

Study of the State Long Term Care Ombudsman Programs

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Study Objectives

To Investigate:

- LTCOP resources (funding, staffing, legal counsel)
- Organizational placement
- Quality of care issues
- Coverage of LTC facilities
- Effectiveness of complaint resolution
- Barriers to LTCOP effectiveness
- Relationship with other agencies
- Advocacy efforts

Research Methodology

- Telephone Interviews
 - 46 state ombudsmen
 - 6 ombudsmen in the state office
- Survey instrument
 - Follow-up on issues from 1995 IOM Report
 - Local advisory group
 - Focus group of national experts
- Statistical analysis
 - Interview responses
 - FY 1999 NORS data

Organizational Placement

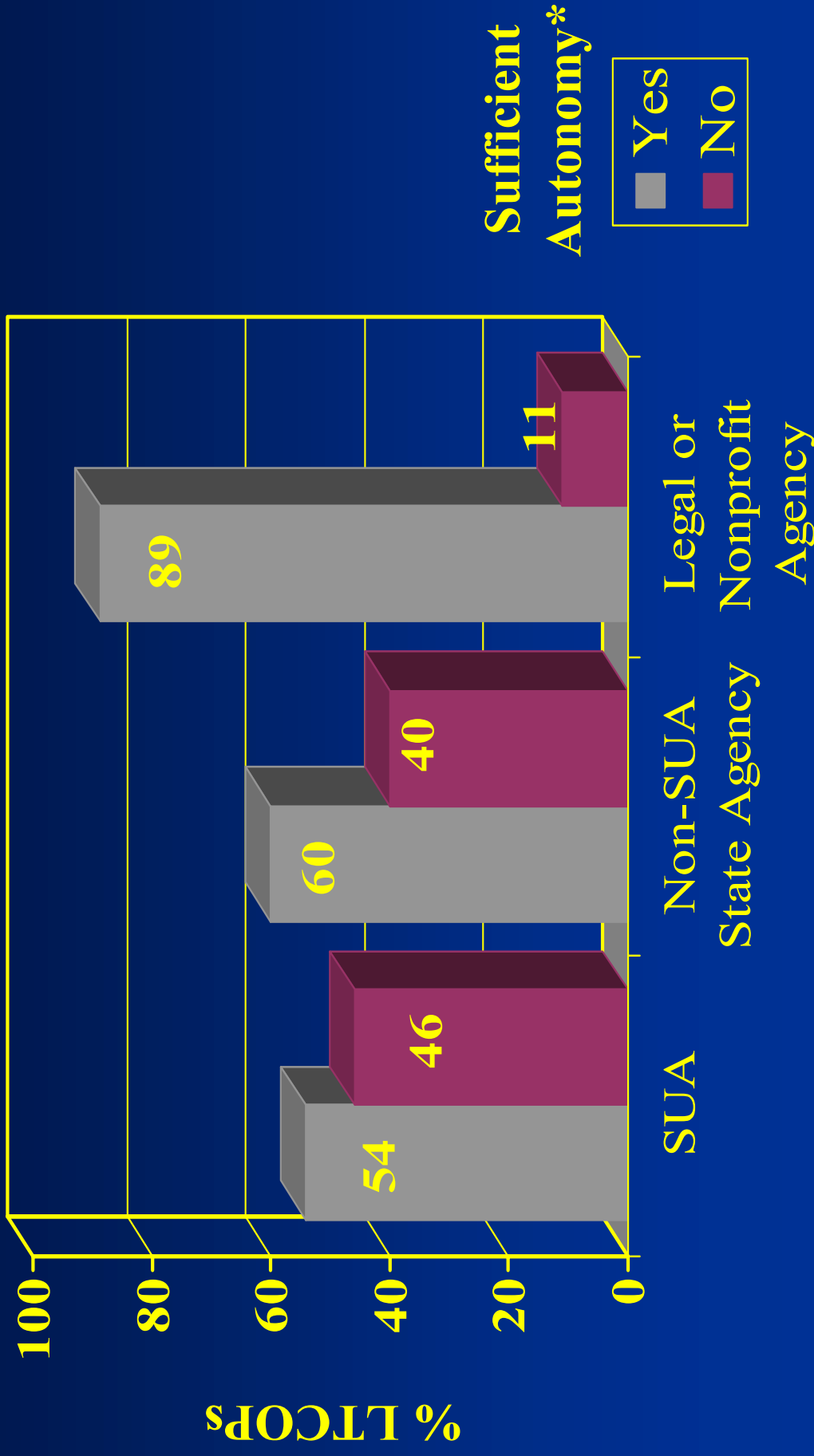
	#	%
SUA	20	38.5
SUA in Umbrella with Licensing Agency	9	17.3
SUA in Umbrella without Licensing Agency	8	15.4
Independent State Agency	4	7.7
Within Other State Agency	2	3.8
Legal Agency	2	3.8
Nonprofit Agency	7	13.5

