are sufficiently detailed in instructions provided to states several times over the past three years, most recently in September, 1998 (see attached). The NORS system, as designed by the state ombudsmen, replaced a previously unworkable system which attempted to account for open cases. This data was difficult to determine and meaningless at the national level. Hence, ombudsmen recommended that case and complaint data be collected on cases only after they are closed - the system adopted in the NORS, although there is one collection element for cases opened during the reporting period. We work closely with new state ombudsmen to help them understand the NORS design. Certainly more could be done to promote broader understanding and to encourage the state ombudsmen to train local ombudsmen in the correct case and complaint documentation.

Thus, the second and fourth recommendations in the reports should read as follows:

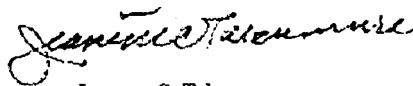
- further highlight and promote strategies for recruiting, training and supervising volunteers;
- ensure that all state ombudsmen understand and use the definitions in the reporting system and train local ombudsmen and volunteers in standard utilization.

Inasmuch as increases to the OAA programs have been small, we appreciate acknowledgment on page 17 that "additional funds may be required." However, to avoid deliberately placing more elders at risk, we request that the phrase "and that this may involve difficult trade-offs" not be included.

**Complaint Trends**

We note that you determine from NORS complaint data that physical abuse is among the top ten most frequently reported complaints in 1997 and that ombudsmen make a distinction between abuse caused by intentional bodily harm and gross neglect due to inadequate staffing. We believe that further articulation of this distinction mentioned on page 16 would be useful to include.

The AoA staff have provided OEI staff with minor corrections and clarifications. Thank you again for the opportunity to comment.



Jeanette C. Takamura

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of the Administrator  
Washington, D.C. 20201

MAR 2 1999

To: June Gibbs Brown  
Inspector General

From: Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration

IG	<input checked="" type="checkbox"/>
EAIG	<input type="checkbox"/>
SAIG	<input type="checkbox"/>
PDIG	<input checked="" type="checkbox"/>
DIG-AS	<input type="checkbox"/>
DIG-EC	<input checked="" type="checkbox"/>
DIG-EI	<input type="checkbox"/>
DIG-OI	<input type="checkbox"/>
DIG-MP	<input type="checkbox"/>
AIG-LC	<input type="checkbox"/>
OGC/IG	<input checked="" type="checkbox"/>
ExecSec	<input type="checkbox"/>
Date Sent	3-4

Subject: Office of the Inspector General Draft Reports: "Long-Term Care Ombudsman Program: Overall Capacity"; and "Long-Term Care Ombudsman Program: Complaint Trends."

I very much appreciate the opportunity to review and comment on these two draft reports that examine trends in Ombudsman complaints and describe the overall capacity of State Long Term Care Ombudsman programs to promote and monitor the quality of care in nursing homes.

Last July, the Clinton Administration unveiled an aggressive comprehensive initiative to ensure that all nursing homes comply with federal standards for the delivery of quality care. Since that time, we have made progress in strengthening nursing home inspection systems and cracking down on nursing homes that repeatedly violate safety rules. In addition, the Administration has taken other steps to reduce the incidence of bed sores, dehydration and malnutrition in nursing homes and to give consumers ready access to comparative information about nursing-home quality. HCFA also has implemented a new system to oversee the States, which have primary responsibility for conducting on-site inspections and recommending sanctions against poor-quality nursing homes. However, HCFA and state agency survey staff cannot be in every nursing home in every state continually monitoring care at all times.

For this reason, President Clinton specifically has called for the reauthorization of the Older Americans Act, which includes the Ombudsman program. Though Ombudsmen lack enforcement and regulatory oversight authority, their function is absolutely critical in maintaining quality care in nursing homes. In making regular visits to nursing homes and acting as advocates for residents, the Ombudsmen frequently are the source of complaint investigations that HCFA and the state survey agencies follow up on. The Ombudsmen are clearly an important partner for HCFA in our mutual goal of enforcing nursing home standards and ensuring that all nursing home residents are treated with dignity and compassion.

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22



Though progress has been made in improving the quality of care in nursing homes, we need to continually build upon it. To this end, HCFA is willing to work with the Administration on Aging (AOA) to increase their effectiveness and to facilitate communications between AoA and State survey agencies to better serve nursing home residents.