Difficulties in Service Provision Due to Placement of LTCOP*

	% YES
SUA	62.2%
Non-SUA State Agency	60.0%
Legal or Nonprofit Agency	22.2%

**self-reported data*

Autonomy Associated with Placement



**self-reported data*

Ombudsman Program Autonomy

*Statistically Significant Associations**

Ability to carry out federal mandates independently from other state agencies

Supportive political and social climate

Effectiveness of advocacy efforts

Freedom from excessive legislative/regulatory restrictions

Lines of authority/accountability clearly defined for state & local ombudsmen

“Sufficient
Autonomy”

**self-reported data*

Ombudsman Program Placement within SUAs

PROS

- Financial support/budget protection
- Administrative assistance
- Technical assistance
- In-house legal services
- Support/Advocacy for the program
- Facilities and supplies (access to state resources)

CONS

- Conflicts of interest
 - If housed with APS, Medicaid, or Licensing
 - As state employees
- Limited autonomy
- Limited contact with legislators/media
- Director may be appointed by governor

Autonomy Issues

“There is a lack of autonomy because we are part of the state... I believe if we were in a more autonomous setting we would be more effective, people would pay more attention to us, and our outcomes would matter more.”

– *State Ombudsman*

“There is a potential conflict of interest simply being in state government, in the department. We are not necessarily able to speak freely on behalf of residents. If the department has a policy that the LTC ombudsman feels may be detrimental, the ombudsman might be instructed not to say anything in court.”

– *State Ombudsman*

Effective Methods for Dealing with Organizational Placement Problems

- Work with more autonomous parties (e.g. CAGs, volunteers) that may:
 - advocate for residents
 - communicate with legislators/media
- Expose conflict of interest issues via media
- Communicate with and educate state agency directors licensing agency legislators

LTCOP Expenditures per LTC Bed

Mean

\$23.62

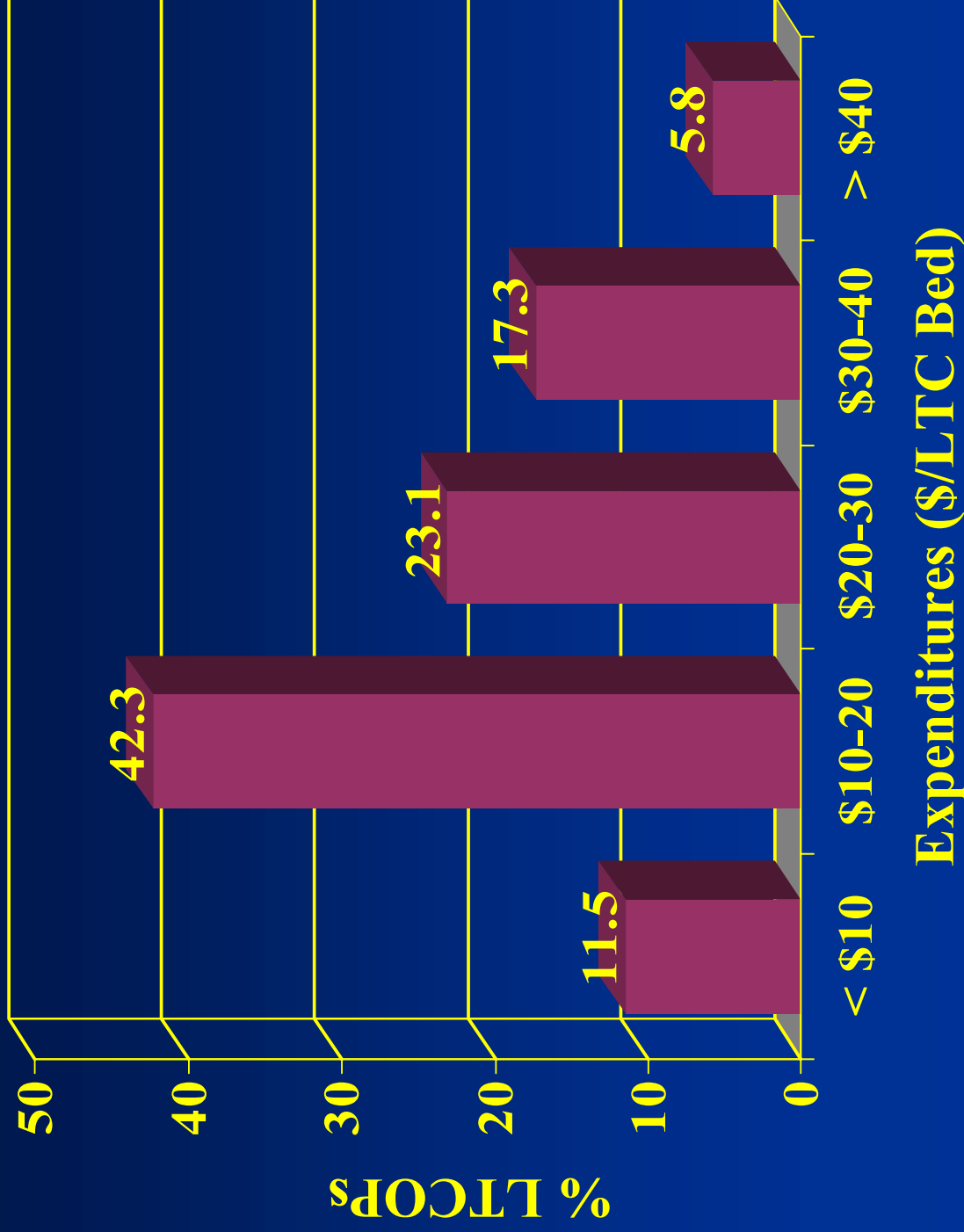
Standard Deviation

\$17.53

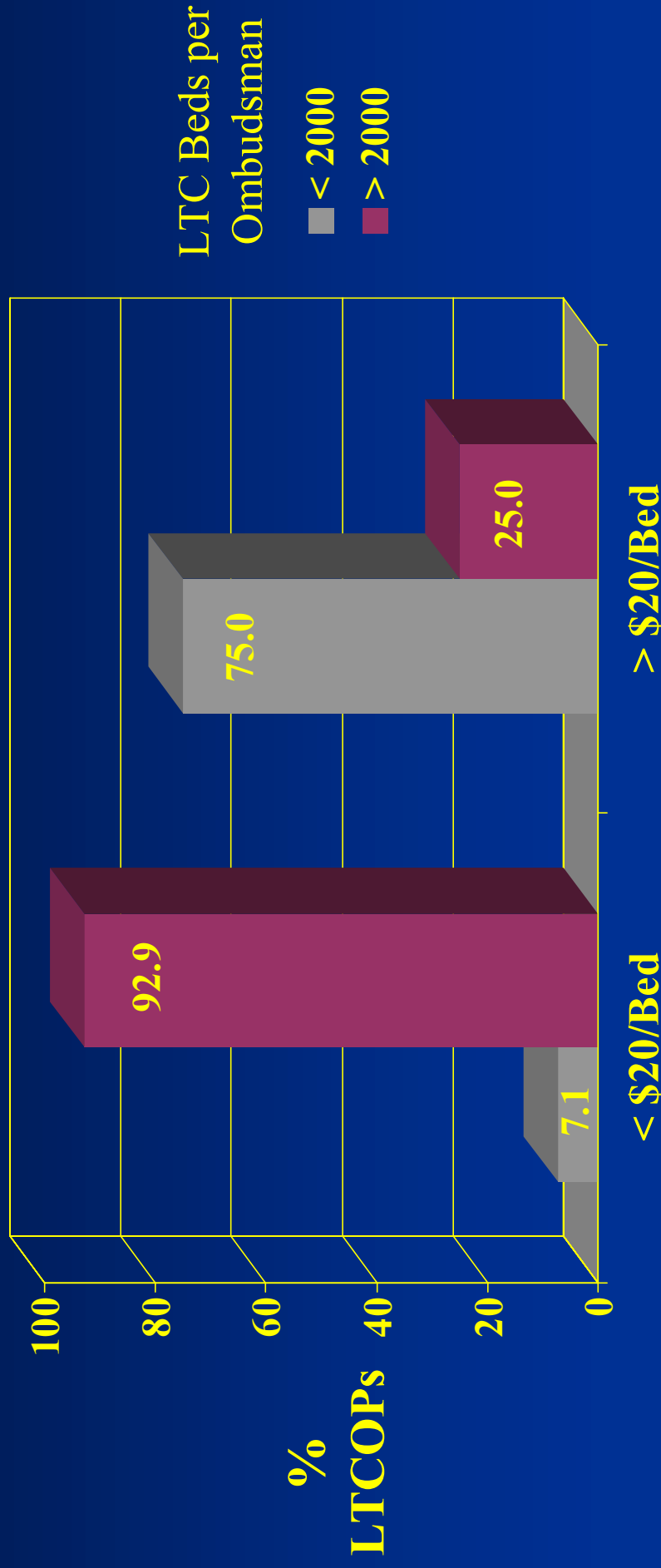
Range

\$4.57 to \$122.85

LTCOP Expenditures per LTC Bed



Funding and the LTC Bed to Ombudsman Ratio



Funding per Bed ($p < 0.001$)

Insufficient funding and inadequate levels of staff and volunteers are the greatest barriers to LTCOP effectiveness.

66.7% Ombudsmen say budget is inadequate to meet **federal** requirements

73.5% Ombudsmen say budget is inadequate to meet **state** requirements

Activities Neglected Due to Inadequate Funding

- Routine visits to facilities
- Community education and outreach
- Complaint investigation and resolution
- Response time to complaints
- Development of resident and family councils
- Systemic advocacy
- Volunteer recruitment/supervision
- Expansion into Board & Care and Assisted Living

Additional Funding Needed to Carry Out LTCOP Mandate

Additional Funding Needed*	%
< \$200,000	38.7
\$200,001 to \$500,000	22.6
\$500,001 to \$700,000	9.7
\$700,001 to \$1,000,000	16.1
> \$1,000,000	12.9

**self-reported data*

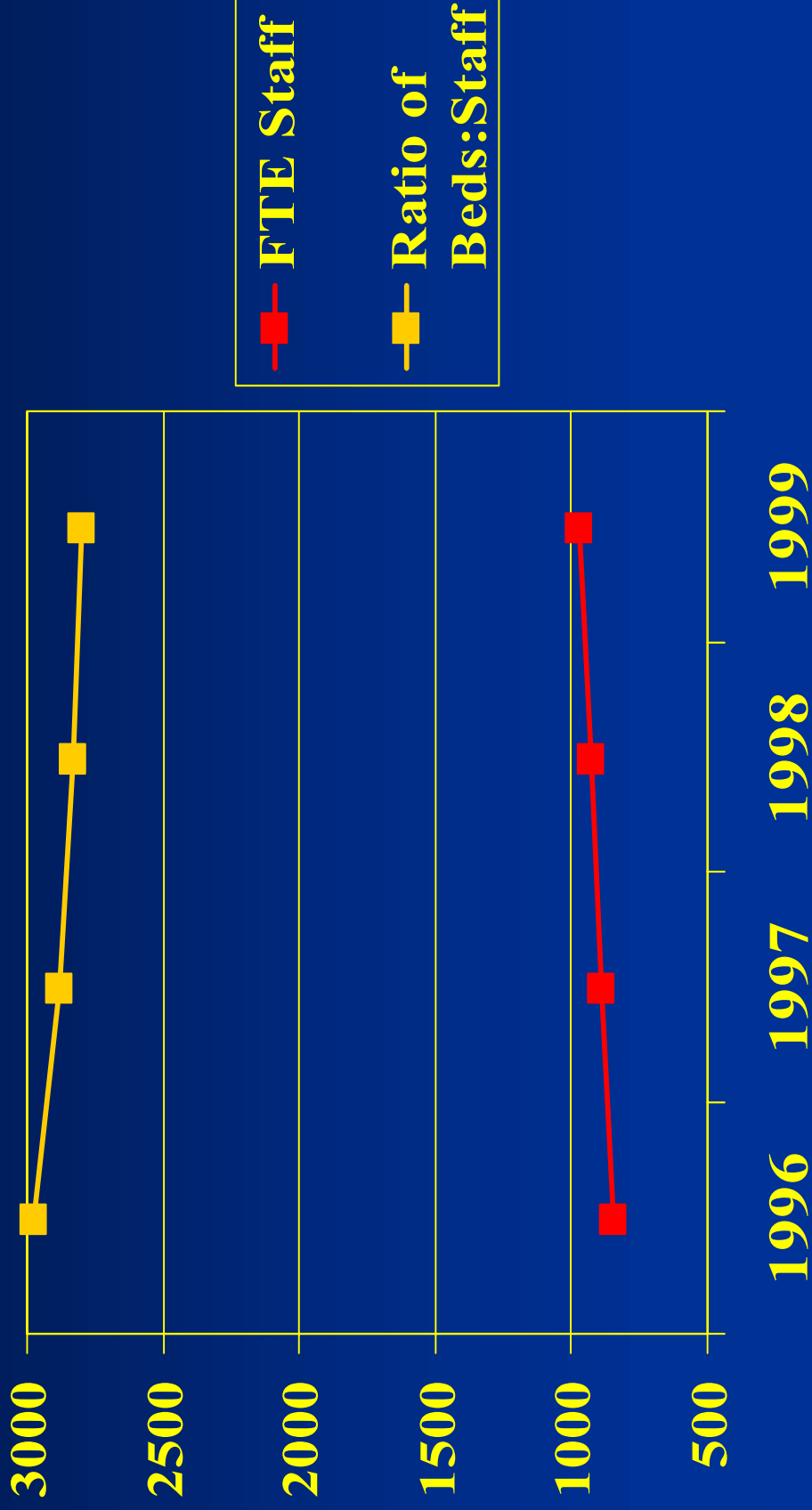
Obstacles to Obtaining Needed Funding

- Political climate/focus
- Lack of program visibility
- LTCOP is not a priority within state agency
- Nursing home industry lobby opposition
- Legislative process
- Fiscal situation in state
- Federal budget process

Staff and Volunteer Trends

	FTE Staff	Certified Volunteers	Ratio of Beds:Staff
FY 1999	974	8,451	2,801
FY 1998	927	7,359	2,832
FY 1997	887	6,795	2,878
FY 1996	847	6,622	2,973

Trends in Ombudsman Staff and Ratio of LTC Beds:Staff (1996-1999)



**Ratio of LTC Beds to Staff is
significantly associated
with the percent of nursing
facilities visited in a year
($p = 0.009$)**

Effectiveness of LTCOPs at the State Level*

	#	%
Very Effective	16	30.8
Somewhat Effective	33	63.5
Neutral	1	1.9
Somewhat Ineffective	2	3.8
Very Ineffective	0	0

**self-reported data*

Effectiveness of LTCOP Program & Resources*

Question	% Yes
Able to represent interests of residents to state agencies	100.0
Freedom from excessive legislative/regulatory restrictions	84.6
Supportive political and social climate	75.5
Adequate communication system	68.8
Sufficient legal services	66.7
Sufficient autonomy due to organizational placement	60.8
Sufficient funding	22.0
Sufficient staff	21.2

**self-reported data*

Effectiveness in Meeting Statutorily Mandated Requirements*

Statutorily Mandated Requirement	% Very Effective	% Somewhat Effective	% Neutral/ Ineffective
Complaint Investigation	61.5	34.6	3.4
Community Education	23.1	63.5	13.5
Resident/Family Education	17.3	67.3	15.3
Monitoring laws and regulations	34.6	51.9	13.5
Legislative/Administrative Advocacy	23.1	50.0	26.9

**self-reported data*

Effectiveness of LTCOPs

- Majority of state ombudsmen rate their programs as effectively meeting OAA responsibilities
- Effectiveness is limited most by:
 - Inadequate autonomy due to placement
 - Inadequate resources (funding, staff, legal services)
 - Inability to conduct systemic advocacy

Recommendations: Organizational Structure/Placement

- Conflicts of interest due to organizational placement should be removed (IOM)
- LTCOP should not be located with APS, Medicaid, or licensing agency (IOM)
- Greater independence from state would allow ombudsmen to freely advocate for LTC residents (IOM)

Recommendations: Resources

- Support the IOM standard of:
1 FTE staff ombudsman per 2000 LTC beds
- Enhance funding to allow LTCOPs to meet federal and state requirements
- Ensure adequate legal services
- Increase legislative support

Recommendations: Systemic Advocacy

- Break down barriers by working with providers, CAGs, and family/resident councils
- Increase funding/staffing to focus ombudsman efforts on advocacy requirements
- Increase program visibility
- Strengthen commitment by policy makers

Recommendations: Quality of Care

- Strengthen advocacy for adequate staffing levels, supervision, and training in LTC settings
- Augment visitation to all LTC settings
- Enhance monitoring of Board & Care, Assisted Living, and other LTC settings

Recommendations: Relationship with Regulatory Agencies

- Continue to work to improve relationship with state agencies that have enforcement authority (IOM)
- Increase communications between parties (i.e. SUA administration and licensing agencies) by setting up work groups or negotiating MOUs.

Recommendations: Interagency Coordination

- **State and Local programs**
 - Training, supervision, technical assistance, educational materials, and information on advocacy issues
- **SUAs**
 - Increase financial and moral support, as well as autonomy
- **Citizen's Advocacy Groups**
 - Work together on legislative agendas, attend each others meetings, sponsor joint training, and form coalitions with resident/family councils

Recommendations: FUTURE RESEARCH

- Conduct research to develop criteria for minimum levels of ombudsman program visits (OIG, 1999)
- Support the development of criteria for ombudsman complaint response and resolution times
- Conduct research on the implications of the Olmstead decision
- Conduct further research on the assisted living facility industry, specifically on monitoring care and residents' rights
- Conduct further research on the implications of managed care